Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 3.31.13

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

KanCare
Section 1115 Quarterly Report
Demonstration Year: 1 (1/1/2013-12/31/2013)
Federal Fiscal Quarter: 2/2013 (1/13-3/13)

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I. Introduction

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

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

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

This five year demonstration will:

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

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

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

integration and coordination of care; and

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

This quarterly report is submitted pursuant to item #79 of the Centers for Medicare & Medicaid Services Special Terms and Conditions (STCs) issued with regard to the KanCare 1115(a) Medicaid demonstration program, and in the format outlined in Attachment A of the STCs.

II. Enrollment Information

The following table outlines enrollment activity related to populations included in the demonstration. It does not include enrollment activity for non-Title XIX programs, including the Children's Health Insurance Program (CHIP), nor does it include populations excluded from KanCare, such as Qualified Medicare Beneficiaries (QMB) not otherwise eligible for Medicaid. The table does include members retroactively assigned for the first quarter known as of April 27, 2013.

Demonstration Population	Enrollees at Close of Qtr. (3/31/2013)	Total Unduplicated Enrollees in Quarter	Disenrolled in Qtr.
Population 1: ABD/SD Dual	17,453	18,650	1,197
Population 2: ABD/SD Non Dual	28,587	29,400	813
Population 3: Adults	31,353	35,175	3,822
Population 4: Children	209,473	222,331	12,858
Population 5: DD Waiver	8,711	8,774	63
Population 6: LTC	21,451	22,765	1,314
Population 7: MN Dual	1,170	1,318	148
Population 8: MN Non Dual	1,178	1,375	197
Population 9: Waiver	4,493	4,626	133
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**323,869**	**344,414**	**20,545**

III. Outreach/Innovation

The KanCare website, www.kancare.ks.gov, is home to a wealth of information for providers, consumers, stakeholders and policy makers. Sections of the website are designed specifically around the needs of consumers and providers, and information about implementation activities, as well as the

Section 1115 demonstration itself, is provided in the interest of transparency and engagement.

KanCare Advisor, the State's electronic implementation newsletter, is distributed to about 200 individual subscribers and various provider and consumer associations. Newsletters were distributed in the first quarter of the Demonstration Year on Jan. 3, Jan. 17, Jan. 31, Feb. 14 and March 5. In addition to distribution to subscribers, the Advisor is also available on the KanCare website.

During the first quarter of the Demonstration Year, the Kansas Department of Health and Environment (KDHE) implemented a targeted $116,145 outreach project, partially supported by a $50,000 grant from the REACH Healthcare Foundation. Projects reached the grantor's service area in Kansas – Wyandotte, Johnson and Allen counties – and other areas statewide, including urban counties such as Sedgwick and Shawnee counties, and rural counties across the state. Project planning took place in December 2012, with the outreach occurring January through April 2013. Under the grant agreement, KDHE partnered with three advocacy organizations—Kansas Association for the Medically Underserved, Kansas Action for Children and Kansas Health Consumer Coalition—to determine the direction of the project and the content of the products. Outreach products included media buys (i.e. radio spots) and postcards mailed to Medicaid patients of safety net clinics. The project also purchased Facebook and Google ads, as well as magazine advertisements in *Active Aging* for the months of February, March and April.

Two radio spots (Phase I and Phase II) were developed in English and in Spanish and were aired on nine stations in the Kansas City area, nine in Sedgwick County, two in Allen County, two in Shawnee County, two in western Kansas, and one in Crawford County. Phase I radio spot ran for two weeks starting Jan. 14, and Phase II ran for two weeks starting Feb. 11. In between the radio spots, the KanCare postcards were mailed to beneficiaries.

Postcards were designed in English and Spanish, printed and distributed to more than 51,000 families, including a mailing supported by a related grant received by one of the advocacy partners (KAMU).The postcard was 6"x9" and included the same information in both English and Spanish language.

The KanCare Consumer Assistance line received calls from consumers asking about the postcard and what it meant to them, especially from those who had not yet opened their KanCare enrollment packet at that time. The targeted outreach project complemented the State's broad outreach efforts and aided overall communication efforts with KanCare beneficiaries and expanded the reach to include soon-to-be consumers (new applicants).

State staff also continued educational tours for consumers during the first quarter of the Demonstration Year. The first quarter meetings were focused on providing consumers with information they would need during the choice period, as well as fielding and responding to questions about the implementation. A summary of consumer and provider outreach activities conducted by the State and the KanCare managed care organizations – Amerigroup Kansas, Sunflower State Health Plan, and United Healthcare Community Plan – follows below.

Outreach activities conducted by State of Kansas staff during the first quarter of the KanCare program include:

Consumer Meetings	
City	Attendees
Olathe	99
Topeka	96
Kansas City	83
Salina	67
Manhattan	51
Garden City	47
Parsons	44
Winfield	43
Dodge City	32
Wichita	24
Fort Scott	17
Hays	16
Total Consumers	619

Provider Meetings	
City	Attendees
Wichita	80
Topeka	60
Olathe	50
Hays	50
Parsons	33
Dodge City	24
Total Providers	297

Nursing Facility Meetings	
City	Attendees
Parsons	6
Hays	6
Topeka	2
Salina	10
Manhattan	18
Junction City	50
Total Nursing Facility Attendees	92

In addition to the formal educational tours, State staff has conducted a number of meetings on request of particular stakeholder groups during the first quarter, including but not limited to:

- Stormont Vail Social Workers
- Haskell Health Clinic
- Early Childhood Collaborative Organization
- Prairie Band Potawatomi Tribal Members
- Families Together
- Leading Age Kansas
- Kansas Healthcare Association
- Kansas Adult Care Executives
- Kansas Advocates for Better Care
- Douglas County Council on Aging
- Kansas Hospital Association
- Kansas Association for the Medically Underserved

Further, Kansas Department for Aging and Disability Services (KDADS) staff have participated in or led the following meetings:

- Monthly KanCare update presentations to Association of Community Mental Health Centers
    - Includes separate meetings (at times weekly for TA) with:
        - Executive Directors
        - Substance Use Disorder agency directors
        - SED waiver provider directors
        - Billing directors
- Psychiatric Residential Treatment Facility stakeholders – weekly for a period of a few months during this time period
- SUD provider group and its association – Kansas Association of Addictions Professionals
- Community Developmental Disability Organization (CDDO) provider group
- Financial Management Services (FMS) provider workgroup

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

Marketing Activities: Amerigroup's first quarter marketing activity was focused on building relationships and learning more about the value it can bring to the community. During this time Amerigroup also participated in conferences, health fairs, community events, including:
- Kansas Mission of Mercy
- KanCare educational tours

Outreach Activities: First quarter activity focused on welcoming new members to the plan, gathering information about the members, and reminding members about the importance of EPSDT services.
- New Member Welcome Calls (phone)
- Immunization Reminder Calls (phone)

- Information about Real Solutions Healthy Rewards program (mail)

Advocacy Activities: First quarter advocacy activity was focused on working with the CDDOs and Independent Living Centers to discuss current and future collaboration activity, services and benefits, and program feedback. Amerigroup is also developing its advisory committees and the strategic direction of these committees.
- SKIL, ILRC
- Tri-Valley and COF CDDO

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

Marketing Activities: Sunflower averages approximately 20 events a month in which it educates members and providers about the services Sunflower provides and the organization as a whole. In addition to the events, Sunflower also regularly updates its website and collateral materials for both providers and members. Sunflower meets with its Medical Management and Provider Relations leads to determine what educational pieces they need to help share Sunflower's message effectively.

Outreach Activities: Sunflower is focused not only on marketing its services to KanCare members but also leveraging its outreach effort in partnership with the community to assist members in unique ways to help improve the quality of members' circumstances when possible. In a recent example, Sunflower joined forces with the Eudora Methodist Church group, Kingdom Builders, to provide a much-needed, accessible ramp for the family of a 13-year-old Eudora boy with a developmental disability. The family found out that their emergency request for a ramp was denied by their CDDO because the need did not meet the crisis definition. The family and their Targeted Case Manager then reached out to Sunflower State Health Plan. Sunflower agreed to work with Kingdom Builders to meet the family's need.

Advocacy Activities: Additionally, in the first quarter, Sunflower has attended the following, along with meeting with CDDOs, Aging and Disability Resource Centers (ARDCs), and other organizations to find out how it can best partner with them to make sure members get the care they need:

Date	Event	Time	Location	Focus of Group (if applicable)	Approx. attendance
3/16/2013	Grant County Health Fair	7am-Noon			300+
3/28/2013	Sunflower State Apartments	1pm	Sunflower Apartments Merriam, KS	Seniors	25+
3/28/2013	United Methodist Mexican-American Ministries	5 days	Dodge City	Mexican-Americans	150+

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

Marketing Activities: UnitedHealthcare's main activities have been focused on education with regard to the changes in KanCare and the benefits of United, through member welcome calls, mailings to those who could not be reached by phone, and sending the first Member Newsletter to those enrolled with United.

- For the initial welcome call campaign, United reached over 80,200 members either live or through voice mail, with over 30,600 of those members live. Through those calls United was able to complete over 23,900 health risk assessments. Of those members United could not reach, the plan mailed postcards to their homes asking them to call. United received over 630 inbound calls from members who received the postcard.

- In January, United mailed newsletters to the members in its initial membership roll, welcoming them to the plan and providing them with information about KanCare as well as United benefits.

Outreach Activities: United has three outreach specialists focused on activities targeted within a designated geographic area of Kansas. Their jobs are to be out in the communities, educating members, community based organizations and provider offices about UnitedHealthcare, its work with KanCare and the benefits of the plan. They especially inform individuals about value added benefits. United also has a Provider Marketing Manager whose role is to work with key provider offices throughout the State to assist them with issues regarding the transition to KanCare and to make sure they are educated on the benefits of United.

- During the first quarter of 2013, United staff personally met with over 6,980 individuals who were members or potential members at community events, at member orientation sessions, and at lobby sits held at key provider offices throughout Kansas.

- During the first quarter of 2013, United staff personally met with over 640 individuals from community based organizations located throughout Kansas. These organizations work directly with members in various capacities.

- During the first quarter of 2013, United staff personally met with over 630 individuals from provider offices located throughout the State.

Advocacy Activities: First quarter activities in advocacy were focused on educational efforts surrounding KanCare and the benefits of UnitedHealthcare to members across the state. That includes special outreach to individuals with developmental disabilities. United has one Outreach Specialist focused specifically on working with Kansans with disabilities and their advocates.

- The outreach specialist to people with disabilities visited with over 275 advocates for people with disabilities in Kansas, providing them with education on KanCare and United benefits.

- That same outreach specialist also began work on receiving requests for proposals from organizations throughout Kansas who would like to work with United's Empower Kansans initiative which will be

focused on providing grant dollars to those organizations who are working to employ people with disabilities throughout Kansas.

IV. Operational Developments/Issues

a. Systems and reporting issues, approval and contracting with new plans: As the State has reported to CMS during weekly/monthly conference call updates, there have been concerns regarding systems and reporting issues, in line with expectations of a transition of this magnitude. Through a variety of accessible forums and input avenues, Kansas has been advised of these types of issues on an ongoing basis and worked either internally, with our MMIS Fiscal Agent, with the operating state agency and/or with the MCOs and other contractors to address and resolve the issues. One issue that continues to be in solution building mode is the timeliness and accuracy of information used via the electronic visit verification, authorization and claims submission process for members who self-direct their HCBS waiver services. Regarding contracting, CMS reviewed and approved contract amendments made during the quarter to conform with the STCs and other regulatory requirements.

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 used, per KanCare MCO's top three value-added services by reported value and total, January-March 2013:

MCO	Value Added Service	Units	Value
Amerigroup	Adult Dental Care	523	$74,247.60
	Healthy Rewards member incentive program	1,089	$48,500.00
	Healthy Families Program	32	$31,496.36
	Totals for Amerigroup – all VAS – Jan-Mar	*11,508*	*$258,321.93*
Sunflower	CentAccount debit card	32,914	$658,385.00
	SafeLink/Cenaccount cell phones	6,029	$288,367.07
	Dental visits for adults	8,918	$192,745.26
	Totals for Sunflower – all VAS – Jan-Mar	*66,480*	*$1,228,064.10*
United	Additional vision services	7,422	$278,028.12
	KAN Be Healthy Screening	6,298	$61,780.00
	Membership to Youth Organization	888	$39,960.00
	Totals for United – all VAS – Jan-Mar	*17,220*	*$445,594.12*
Combined Totals – all MCOs – Jan-Mar 2013		**95,208**	**$1,931,980.15**

c. Enrollment issues: For the first quarter of 2013 there were 12 American Indians/Alaska Natives who chose to not be enrolled in KanCare per the opt-out provision available to AI/AN members.

The table below represents the enrollment reason categories for the first quarter of 2013 (months February and March). All KanCare eligible members were assigned to a plan for January 1, 2013, and had the opportunity to choose a different plan prior to January 1. Changes requested after January 1 were effective the first day of the following month. The numbers below represent those persons who made a change in their MCO assignment or were newly eligible after the enrollment date of January 1, 2013.

Enrollment Reason Categories:

Start Reasons	Total
Newborn assignment	6
KDHE- administrative change	6
WEB - Change Assignment	22
KanCare Default - Case Continuity	791
KanCare Default - Morbidity	797
KanCare Default - Previous Assignment	3907
KanCare Default - Continuity of Plan	427
Choice - Enrollment into KanCare via Medicaid App	609
Change – Enrollment Form	2481
Change-Choice	13,250
Total	22,296

d. Grievances, appeals and state hearing information

Information related to Amerigroup Kansas

Total Member Appeals Received in Quarter	6
Total # of Received Appeals that are Resolved	6
Total # of Appeals Where Decision was Upheld	1
Total # of Appeals Where Decision was Overturned	3

Summary of Appeals Received:
Six (6) member appeals were received in Quarter 1. Two were withdrawn because they were grievances for balance billing (there was no denial of services); they were rerouted to Amerigroup's grievance specialist. Of the remaining four, three were pharmacy appeals and one was for high technology radiology (MRI). The MRI was overturned with additional information provided that supported medical necessity. Of the three pharmacy appeals, one (Remicade) appeal was upheld, and the other three were overturned. Lidoderm was overturned under the Continuity of Care Policy and the other two appeals (for Elidel cream and Suboxone) were overturned with additional information provided to support medical necessity.

Total Grievances Received in Quarter	226
Total # of Above Grievances Resolved	202
Transportation-Related Grievances Received in Quarter	104

This includes grievances resolved during the reporting period

Transportation Related Grievance Trends and Actions to Prevent Recurrence

One hundred four (104) transportation related grievances. Eighty-seven (87) availability, 10 attitude/service of staff, five billing and financial issues, and two accessibility of office. Access 2 Care was made aware of and worked to resolve the transportation issues. Transportation is available, and Access 2 Care is actively reaching out to members, and has taken corrective action with contracted transportation providers who have violated company policies such as arriving late and canceling appointments without adequate notification. Additionally, members have received mileage reimbursement for transportation they have provided and arrangements have been made for requesting members to ride exclusively with their preferred transportation providers.

Count of Non-Transportation Grievances By Category	#
Access to Service or Care	1

Information regarding available participating providers given to members, assistance finding preferred providers in their geographic area. Provider Relations continues network outreach/contracting for the expansion of participating providers.

	#
Service or Care Disruption	3

Not all current PCPs are available to members as participating providers. Assistance has been provided to help. Members wanted to change PCPs, but preferred provider that is either not in the Amerigroup network or had not completed the credentialing process yet. Provider Relations continues network outreach/contracting for the expansion of participating providers.

	#
Benefit Denial or Limitation	13

Some members had challenges with qualifying for Safelink for a variety of reasons, such as not living where this benefit is provided, not providing a physical address. Other members were not pleased with the dispensing of generic medications or want Chiropractic services to be covered. Amerigroup assisted members to locate participating providers.

	#
Claims/Billing Issues	23

Members received bills from a variety of providers and facilities. Provider Relations Representatives have contacted providers and facilities for re-education that members are not to be balanced billed for services.

	#
Member Rights/Dignity	4

Members felt their provider didn't have time to help them, listen when they were trying to explain their issues, do thorough examination, or schedule procedures they think they should

have. All issues related to possible quality of care concerns were directed to the Quality Management Nurses for investigation. Any substantiated concerns were elevated to the medical director who followed up with providers for corrective action, as warranted.	

	#
Customer Service	49
Members felt their providers/staff/vendors didn't treat them well, wanted new case worker, or were fired by their PCP. Some members had use issues with their healthy rewards card or wanted a larger ID card. Grievances related to staff attitudes were directed to the respective management area for staff education and follow-up. Issues related to possible quality of care concerns were directed to the Quality Management for investigation. Any substantiated concerns were elevated to the medical director who followed up with providers for corrective action, as warranted.	

	#
Health Plan Administration	9
Members had issues with confirming eligibility, ordering OTC medications online, and wanted to change their assigned PCPs. Members were provided education on how to obtain assistance.	

	#
Clinical/Utilization Management	2
A member complained about his LTSS Coordinator. Another member said there was a delay when he tried to get in contact with Case Management. Complaints regarding individual service coordinators or case managers were referred to the appropriate management area for staff education and follow-up.	

	#
Quality of Service or Care	5
Members felt they received inappropriate treatment. These issues went to Quality Management Nurses as a Quality of Care concern. They were investigated and any substantiated concerns were elevated to the medical director who followed up with providers on corrective action.	

	#
Other	13
Members requesting additional assistance with services such as getting new eyeglasses, specialist referrals, respite care, and reimbursement. Members were provided education on how to obtain assistance.	

Information related to Sunflower State Health Plan

Total Member Appeals Received in Quarter	16
Total # of Received Appeals that are Resolved	16
Total # of Appeals Where Decision was Upheld	9
Total # of Appeals Where Decision was Overturned	7

Summary of Appeals Received:
The only duplicate appeals were for anesthesia during dental work and epidural steroid injections. No other trends were identified.

Total Grievances Received in Quarter	115
Total # of Above Grievances Resolved	115
Transportation-Related Grievances Received in Quarter	87

Transportation Related Grievance Trends and Actions to Prevent Recurrence

Many of the transportation issues in the first quarter were identified as process issues with vendor. The decision was made to change vendors on 3/1/13.

Count of Non-Transportation Grievances By Category	#
Access to Service or Care	6

Members were not assigned to the PCP they would like to have or the family had several different PCP's. All issues identified were corrected immediately.

	#
Service or Care Disruption	0

N/A

	#
Benefit Denial or Limitation	0

N/A

	#
Claims/Billing Issues	7

No trends identified at this time

Member Rights/Dignity	0

N/A

	#
Customer Service	3

No trends have been identified at this time. All customer service issues are followed up with each provider.

Health Plan Administration	# 8
Members' initial member cards were all in this issue. The members did not receive them timely, or had the wrong PCP on them.	

Clinical/Utilization Management	# 2
Members had concerns about medications.	

Quality of Service or Care	# 2
No trends identified at this time	

Other	# 0
N/A	

Information related to UnitedHealthcare Community Plan

Total Member Appeals Received in Quarter	8
Total # of Received Appeals that are Resolved	3
Total # of Appeals Where Decision was Upheld	2
Total # of Appeals Where Decision was Overturned	1

Summary of Appeals Received

With only three closed member appeals, there is not much of a trend. There was an appeal for a non-covered dental service, a pre-service appeal (lack of medical necessity) for durable medical equipment, and a post-service appeal based on lack of medical necessity documentation. The lack of documentation appeal was overturned upon appeal and receipt of the necessary information.

Total Grievances Received in Quarter	113
Total # of Above Grievances Resolved	90
Transportation-Related Grievances Received in Quarter	80

Transportation Related Grievance Trends and Actions to Prevent Recurrence

The majority of the transportation grievances were related to provider no shows or late rides, with a few regarding rudeness of the driver. Prior to and During start-up, UnitedHealthcare had daily communication with Logisticare regarding initial member needs and ensuring the transition for critical members was smooth. Since then, United has had open communications with Logisticare management as well as monthly meetings to review statistics and outstanding issues. When a grievance is received, Logisticare provides prompt training and education to drivers who have had grievances filed against them. The volume of transportation related grievances continues to decrease.

Count of Non-Transportation Grievances By Category (29 non-transportation member grievances were closed in the first quarter)

	#
Access to Service or Care	9
These grievances were related to provider network gaps and eligibility. The provider network continues to grow and eligibility issues have been mitigated since the beginning of the year.	
Service or Care Disruption	0
n/a	
Benefit Denial or Limitation	3
Each of these grievances was related to a specific benefit limitation. No trends were identified.	
Claims/Billing Issues	5
Three of these grievances were related to providers billing members. The health plan continues to educate providers regarding the legality of billing members.	
Member Rights/Dignity	0
n/a	
Customer Service	0
n/a	
Health Plan Administration	0
n/a	
Clinical/Utilization Management	0
n/a	
Quality of Service or Care	12
Seven of the twelve grievances were Quality of Care grievances that have been handled through	

the formal Quality of Care process. The other five were related to services received in the provider's office. Each of these providers has been consulted and provided feedback and/or reeducation as appropriate.

Other	#
n/a	0

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

f. Changes in provider qualification standards: None occurred during the quarter.

g. Access: The 90-day continuity of care period, which included the ability for members to continue to see providers with whom they had established relationships, even if those providers were not yet in network with a member's MCO, was a successful transitional tool. Still, State staff worked in close coordination with the KanCare call center to identify and respond to access concerns and issues raised during the first quarter. That included outreach to providers to provide clarifying information about the continuity of care period and address their questions so that members were able to access those providers.

In another example, to mitigate provider questions about eligibility during the short time between when beneficiaries are deemed eligible for KanCare and when the MCOs and their subcontractors receive and load the eligibility files (within 24 hours for the MCOs and two days for subcontractors), the State conducted provider education regarding preferred alternatives for confirming eligibility.

As noted in the MCO grievance summaries above, the first month of implementation revealed some issues with transportation, including beneficiaries who had not updated their addresses and therefore the NEMT subcontractors would not schedule transportation; beneficiaries appearing ineligible; NEMT no-shows for pick-ups; and late pick-ups. The MCOs have been responsive to the grievances and other concerns expressed regarding transportation services, including the change of transportation vendors by one of the MCOs, effective April 1. The State anticipates a marked drop in NEMT-related grievances in the quarter beginning April 1.

Concerns about pharmacy services were identified early, as the billing is point of sale. Issues included the previously noted lag between initial eligibility and eligibility in the MCOs' systems, conformity with State prior authorization and other policies, and provider confusion regarding spenddown and how these claim payments looked compared to fee for service. As described above, the State has worked with the MCOs on provider education to alleviate the first of these

issues. Conformity with State policy has been addressed with the plans by the KDHE Pharmacy Program Manager during weekly calls with all three MCOs as well as during weekly calls with each plan individually. Many details have been clarified regarding prior authorizations, NDC coverage, third party liability and Medicare Part D copays. The State continues to work with the MCOs to resolve issues as they arise.

At the end of the first quarter, at the request of the State, the MCOs extended the initial 90-day continuity of care (COC) period to providers in the process of contracting and credentialing to facilitate access as the plans continued to develop their networks.

To address access issues post-COC and choice period, KDHE will implement a Good Cause Change Request process after the choice period ends, April 5, 2013. This will allow a beneficiary to request to change plans if the current plan is not able to meet his/her needs, which includes providing access to care within the Geo Access standards set forth in the contract. The plans are tasked with proving network adequacy, attempting to contract with the provider whom the member is requesting, and offering other providers of like type/specialty.

In terms of Network Adequacy relating to access issues for members, the first quarter showed continued growth in each Plan's network. The Plans continue to aggressively add providers and work through the contracts and credentialing documents. Numbers of contracting providers are as follows (for this table, providers were de-duplicated by NPI):

KanCare MCO	# of Unique Providers as of 1/14/13	# of Unique Providers as of 3/26/13
Amerigroup	9,240	11,746
Sunflower	9,047	10,006
UHC	8,542	11,105

h. Proposed changes to payment rates: SPA #KS 13-03 re: Primary Care Physician Bonus. This SPA was approved on 4/25/13. The payments for qualifying Primary Care Physicians and Mid-level Practitioners are retroactive to 1/1/13.

i. Health plan financial performance that is relevant to the demonstration: There are no significant issues with health plan financial performance to report during this period.

j. MLTSS implementation and operation:
   1. The state, MCOs and at times providers meet weekly to provide technical assistance on various waiver topics through this quarter. Some of the topics have included: Money Follows the Person workflow, Substance Use Disorder specifics with providers, FMS specifics with providers, PRTF specifics with providers, SED waiver specifics with providers, Mental Health screening with providers, PRTF screening and appeals, HCBS specifics and

ICF/MR specifics with providers.

2. Beginning January 2013, the MCOs began using the State's Electronic Visit Verification (EVV) system. The State, the EVV contractor and MCOs continue to work through identified issues with providers to ensure the appropriate authorizations are in place in the system for both service delivery and billing. The State is in the process of identifying and making EVV system changes in order to make the process more efficient.
3. There were no Plan of Care (POC) reductions in the first quarter of KanCare. POC reductions must be reviewed and approved by the State. The State has developed an electronic process in which the MCO submits a POC reduction request along with requested customer information, and the HCBS program team reviews the request. If necessary the HCBS program staff will request additional information from the MCO and then deny or approve the MCO request. Because of the 90-day continuity of care period, no POC reduction requests were submitted in the quarter ending March 31, 2013.
4. MCOs are to have all members' initial Plans of Care complete within the first 180 days of KanCare. Status of that effort is reflected in the table below. The State reviews these totals weekly with MCOs. These totals are roughly half of the total membership, and the MCOs appear on track to have these initial POCs completed timely. LTSS Plans of Care completed by KanCare MCOs – as of 4.15.13:

Member Category	Amerigroup	Sunflower	United	Totals
HCBS	3959	3193	4434	*11,586*
Nursing Facility	1332	131	871	*2,334*
WORK Program	9	39	25	*73*
Totals	*5,300*	*3,363*	*5,330*	*13,993*

k. Updates on the safety net care pool, including Delivery System Reform Incentive Payment (DSRIP) Pool activities: Beginning in early 2013, State staff and partners from the two participating DSRIP hospitals (the University of Kansas Hospital and Children's Mercy Hospital) formed a DSRIP project team. In addition to representatives from the University of Kansas Hospital and Children's Mercy Hospital, the team includes the membership of the Kansas Department of Health and Environment (KDHE) Secretary, Dr. Robert Moser, KDHE Division of Health Care Finance Director Kari Bruffett, and Medicaid Director Dr. Susan Mosier. Additional project team members include staff from both DHCF and the Division of Public Health at KDHE. The project team will also incorporate input from the State's External Quality Review Organization (EQRO) and actuarial contractors for specific program deliverables. The project team will work to ensure the DSRIP project is implemented on time and according to the requirements of the Special Terms and Conditions (STCs) of Kansas Medicaid's Section 1115 Demonstration Waiver.

The team completed the following initial projects during the first quarter of Calendar Year 2013:

- Preparing a timeline of required deliverables for the DSRIP program based on the STCs;
- Developing a summary document of the DSRIP program to share with stakeholders and

other interested parties;

- Brainstorming focus areas and strategies for ensuring meaningful input from a variety of stakeholders;
- Completing stakeholder input activities in partnership with the Healthy Kansans 2020 Steering Committee; and
- Developing draft focus areas and submitting an associated report to CMS on March 29, 2013.

The project team continues to work toward the next set of deliverables for the DSRIP project—the planning and funding and mechanics protocols. These protocols will be vetted through a webinar and on the State's website for public comment during the next few months and submitted to CMS in accordance with the timeline stipulated in the STCs.

l. Information on any issues regarding the concurrent 1915(c) waivers and on any upcoming 1915(c) waiver changes (amendments, expirations, renewals):
   - TA waiver renewal due to CMS 4.30.13; effective 8.1.13
   - The State intends to amend the 1915(c) waiver for members with intellectual or developmental disabilities concurrent with the Section 1115 amendment to include LTSS for those members in KanCare.

m. Legislative activity: During the quarter ending March 31, the Legislature developed budgets for State Fiscal Years 2014 and 2015 that include funding for KanCare. Legislation to extend the carve-out of long-term services and supports for members with intellectual/developmental disabilities was proposed and had a hearing in the quarter, but it did not pass out of committee. In the report covering the next quarter, the State will detail efforts to use a designated portion of KanCare savings to reduce the waiting lists for the PD and I/DD waivers, as well as a budget proviso to require certain transition protections for I/DD members when their long-term services and supports are included in KanCare.

n. Other operational issues: The KanCare Advisory Council has continued to meet on a bimonthly basis. During the quarter, four external workgroups that were established in 2012 were consolidated into two workgroups, the Consumer and Specialized Issues workgroup, and the Provider and Operations Issues workgroup, each of which will meet quarterly. The Tribal Technical Advisory Group continued to meet on a monthly basis.

V. Policy Developments/Issues

In addition to the KanCare-specific legislative activity noted above, during the quarter ending March 31, 2013, the Legislature also reviewed options and analysis for Medicaid expansion under the Affordable Care Act. KDHE engaged Aon Hewitt actuaries to conduct an independent analysis of the estimated

enrollment and cost growth of a full expansion. The results of the analysis, as well as analyses performed the Kansas Policy Institute and the Kansas Health Institute, were shared with legislators and other policy makers during the quarter.

Governor Sam Brownback continued to have conversations with legislators and stakeholders as the State considers the most effective and sustainable solutions for the unique Kansas health care system. In late March a proviso was added by the Senate to the state budget that would require express consent of the Legislature before any ACA-related eligibility expansion could be implemented. Work on the budget continued into the second calendar quarter and will be detailed in the report covering that quarter.

Separately, KDHE and the Department for Children and Families continued to meet milestones in the development of the Kansas Eligibility Enforcement System, on pace for October 2013 Phase II go-live.

VI. Financial/Budget Neutrality Development/Issues

Budget neutrality: Because KDHE issues retroactive monthly capitated payments, only two payments were made during the quarter ending March 2013 (DY1-Q1): (1) a payment in February for January, (2) a payment in March for February. KDHE contacted CMS to inquire if only the two months of expenditures (and corresponding enrollment counts) reflected on the QE March CMS-64 should be reported on the budget neutrality report. Based on CMS guidance to include three months of data for DY1-Q1 (QE 3-31-13) in the quarterly report, the KanCare Budget Neutrality Monitoring Spreadsheet, attached, will not be able to be tied back to the CMS-64 on a quarterly basis. For the quarter ending June 2013 (DY1-Q2), the State will need to back out the April payment amount/enrollment for March and key in the July payment amount/enrollment for June. Based on this, the State is not using the CMS-64 as the source document, but rather is using a monthly financial summary report provided by HP, the State's fiscal agent.

Utilizing the HP-provided monthly financial summary, the data is filtered by MEG excluding CHIP and Refugee, and retro payments in the DY are included. KDHE collected payment data for long-term services and supports and targeted case management for members on the I/DD HCBS waiver, services which are currently carved out from managed care but required to be included in Budget Neutrality reporting. Expenditures for first quarter service dates (limited to those paid through April 30) have been added to MEG 5 (DD Waiver), and will be updated in the next report to include payments after April 30 for services in the first quarter.

General reporting issues: KDHE continues to work with HP, the fiscal agent, to create and revise reports in order to have all data needed in an appropriate format for efficient Section 1115 demonstration reporting.

VII. Member Month Reporting

MEG	2013-01	2013-02	2013-03	Grand Total
Population 1: ABD/SD Dual	17,788	17,593	17,466	**52,847**
Population 2: ABD/SD Non Dual	28,716	28,628	28,607	**85,951**
Population 3: Adults	31,820	31,603	31,355	**94,778**
Population 4: Children	213,118	211,158	209,478	**633,754**
Population 5: DD Waiver	8,706	8,712	8,718	**26,136**
Population 6: LTC	22,087	21,899	21,726	**65,712**
Population 7: MN Dual	1,240	1,214	1,182	**3,636**
Population 8: MN Non Dual	1,189	1,162	1,183	**3,534**
Population 9: Waiver	4,528	4,536	4,495	**13,559**
Grand Total	**329,192**	**326,505**	**324,210**	**979,907**

VIII. Consumer Issues

Summary of most common consumer issues seen during first quarter of KanCare program:

Issue	Resolution	Action Taken to Prevent Further Occurrences
Member's eligibility cannot be confirmed by pharmacy through MCO's system, so prescriptions cannot be filled (often within a day or two of eligibility being established)	When referred to the State, eligibility was confirmed, the MCO called pharmacy and prescriptions filled	Assurance that eligibility file is loaded in timely fashion by MCOs and their vendors Providers can confirm eligibility by directly accessing KMAP or calling customer service One MCO has identified an issue that they will address by making a program update to the monthly file; it is expected to reduce the number of these inquiries.
Incorrect information given to members and providers by customer service representatives	Instruction/correction of individual staff when issues were called to MCO's attention In one known case, MCO has covered services which were provided on the basis of incorrect information	Ongoing education of CSRs to understand the eligibility information available to them, the services which are covered by KanCare, and correct routing of calls

Unsatisfactory Assignment of Primary Care Physician/ Incorrect PCP named on Member ID card	Members are not restricted to seeing the physician named on ID card. During the 90-day "continuity of care" period, this could be an in-network or out-of-network provider. CSRs and providers were educated, when questions arose. Member's request to change PCP was honored, if the provider was in network; new ID card was issued with new PCP named. During the initial 90-day period, members could change to a different MCO to correspond with their preferred provider's network.	MCOs continue to add physicians to their networks, so there is an increasing number of "matches" between members and PCPs.
Contracting/Credentialing delays created PCP assignment issues	Some plans were able to capture member's preference and update PCP election when the provider's credentialing was completed and the system reflected him/her as "in network"	Contracting timelines are being closely monitored
Individuals in family units assigned to different MCOs	Members were allowed to request reassignment, as desired, during 90-day choice period.	Members joining a new family unit are allowed to change MCOs (this is considered a "good cause reason" for reassignment)
Transportation issues: difficult to arrange rides; rude drivers; drivers late for appointments or fail to show up.	Transportation vendors provide ongoing education of staff and drivers in response to grievances.	One MCO changed NEMT vendor at the end of the quarter.
System only shows one "responsible person" which caused CSRs to refuse to speak with other family members (i.e., father listed as RP for a child, but mother calls in to discuss case.)	MCOs created a field for additional responsible party(ies) to be named, once proper documentation is provided.	Ongoing education of CSRs
Prescriptions and other services delayed or denied for lack of a prior authorization (PA)	Some PA requirements were relaxed per advice of State Program Managers and Pharmacist. Providers advised of necessary documentation needed to obtain PA, and allowed to resubmit.	For pharmacy, the State's Pharmacist is monitoring MCOs' PA lists to ensure they are consistent with State policy.
Incorrect application of spenddown	MCO education to providers on how to properly apply claims to patient responsibility (spenddown)	

IX. Quality Assurance/Monitoring Activity

Kansas has created a broad-based structure to ensure comprehensive, collaborative and integrated oversight and monitoring of the KanCare Medicaid managed care program. KDHE and KDADS have

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

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

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

The State values a collaborative, race-to-the-top approach that will allow all KanCare MCOs, providers, policy makers and monitors to maximize the strength of the KanCare program and services. Kansas recognizes that some of the performance measures for this program represent performance that is above the norm in existing programs, or first-of-their-kind measures designed to drive to stronger ultimate outcomes for members, and will require additional effort by the KanCare MCOs and network providers. Therefore, Kansas will 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 operationalize; 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 has been completed (and as it recurs over time), as determined by Kansas, the final details as to each measure will be communicated and will be binding upon each MCO. These operational adjustments and updates will not require contract amendments, but will be documented as part of the quality strategy or in related operational guidelines and will be binding upon and put into place by each MCO.

During the first quarter of KanCare operation, some of the key quality assurance/monitoring activities have been:

- Ongoing and at least weekly business meetings between KDHE's KICCM team, other state staff as relevant to the subject matter, and cross-function/leadership MCO staff to develop extensive operational details and clarity regarding the KanCare State Quality Strategy. Specific attention was paid to developing additional specificity for each of the performance measures and pay-for-performance measures in the KanCare program.
- Deployment of focused cross-agency and MCO staff task teams to update each portion of the State Quality Strategy with additional details to guide the launch and operation of the KanCare program.
- Extensive interagency and cross-agency collaboration, and coordination with MCOs, to develop and communicate to the MCOs both specific templates to be used for reporting key components of performance for the KanCare program, as well as the protocols, processes and timelines to be used for the receipt, distribution, review and feedback regarding submitted reports.
- Development of the EQRO work plan for calendar year 2013, and beginning of the associated deliverables detail.
- Draft of the charter that will guide the Interagency Monitoring Team's work, and scheduling the orientation meeting for state staff who will be standing members, part of a rotating group of members, or resource persons for the IMT.
- Implementation and management of the KanCare Key Management Activities Reporting (KKMAR) tool and related process, to capture daily and later multi-weekly snapshots of MCO performance in five key early-operation categories:
    - Customer Servcie Management
    - Call Center Management
    - Member & Provider Appeal/Member Grievance Management
    - Claims Processing & Claims Denial Management
    - Provider Network, LTSS Transition & Hot Spot Management
- Facilitation of daily and then multi-weekly KanCare Rapid Response Stakeholder Calls, to hear from providers, members, advocates and other stakeholders as to any issue of concern or question related to the launch and operation of the KanCare program. Those calls resulted in quick turnaround responsive action to either address the question or build a solution to the concern. The calls also resulted in the developing/regular updating/posting of the KanCare Rapid Response Stakeholder Issues Log that is posted at the www.KanCare.ks.gov website for ready access.
- Participation in Program Implementation Beneficiary Protection Calls and Bi-Monthly Monitoring calls with CMS, pursuant to STCs 77 and 78.
- Identification of timetable to accomplish during the first year of KanCare operation, the completed merger of HCBS waiver-based performance measures and practices within the comprehensive Kansas state quality strategy. That timetable includes these core features:
    - Quarter 1: Clarify the details of current HCBS waiver performance measures and specify

measurement features as well as monitoring roles/responsibilities for each; and initiate ride alongs between state quality staff and MCO care management staff.
    - Quarter 2: Complete performance measure updates; complete ride alongs; and begin focused discussions about lessons learned and effective ways to complete the merger of the programs/measures/monitoring responsibilities into the KanCare structure.
    - Quarter 3: complete evaluation of merger options and decide on strategies to complete the merger and specify monitoring roles/responsibilities in the new structure; start process of amending each relevant HCBS waiver.
    - Quarter 4: Finalize and submit HCBS wavier amendments.
    - Quarter 5: Develop related State Quality Strategy revisions.
- Development and implementation of process to ensure LTSS-related ride alongs are occurring between MCO staff and state quality monitoring staff; and process to receive and either approve or disapprove any MCO-initiated reduction in LTSS services Plans of Care.
- Identification of key KanCare monitoring responsibilites across the state agencies responsible for integrated program implementation and operation.

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

X. Managed Care Reporting Requirements

a. A description of network adequacy reporting including GeoAccess mapping:

Each MCO submits a weekly network adequacy report. The State uses this weekly report to monitor quality of network data and additions to the networks, drill down into provider types and specialties, and extract data to respond to requests received from various stakeholders.

In addition, each MCO submits monthly network reports that serve as a tool for KanCare managers to monitor accessibility to certain provider types. Based on these network reports, two reports are published to the KanCare website monthly for public review.

1. Summary and Comparison of Physical and Behavioral Health Network is posted at http://www.kancare.ks.gov/download/KanCare_MCO_Network_Access.pdf. This report pulls together the summary table from each MCO and provides a side-by-side comparison of the access maps for each plan by provider type.

2. HCBS Service Providers by County, http://www.kancare.ks.gov/download/HCBS_Report_Update.pdf, includes the network status table of waiver services for each MCO.

b. Customer service reporting, including average speed of answer at the plans and call abandonment rates: MCO performance reporting in all core customer service/call center functions is reflected for January-March 2013 in the Attachment "KanCare Key Management Activities Report."

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

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

e. Summary of ombudsman activities :

The Office of Ombudsman has maintained a consistent and manageable work load. Contact volume averaged 70 contacts per week with an average response time of 4 hours (from the initial contact). A web-based application has been developed, the Ombudsman Contact Log, with 632 calls during the first quarter and 489 consumer E-mails. Of the 1,121 contacts, 957 were resolved for an 86% resolution rate. An inquiry is classified resolved when the consumer's question has been answered. Using the information contained in the contact log, the ombudsman will construct reports and monitor activity and trends via the web application.

In general terms, most inquiries are consumer requests for information and assistance in resolving eligibility, choice and benefit concerns. Most inquiries require contacting the plans, state agencies and providers. Once the requested information is obtained, the answer can be provided by the relevant party or submitted back to the ombudsman to communicate with the consumer. The unresolved concerns are matters that have been pended for follow-up.

Specific concerns or questions that emerged in the first quarter were related to (in order of prevalence):

1) Eligibility for KanCare and choice of plan
2) Status of plan provider networks and choice of primary care provider
3) Establishing a relationship and communication with the plans
4) Pharmacy prior authorizations and denials
5) Transportation concerns and scheduling
6) Claim denials and grievance/appeal process

Early during the quarter, billing questions and provider inquiries were emerging. The ombudsman has kept focused on consumer concerns by referring providers to the rapid response call or to provider resources. The ombudsman continues to investigate billing and payment concerns when it involves an individual consumer. Often, the consumer communicates concerns that have been expressed to them

by providers. In these instances, the ombudsman contacts the providers and works with them if the concern is unique to the consumer, or refers them to State or plan staff to address system issues.

Emerging issues include changes in plans of care (services) and switching their plan after open enrollment "for cause." These concerns involve a more extensive investigation of individual circumstances. To this end, the ombudsman has requested additional staff support during the second quarter to allow him to meet with consumers individually. The additional staff will also improve customer service by reducing reliance on voice mail and will allow for better documentation and classification of concerns and resolutions.

The ombudsman is involved in various workgroups:

1) I/DD Waiver Pilot
2) HCBS Technical Workgroup
3) KDADS Internal I/DD Workgroup
4) KDADS KanCare Weekly Workgroup
5) KanCare Weekly Rapid Response Call and Ombudsman Weekly Report
6) CMS Implementation Monitoring Meetings

The ombudsman has presented at various forums:

1) Aging and Disability Resource Center
2) Kansas Association for Independent Living
3) Kansas Mental Health Coalition
4) Kansas Council on Disability Concerns
5) Families Together

The ombudsman has attended and participated in the KanCare Consumer Tours and writes articles for the KanCare Advisor news bulletin.

The ombudsman has also had extensive interaction and training with the State Waiver Managers and Quality Assurance staff. He has access to and has been trained in the Medicaid Management Information System (MMIS) and Kansas Aging Management Information System (KAMIS). The ombudsman has also toured and met with the leadership teams at each of the plans. Subsequently, he developed a "single point of contact" with each plan to assure prompt and responsive answers to consumer concerns.

Finally, the ombudsman has had the pleasure of meeting and sharing personal experiences with hundreds of Kansas Medicaid consumers. Through these interactions, he has developed an insight into both the challenges and opportunities of KanCare. He thus tries to provide an objective and collaborative approach to be responsive to consumer concerns and questions. By being respectful and listening to consumers, the ombudsman believes they have a resource that they have not had available in the past. He continues to look forward to working to make sure the consumers' voice is heard.

f. Summary of MCO critical incident report:

On January 1, 2013, KDADS began the transition to a centralized Adverse Incident Reporting (AIR) web-based system. All providers (all HCBS waiver providers, mental health and substance use disorder providers) are given access to this system through KDADS IT staff and enter incidents here. There is logic in the system that notifies (via a secure email) the program manager and the appropriate MCO of each incident. MCOs and appropriate state staff investigate incidents and add this information into the portal throughout the process.

From January 2013 to March 2013 the HCBS waiver providers along with the KDADS HCBS program and Quality staff used the prior manual reporting process and information was collected in a single KDADS data system. As of April 2013, all providers, excluding HCBS/DD are required to use AIR system in lieu of the prior process. For the first quarter only, the report differentiates between incidents reported through AIR and those that used the manual reporting process.

MCO incidents reported out of the AIR system (primarily behavioral health):

Total Critical Incidents Received in Quarter	43
Total # of Critical Incidents Reviewed	36
Total # of Critical Incidents Pending	7

KDADS reports the following HCBS critical incidents manually reported for January through March 2013 time period. Of the 300 incidents received in the quarter, 133 were substantiated.

Total Critical Incidents Received in Quarter	300
Total # of Critical Incidents Reviewed	247
Total # of Critical Incidents Pending	53

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 UC Pool Applications were approved by CMS and sent on March 5, 2013, to the participating hospitals listed in Attachment C of the STCs. The hospitals were required to complete the application prior to receiving a pool payment. The State's changes to the UC Pool Uniform Percentages Table were approved on April 26, 2013, and are effective with the first quarter payment. The first quarter payments are scheduled to be processed in conjunction with the second quarter payments on May 9, 2013, for the HCAIP Pool. The first quarter LPTH/BCCH Pool payments were processed on March 28, 2013. The Attachment Safety Net Care Pool Report identifies pool payments to participating hospitals, including funding sources, applicable to the first quarter.

The State created new Program and Reason codes in MMIS for reporting on the CMS 64. The HCAIP Pool Payments for the first quarter of DY 1 and all future SNCP payments will be entered using the

following information:

Expenditure/AR Reason Codes:

Code	Description
HCAP	Health Care Access Imp Program Pool
LPBC	Large Public Teaching Border City Children Hospital

MMIS Entry of Weekly Expenditures and/or ARs:

Reason: **HCAP**
PCA Code: **03264** – Regular Medical
CMS COS: **011** – Inpatient Hospital
DY/Qtr: **CCYY/1, 2, 3 or 4**
Liability Date: **CCYY/MM/DD** (Last Day of the Qtr that the Exp/AR is being made for)
Reason: **LPBC**
PCA Code: **04264** – Regular medical
CMS COS: **011** – Inpatient Hospital
DY/Qtr: **CCYY/1, 2, 3 or 4**
Liability Date: **CCYY/MM/DD** (Last Day of the Qtr that the Exp/AR is being made for)

State Plan Amendments were submitted during the quarter, per STC 67(c), to remove previous supplemental payments replaced by the pools. Disproportionate Share Hospital payments continue, as does support for graduate medical education.

XII. Demonstration Evaluation

In the first quarter of the KanCare program, KDHE selected an evaluation entity and worked with that entity to develop an initial overview evaluation plan, obtain input on the evaluation design from a variety of stakeholder groups, and begin the development of a draft evaluation plan for submission to CMS. The following summarizes the evaluation plan and related activity:

Evaluation is required to measure the effectiveness and usefulness of the demonstration as a model to help shape health care delivery and policy. The KanCare evaluation is to be completed by the Kansas Foundation for Medical Care, Inc., who will subcontract as needed for targeted review. Evaluation requirements are outlined in the Centers for Medicare & Medicaid Services Special Terms and Conditions document.

Timeline

- Present overview and obtain feedback from KanCare Advisory Council, March 12, 2013.
- Present overview/design specifications and obtain feedback from combined meeting of Consumer and Specialized Issues (CSI) workgroup and the Provider and Operations Issues (POI) workgroup, on March 27, 2013.
- Revise draft by April 19, 2013, based on feedback obtained from Advisory Council and

workgroups. Revisions included:
    - Adding Substance Use Disorder Consumer Survey results;
    - Clarifying the areas involving stratification by population categories and adding this stratification to the grievance reviews; and
    - Adding the population with development disabilities to the Healthy Life Expectancy composite measure.
- Draft Evaluation Design to CMS by April 26, 2013.
- CMS will have until end of June 2013 for review and feedback.
- Final design will be completed by August 28, 2013.
- Quarterly and Annual evaluation progress reports will be submitted.
- Draft evaluation report to be submitted 120 days after expiration of the demonstration.

Goals

KFMC will evaluate the extent to which KanCare achieved its intended goals to:

- **Provide integration and coordination of care** across the whole spectrum of health to include physical health, behavioral health (mental health and substance use disorders), and LTSS;
- **Improve the quality of care** Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- **Control Medicaid costs** by emphasizing health, wellness, prevention and early detection, as well as integration and coordination of care; and
- **Establish long-lasting reforms** that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms as well.

Hypotheses

KFMC will test the following KanCare hypotheses:

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

XIII. Other (Post Award Forums; I/DD Pilot Project)

a. Post Award Forum: The first Post-Award Forum has been scheduled for June 25 during a meeting of the KanCare Advisory Council. A notice has been posted prominently on the KanCare website's Provider Events and Consumer Events pages, and is linked from the About Us page under Section 1115 Waiver and Comments.

b. Currently, long-term services and supports for members on the HCBS waiver for intellectual or developmental disabilities are carved out of KanCare. However, through a 2012 state legislative proviso and STC 52, the State is able to offer a voluntary pilot project for I/DD members.

Preparation for the pilot began in July 2012 with KDADS' assembly of an advisory committee. The committee developed the project design which included development of work flows for many current waiver services and TCM system processes such as entrance into and application for I/DD services, the eligibility process, access to supports, extraordinary funding, gatekeeping and appeal processes.

The pilot project is for people currently using I/DD services or TCM. While people using I/DD services came into the KanCare program on January 1, 2013, for all non-HCBS services, a limited number of people can come into the KanCare program for more direct engagement related to I/DD services via the pilot project. The pilot started March 1, 2013, and will be a 10-month program.

To date, 550 consumers and 25 providers have chosen to participate in the pilot.

Activity from March start date:

- Participants received a letter from KDADS to provide them with an overview of the pilot.
- Initial contacts made in March from KanCare Managed Care Organization (MCO) Care Coordinators to consumers and family members/guardians.
- Consumers began participation in value-added services including hospital companion, local crisis intervention teams, mental and behavioral health supports, member career development, in-home caregiver support, respite, personal assistant services, transportation, and access to caregiver support kits. Additional information on these value-added services can be accessed through the I/DD Pilot Advisory Committee Report at http://www.kdads.ks.gov/CSP/IDD/DD_Pilot_Advisory_Group_Report.pdf.

Ongoing/future activities include:

- An evaluation survey from Wichita State University was sent out to family members/guardians to assess current knowledge of KanCare as well as current satisfaction rate with HCBS.
- Training plan with materials for providers/participants ready by end of May with training the first week of June at four locations around the state (Garden City, Arkansas City,

Parsons, and Lawrence). Each site will include two training sessions. One will be focused on providers and the other will be for participants.

- Credentialing and contracting process for pilot providers in May and June.
- Begin provider claims submission and payment through MCOs in July (assumes CMS approval of this element; services would still be carved out of managed care per STC 52).
- Begin collaborative MCO Care Coordination and I/DD Targeted Case Manager plan of care process in July.
- Statewide educational forums with consumers and providers in the fall of 2013.
- Pilot goals and action plans related to employment and collaboration with mental health providers are currently being developed by the Advisory Council.

XIV. Enclosures/Attachments

Item VI refers to the KanCare Budget Neutrality Monitoring spreadsheet, which is attached.

Item X(b) refers to an attachment reflecting the MCOs' first quarter customer service and call center performance is attached, entitled KanCare Key Management Activities Report.

Item XI refers to the Safety Net Care Pool Report, which details sources of funding for pool payments applicable to this quarter, per STC 67(b). It is attached.

XV. State Contacts(s)

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XVI. Date Submitted to CMS

May 31, 2013

KanCare BN Monitoring Report DY1-Q1

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

Quarter 1
Start Date: 1/1/2013
End Date: 3/31/2013

	Total Expenditures	Total Member-Months
Jan-13	183,007,605.79	329,192
Feb-13	183,065,066.59	326,505
Mar-13	185,146,751.86	324,210
Q1 Total	551,219,424.24	979,907

Actual[1]

	Population 1: ABD/SD Dual	Population 2: ABD/SD Non Dual	Population 3: Adults[2]	Population 4: Children	Population 5: DD Waiver[3]	Population 6: LTC	Population 7: MN Dual	Population 8: MN Non Dual	Population 9: Waiver
Jan-13									
Expenditures	3,860,448.22	27,160,740.80	11,855,600.09	38,194,934.35	33,571,993.09	53,708,046.56	1,154,809.36	1,517,485.31	11,983,548.01
Member-Months	17,788	28,716	31,820	213,118	8,706	22,087	1,240	1,189	4,528
Feb-13									
Expenditures	3,928,802.39	27,982,510.01	12,476,387.26	39,947,685.29	29,987,288.43	53,662,128.40	1,266,789.79	1,784,198.09	12,029,276.93
Member-Months	17,593	28,628	31,603	211,158	8,712	21,899	1,214	1,162	4,536
Mar-13									
Expenditures	4,031,577.56	28,222,631.71	13,176,660.66	39,606,534.78	31,349,861.30	53,503,085.93	1,583,941.72	1,796,645.72	11,875,812.48
Member-Months	17,466	28,607	31,355	209,478	8,718	21,726	1,182	1,183	4,495
Q1 Total									
Expenditures	11,820,828.17	83,365,882.52	37,508,648.01	117,749,154.42	94,909,142.82	160,873,260.89	4,005,540.87	5,098,329.12	35,888,637.42
Member-Months	52,847	85,951	94,778	633,754	26,136	65,712	3,636	3,534	13,559
DY 1 - Q1 PMPM	223.6802	969.9234	395.7527	185.7963	3,631.3569	2,448.1565	1,101.6339	1,442.6511	2,646.8499

[1] Includes capitation payments made through 4/30 for first quarter enrollment
[2] Preliminary: Excludes delivery payments; to be updated in future reports
[3] Preliminary: Includes LTSS expenditures for first quarter service dates paid through 4/30; to be updated in future reports

KanCare Key Management Activities Report

Excerpt

Dates/Times Covered by Report	Date of Report
3/26/2013 (12:00 a.m.) to 4/01/2013 (11:59 p.m.)	**Tuesday, April 02, 2013**

Cumulatively Covers
1/1/2013 to date noted above

KanCare

Amerigroup Kansas, Inc.

KanCare Key Management Activities Report

SUBJECT AREA I: CUSTOMER SERVICE MANAGEMENT

Members

# of Calls Documented - Reporting Period	2,261
# of Calls Documented - Cumulative	49,102

Inquiry Type	# Reporting Period	# Cumulative
1. Benefit Inquiry – regular or VAS	278	7,314
2. Concern with access to service or care; or concern with service or care disruption	137	2,496
3. Care management or health plan program	87	2,191
4. Claim or billing question	81	1,006
5. Coordination of benefits	38	525
6. Disenrollment request	20	370
7. Eligibility inquiry	100	1,355
8. Enrollment information	96	1,655
9. Find/change PCP	1,043	22,256
10. Find a specialist	46	946
11. Assistance with scheduling an appointment	2	38
12. Need transportation	72	1,885
13. Order ID card	121	3,242
14. Question about letter or outbound call	17	661
15. Request member materials	11	386
16. Update demographic information	56	1,148
17. Member emergent or crisis call	0	28
18. Other	56	1,600

Standard	Reporting Period	Cumulative
% resolved within 2 business days	100.0%	100.0%
% resolved within 5 business days	0.0%	0.0%
% resolved within 8 business days	0.0%	0.0%
% resolved within 15 business days	0.0%	0.0%
% resolved > 15 business days	0.0%	0.0%
% pending	0.0%	0.0%

Note on Standards: Per the Contract, 95% of inquiries must be resolved within 2 business days of receipt and 98% must be resolved within 5 business days of receipt. To be eligible for pay-for-performance payments, 98% of inquiries must be resolved within 2 business days of receipt and 100% must be resolved within 8 business days of receipt.

Providers

# of Calls Documented - Reporting Period	1,066
# of Calls Documented - Cumulative	18,780

Inquiry Type	# Reporting Period	# Cumulative
1. Authorization – New	156	5,628
2. Authorization – Status	147	2,715
3. Benefits inquiry	122	2,153
4. Claim Denial Inquiry	82	860
5. Claim Status Inquiry	320	3,045
6. Claim Payment Question/Dispute	42	567
7. Billing Inquiry	20	181
8. Coordination of Benefit	4	80
9. Member Eligibility Inquiry	28	514
10. Recoupment or Negative Balance	0	0
11. Pharmacy/Prescription Inquiry	10	206
12. Request Provider Materials	8	71
13. Update Demographic Information	1	45
14. Verify/Change Participation Status	21	274
15. Web Support	60	1,788
16. Credentialing Issues	33	278
17. Other (including to provider services or provider representatives)	12	375

Standard	Reporting Period	Cumulative
% resolved within 2 business days	100.0%	100.0%
% resolved within 5 business days	0.0%	0.0%
% resolved within 8 business days	0.0%	0.0%
% resolved within 15 business days	0.0%	0.0%
% resolved > 15 business days	0.0%	0.0%
% pending	0.0%	0.0%

Note on Standards: Per the Contract, 95% of inquiries must be resolved within 2 business days of receipt and 98% must be resolved within 5 business days of receipt. To be eligible for pay-for-performance payments, 98% of inquiries must be resolved within 2 business days of receipt and 100% must be resolved within 8 business days of receipt.

Other

Inquiry Type	# Reporting Period	# Cumulative
1. Potential Member	67	873
2. Community Service Organization	0	6
3. Other Public or Private Entities	0	16

KanCare

Amerigroup Kansas, Inc.

KanCare Key Management Activities Report

SUBJECT AREA II: CALL CENTER MANAGEMENT

Call Center and Other Responsiveness – Issue (Member and Provider unless otherwise stated)	Requirement	Performance Result this Reporting Period		Performance Result Cumulative from 1.1.13	
No busy signal	**Requirement:** 99% of calls will be answered by an individual or an electronic device without receiving a busy signal	100.0%		100.0%	
Hold time in seconds – initial connection	**Requirement:** 95% of all calls, whether incoming or outgoing, will be placed on hold for no more than one minute	4037	98.7%	67341	97.6%
Hold time in seconds – subsequent to initial connection	**Monitoring Only:** Average hold time	2:09		2:17	
# and % of calls resolved during initial contact	**Requirement:** 90% of calls answered will be resolved by the MCO during the initial contact	3443	100.0%	71065	100.0%
# and % of calls recorded and recording maintained	**Requirement:** 100% of received phone calls are recorded and the recordings maintained	4110	100.0%	69480	99.8%
# of calls left on voice mail during working hours; #/% that are retrieved and returned within one business day *[For Amerigroup: # of calls that utilized virtual*	**Requirement:** 100% of calls left on voice mail during or after working hours will be retrieved and returned during one business day				
	Number & Percentage of Calls that Utilized Virtual Hold and Call Returned within One Day or Less	0	100.0%	557	100.0%
# of calls left on voice mail after working hours; #/% that are retrieved and returned within one business day	**Requirement:** 100% of calls left on voice mail during or after working hours will be retrieved and returned within one business day	44	100.0%	499	100.0%
# fax calls that receive a busy signal, and # of fax calls received	**Requirement:** 98% of the time, fax lines shall meet customer demand				
	Total Number of Fax Calls Received	580		8,567	
	Number & Percentage of Fax Calls that DO NOT Receive a Busy Signal	568	97.9%	8,431	98.4%
# and % of member calls abandoned	--	5	0.2%	211	0.4%
# and % of provider calls abandoned	--	10	0.7%	154	0.8%
Average member call length	--	6:53		7:28	
Average provider call length	--	5:34		5:49	
Average seconds to answer member calls	--	0:07		0:08	
Average seconds to answer provider calls	--	0:16		0:16	

KanCare

SUNFLOWER STATE HEALTH PLAN

KanCare Key Management Activities Report

SUBJECT AREA I: CUSTOMER SERVICE MANAGEMENT

Members

# of Calls Documented - Reporting Period	5,373
# of Calls Documented - Cumulative	114,459

Inquiry Type	# Reporting Period	# Cumulative
1. Benefit Inquiry – regular or VAS	864	13,613
2. Concern with access to service or care; or concern with service or care disruption	92	2,397
3. Care management or health plan program	248	3,052
4. Claim or billing question	55	562
5. Coordination of benefits	8	445
6. Disenrollment request	12	269
7. Eligibility inquiry	422	8,269
8. Enrollment information		85
9. Find/change PCP	2,054	44,096
10. Find a specialist	134	2,556
11. Assistance with scheduling an appointment		5
12. Need transportation	391	3,291
13. Order ID card	258	5,749
14. Question about letter or outbound call	94	18,921
15. Request member materials	247	4,821
16. Update demographic information	181	3,341
17. Member emergent or crisis call	75	937
18. Other	148	2,050

Standard	Reporting Period	Cumulative
% resolved within 2 business days	100%	100%
% resolved within 5 business days		
% resolved within 8 business days		
% resolved within 15 business days		
% resolved > 15 business days		
% pending	0%	0%

Note on Standards: Per the Contract, 95% of inquiries must be resolved within 2 business days of receipt and 98% must be resolved within 5 business days of receipt. To be eligible for pay-for-performance payments, 98% of inquiries must be resolved within 2 business days of receipt and 100% must be resolved within 8 business days of receipt.

Providers

# of Calls Documented - Reporting Period	740
# of Calls Documented - Cumulative	7,914

Inquiry Type	# Reporting Period	# Cumulative
1. Authorization – new		9
2. Authorization – status	54	931
3. Benefits inquiry	53	596
4. Claim denial inquiry		0
5. Claim status inquiry	357	2,931
6. Claim payment question/dispute	59	466
7. Billing inquiry		1
8. Coordination of benefit	1	7
9. Member eligibility inquiry	53	703
10. Recoupment or negative balance	1	7
11. Pharmacy/prescription inquiry	3	110
12. Request provider materials	3	34
13. Update demographic information	88	1,332
14. Verify/change participation status	18	200
15. Web support		60
16. Credentialing issues	17	182
17. Other (including to provider services or provider representatives)	33	345

Standard	Reporting Period	Cumulative
% resolved within 2 business days	100%	100%
% resolved within 5 business days		
% resolved within 8 business days		
% resolved within 15 business days		
% resolved > 15 business days		
% pending	0%	0%

Note on Standards: Per the Contract, 95% of inquiries must be resolved within 2 business days of receipt and 98% must be resolved within 5 business days of receipt. To be eligible for pay-for-performance payments, 98% of inquiries must be resolved within 2 business days of receipt and 100% must be resolved within 8 business days of receipt.

Other

Inquiry Type	# Reporting Period	# Cumulative
1. Potential Member	540	6,888
2. Community service organization		4
3. Other public or private entities	32	621

KanCare

SUNFLOWER STATE HEALTH PLAN

KanCare Key Management Activities Report

SUBJECT AREA II: CALL CENTER MANAGEMENT

Call Center and Other Responsiveness – Issue (Member and Provider unless otherwise stated)	Requirement	Performance Result this Reporting Period	Performance Result Cumulative from 1.1.13
No busy signal	**Requirement:** 99% of calls will be answered by an individual or an electronic device without receiving a busy signal	100	100
Hold time in seconds – initial connection	**Requirement:** 95% of all calls, whether incoming or outgoing, will be placed on hold for no more than one minute	Mbr-7 Sec-96.99% (3/26) Mbr-2 Sec-99.89% (3/27) Mbr-3 Sec-99.54% (3/28) Mbr-24 Sec-82.51% (4/1) Prv-4 Sec-98.19% (3/26) Prv-6 Sec-96.41% (3/27) Prv-5 Sec-96.55% (3/28) Prv-19 Sec-85.% (4/1)	Member-13 Sec-92.16% Provider-10 Sec-92.97%
# and % of calls resolved during initial contact	**Requirement:** 90% of calls answered will be resolved by the MCO during the initial contact	100	100
# and % of calls recorded and recording maintained	**Requirement:** 100% of received phone calls are recorded and the recordings maintained	100	100
# of calls left on voice mail during working hours; #/% that are retrieved and returned within one business day	**Requirement:** 100% of calls left on voice mail during or after working hours will be retrieved and returned during one business day	0	0
# of calls left on voice mail after working hours; #/% that are retrieved and returned within one business day	**Requirement:** 100% of calls left on voice mail during or after working hours will be retrieved and returned within one business day	176 vm calls, 100% returned	1126 vm calls left, 97% returned
# fax calls that receive a busy signal, and # of fax calls received	**Requirement:** 98% of the time, fax lines shall meet customer demand		
	Total Number of Fax Calls Received	0	0
	Number & Percentage of Fax Calls that DO NOT Receive a Busy Signal	0	0
# and % of member calls abandoned	--	. Ab, 0.39% (3/26) 1 Ab, 0.11% (3/27) 1 Ab, 0.12% (3/28) 34 Ab, 2.31% (4/1)	811 Aban,1.06%
# and % of provider calls abandoned	--	0 Ab, 0% (3/26) 1 Ab, .45% (3/27) 0 Ab, 0% (3/28) 6 Ab, 2.27% (4/1)	102 Aban, 0.85%
Average member call length	--	5:17 (3/26) 5:30 (3/27) 5:45 (3/28) 5:24 (4/1)	5:45
Average provider call length	--	7:11 (3/26) 7:03 (3/27) 6:04 (3/28) 5:31 (4/1)	6:07
Average seconds to answer member calls	--	7 (3/26) 2 (3/27) 3 (3/28) 24 (4/1)	13
Average seconds to answer provider calls	--	4 (3/26) 6 (3/27) 5 (3/28) 19 (4/1)	10
Average Hold Time in Seconds - Members	--	37 (3/26) 38 (3/27) 38 (3/28) 41 (4/1)	38
Average Hold Time in Seconds - Providers	--	33 (3/26) 45 (3/27) 45 (3/28) 23 (4/1)	41

KanCare Key Management Activities Report

United Healthcare

SUBJECT AREA I: CUSTOMER SERVICE MANAGEMENT

Members

# of Calls Documented - Reporting Period	3,313
# of Calls Documented - Cumulative	58,563

Inquiry Type	# Reporting Period	# Cumulative
1. Benefit Inquiry – regular or VAS	853	19,709
2. Concern with access to service or care; or concern with service or care disruption	0	0
3. Care management or health plan program	198	2,977
4. Claim or billing question	171	1,368
5. Coordination of benefits	181	994
6. Disenrollment request	53	1,172
7. Eligibility inquiry	283	3,120
8. Enrollment information	93	3,018
9. Find/change PCP	889	18,523
10. Find a specialist	133	1,082
11. Assistance with scheduling an appointment	33	174
12. Need transportation	35	675
13. Order ID card	213	3,063
14. Question about letter or outbound call	40	510
15. Request member materials	13	255
16. Update demographic information	35	803
17. Member emergent or crisis call	0	18
18. Other	49	1,713

Standard	Reporting Period	Cumulative
% resolved within 2 business days	98.9%	98.5%
% resolved within 5 business days	100.0%	100.0%
% resolved within 8 business days	0%	0%
% resolved within 15 business days	0%	0%
% resolved > 15 business days	0%	0%
% pending	0%	0%

Note on Standards: Per the Contract, 95% of inquiries must be resolved within 2 business days of receipt and 98% must be resolved within 5 business days of receipt. To be eligible for pay-for-performance payments, 98% of inquiries must be resolved within 2 business days of receipt and 100% must be resolved within 8 business days of receipt.

Providers

# of Calls Documented - Reporting Period	1,142
# of Calls Documented - Cumulative	12,441

Inquiry Type	# Reporting Period	# Cumulative
1. Authorization – new	40	394
2. Authorization – status	57	688
3. Benefits inquiry	244	1,805
4. Claim denial inquiry	52	1,002
5. Claim status inquiry	188	1,642
6. Claim payment question/dispute	51	514
7. Billing inquiry	38	519
8. Coordination of benefit	78	357
9. Member eligibility inquiry	252	1,498
10. Recoupment or negative balance	16	234
11. Pharmacy/prescription inquiry	52	466
12. Request provider materials	8	223
13. Update demographic information	14	372
14. Verify/change participation status	6	176
15. Web support	3	113
16. Credentialing issues	12	226
17. Other (including to provider services or provider representatives)	31	507

Standard	Reporting Period	Cumulative
% resolved within 2 business days	99.9%	99.8%
% resolved within 5 business days	100%	100%
% resolved within 8 business days	0%	0%
% resolved within 15 business days	0%	0%
% resolved > 15 business days	0%	0%
% pending	0%	0%

Note on Standards: Per the Contract, 95% of inquiries must be resolved within 2 business days of receipt and 98% must be resolved within 5 business days of receipt. To be eligible for pay-for-performance payments, 98% of inquiries must be resolved within 2 business days of receipt and 100% must be resolved within 8 business days of receipt.

Other

Inquiry Type	# Reporting Period	# Cumulative
1. Potential Member	39	518
2. Community service organization	0	10
3. Other public or private entities	0	22

KanCare

KanCare Key Management Activities Report

United Healthcare

SUBJECT AREA II: CALL CENTER MANAGEMENT

Call Center and Other Responsiveness – Issue (Member and Provider unless otherwise stated)	Requirement	Performance Result this Reporting Period	Performance Result Cumulative from 1.1.13
No busy signal	**Requirement:** 99% of calls will be answered by an individual or an electronic device without receiving a busy signal	100%	100%
Hold time in seconds – initial connection	Requirement: 95% of all calls, whether incoming or outgoing, will be placed on hold for no more than one minute	98.2%	96.3%
Hold time in seconds – subsequent to initial connection	**Specific requirement not stated. For KDHE monitoring purposes only.**		
	Total number of calls placed on hold - Member	927	17,200
	Average Hold Time - Member	100	80
	Total number of calls placed on hold - Provider	248	3,135
	Average Hold Time - Provider	228	125
# of calls resolved during initial contact	**Requirement:** 90% of calls answered will be resolved by the MCO during the initial contact	4418	68633
% of calls resolved during initial contact	**Requirement:** 90% of calls answered will be resolved by the MCO during the initial contact	99.17%	98.80%
# of calls recorded and recording maintained	**Requirement:** 100% of received phone calls are recorded and the recordings maintained	4460	67032
% of calls recorded and recording maintained	**Requirement:** 100% of received phone calls are recorded and the recordings maintained	100%	100%
# of calls left on voice mail during working hours; #/% that are retrieved and returned within one business day *[For Amerigroup: # of calls that utilized virtual hold; #/% returned within one day or less.]*	**Requirement:** 100% of calls left on voice mail during or after working hours will be retrieved and returned during one business day		
	Number of Calls that Utilized Virtual Hold and Call Returned within One Day or Less	**NA**	**NA**
	Percentage of Calls that Utilized Virtual Hold and Call Returned within One Day or Less	**NA**	**NA**
# of calls left on voice mail after working hours; #/% that are retrieved and returned within one business day	**Requirement:** 100% of calls left on voice mail during or after working hours will be retrieved and returned within one business day	**8 / 100%**	**225 / 100%**
# fax calls that receive a busy signal, and # of fax calls received	**Requirement:** 98% of the time, fax lines shall meet customer demand		
	Total Number of Fax Calls Received	0	0
	Number of Fax Calls that DO NOT Receive a Busy Signal	0	0
	Percentage of Fax Calls that DO NOT Receive a Busy Signal	100%	100%
# of member calls abandoned	--	4	446
% of member calls abandoned	--	0.10%	0.8%
# of provider calls abandoned	--	1	42
% of provider calls abandoned	--	0.00%	0.30%
Average member call length	--	292	335
Average provider call length	--	480	495
Average seconds to answer member calls	--	2.2	8.94
Average seconds to answer provider calls	--	4.7	2.69

Safety Net Care Pool Report
Demonstration Year 1 - QE March 2013

Health Care Access Improvement Pool
Paid 5-8-2013

Hospital Name	HCAIP DY/QTR: 2013/1	Provider Access Fund 2443	Federal Medicaid Fund 3414
Bob Wilson Memorial Hospital	30,672.00	13,339.25	17,332.75
Children's Mercy Hospital South	132,776.00	57,744.28	75,031.72
Coffey County Hospital	22,628.00	9,840.92	12,787.08
Coffeyville Regional Medical Center, Inc.	85,288.00	37,091.75	48,196.25
Cushing Memorial Hospital	121,789.00	52,966.04	68,822.96
Galichia Heart Hospital LLC	36,289.00	15,782.09	20,506.91
Geary Community Hospital	108,556.00	47,211.00	61,345.00
Hays Medical Center, Inc.	372,362.00	161,940.23	210,421.77
Kansas Heart Hospital LLC	30,369.00	13,207.48	17,161.52
Kansas Medical Center LLC	46,233.00	20,106.73	26,126.27
Kansas Rehabilitation Hospital	6,317.00	2,747.26	3,569.74
Kansas Surgery & Recovery Center	4,846.00	2,107.53	2,738.47
Labette County Medical Center	90,810.00	39,493.27	51,316.73
Lawrence Memorial Hospital	223,486.00	97,194.06	126,291.94
McPherson Memorial Hospital, Inc.	42,456.00	18,464.11	23,991.89
Menorah Medical Center	207,646.00	90,305.25	117,340.75
Mercy Health Center - Ft. Scott	82,850.00	36,031.47	46,818.54
Mercy Health Center - Independence	47,986.00	20,869.11	27,116.89
Mercy Hospital - Moundridge	3,239.00	1,408.64	1,830.36
Mercy Reg Health Ctr	170,152.00	73,999.10	96,152.90
Miami County Medical Center	57,668.00	25,079.81	32,588.19
Mid-America Rehabilitation Hospital	17,575.00	7,643.37	9,931.63
Morton County Health System	35,477.00	15,428.95	20,048.05
Mount Carmel Regional Medical Center	207,216.00	90,118.24	117,097.76
Newman Regional Health	127,347.00	55,383.21	71,963.79
Newton Medical Center	123,879.00	53,874.98	70,004.02
Olathe Medical Center	366,181.00	159,252.12	206,928.88
Overland Park Regional Medical Ctr.	585,431.00	254,603.94	330,827.06
Pratt Regional Medical Center	57,255.00	24,900.20	32,354.80
Promise Regional Medical Center	290,352.00	126,274.08	164,077.92
Providence Medical Center	396,598.00	172,480.47	224,117.53
Ransom Memorial Hospital	73,654.00	32,032.12	41,621.88
Saint Catherine Hospital	172,435.00	74,991.98	97,443.02
Saint Francis Health Center	619,423.00	269,387.06	350,035.94
Saint John Hospital	99,673.00	43,347.79	56,325.21
Saint Luke's South Hospital, Inc.	121,261.00	52,736.41	68,524.59
Salina Regional Health Center	263,396.00	114,550.92	148,845.08
Salina Surgical Hospital	654.00	284.42	369.58
Select Specialty Hospital - Kansas City	5,211.00	2,266.26	2,944.74
Select Specialty Hospital - Wichita	5,736.00	2,494.59	3,241.41
Shawnee Mission Medical Center, Inc.	707,194.00	307,558.67	399,635.33
South Central KS Reg Medical Ctr	21,473.00	9,338.61	12,134.39
Southwest Medical Center	117,327.00	51,025.51	66,301.49
Specialty Hospital of Mid America	376.00	163.52	212.48
Stormont Vail Regional Health Center	943,679.00	410,406.00	533,273.00
Summit Surgical LLC	776.00	337.48	438.52

Safety Net Care Pool Report
Demonstration Year 1 - QE March 2013

Health Care Access Improvement Pool
Paid 5-8-2013

Hospital Name	HCAIP DY/QTR: 2013/1	Provider Access Fund 2443	Federal Medicaid Fund 3414
Sumner Regional Medical Center	27,744.00	12,065.87	15,678.13
Susan B. Allen Memorial Hospital	114,299.00	49,708.64	64,590.36
Via Christi Hospital St Teresa	161,584.00	70,272.88	91,311.12
Via Christi Regional Medical Center	1,465,595.00	637,387.27	828,207.73
Via Christi Rehabilitation Center	17,202.00	7,481.15	9,720.85
Wesley Medical Center	1,000,423.00	435,083.96	565,339.04
Western Plains Medical Complex	125,520.00	54,588.65	70,931.35
Total	**10,196,364.00**	**4,434,398.70**	**5,761,965.30**

Safety Net Care Pool Report

Demonstration Year 1 - QE March 2013

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

Paid 3/28/13

Provider Name	1st Qtr Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	2,491,034.38	1,083,350.85	1,407,683.53
University of Kansas Hospital	7,473,103.00	3,250,052.49*	4,223,050.51
Total	**9,964,137.38**	**4,333,403.35**	**5,630,734.03**

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