

Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 3.31.14



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

KanCare

Section 1115 Quarterly Report

Demonstration Year: 2 (1/1/2014-3/31/2014)

Federal Fiscal Quarter: 2/2014 (01/14-03/14)

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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 30, 2014.

Demonstration Population	Enrollees at Close of Qtr. (03/31/14)	Total Unduplicated Enrollees in Quarter	Disenrolled in Qtr.
Population 1: ABD/SD Dual	17,859	18,575	716
Population 2: ABD/SD Non Dual	29,294	29,956	662
Population 3: Adults	37,622	39,671	2,049
Population 4: Children	222,637	225,531	2,894
Population 5: DD Waiver	8,752	8,800	48
Population 6: LTC	21,147	22,294	1,147
Population 7: MN Dual	1,193	1,298	105
Population 8: MN Non Dual	1,069	1,197	128
Population 9: Waiver	4,229	4,294	65
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	343,802	351,616	7,814

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. In addition, the KanCare Advisor, the State's electronic implementation newsletter, is distributed to about 300 individual subscribers and various provider and consumer associations. Newsletters were distributed in the first quarter of this Demonstration Year January 23, February 24, and March 24, 2014. In addition to distribution to subscribers, the Advisor is also available on the KanCare website.

During the first quarter, Tribal Technical Advisory Group (TTAG) meetings with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations continued, on the following dates with attendees in person and by phone: January 7 (11 attendees), February 11 (18 attendees), March 4 (13 attendees).

KanCare's first open enrollment period ended March 4, 2014. This first open enrollment period will be the largest of the year as it represents everyone who came into KanCare at the beginning of the program in January 2013. Out of the 331,387 people that were open to change KanCare Health Plans from December to March, 10,538 people changed plans. Open enrollment periods will now be a monthly process for KDHE as people who were approved for KanCare benefits after January 2013 will reach their one year anniversary. KDHE mailed out 188,599 Open Enrollment Packets at the end of November with instructions on how to change their KanCare Health Plan if desired. If people were satisfied with the plan they were in, they were not required to do anything and remained in the same plan that they were in in 2013.

Additional outreach was completed by KDHE's out-stationed workers (OSWs) during the first quarter of 2014. OSWs completed 116 community outreach events, which include community partner meetings, Health Fairs, pregnant women parenting meetings, WIC clinics, etc. During these events, OSWs shared information on new MAGI eligibility requirements, on line application processes, gathered new applications, and assisted consumers with questions or problems with their KanCare services. OSWs completed training and implemented new eligibility policies and for KEES computer implementation. OSW's processed 509 applications for KanCare during this 3 month time period.

Also during this quarter, the state's Kancare Advisory Council held the second meeting of the newly appointed council on March 26, 2014. The 2013 Advisory Council consists of 13 members: 3 legislative members representing the House and Senate, 1 member representing mental health providers, 1 member representing CDDOs, 2 members representing physicians and hospitals, 3 members representing KanCare members, 1 member representing the developmental disabilities community, 1 member former Kansas Senator, 1 member representing pharmacists.

The agenda for the council's March meeting:

- I. Welcome
- II. Review and Approval of Minutes from Council meeting, December 18, 2013
- III. Updates on KanCare
 - a. UnitedHealthcare Community Plan
 - b. Amerigroup Kansas
 - c. Sunflower State Health Plan
- IV. Q & A with KanCare MCOs – Director Kari Bruffett, Division of Health Care Finance, Kansas Department of Health and Environment
- V. Update on I/DD Implementation – Secretary Shawn Sullivan, Kansas Department for Aging and Disability Services
- VI. Overview of Healthy Kansans 2020 – Secretary Bob Moser, MD, Kansas Department of Health and Environment
- VII. External Workgroups
 - a. Consumer and Specialized Issues Workgroup – Russell Nittler
 - b. Provider and Operational Issues Workgroup – Shirley Norris
- VIII. Update from KanCare Ombudsman – Kerrie Bacon
- IX. Review of KanCare Executive Summary – Director Kari Bruffett, Division of Health Care Finance, Kansas Department of Health and Environment
- X. Next Meeting of KanCare Advisory Council
 - a. June 11, 2014, Curtis State Office Building, Room 530, 2:00 to 3:30 p.m.
- XI. Adjourn

In addition, Kansas has initiated some specific outreach activities during the first quarter of 2014, including:

Provider Experience Improvement Project: Following a survey of providers in December 2013 and January 2014, Kansas launched the Provider Experience Improvement (PEI) Project in March 2014. The PEI Project is designed to resolve provider-specific issues and strengthen the overall experience of providers who serve KanCare members. The PEI Project has three components:

- Outreach to each provider who indicated a concern in response to the provider experience survey completed in January 2014. This included issues related to prior authorization processes, claim payment accuracy or timeliness, and customer service experiences.
- Detailed analysis of both timeliness and accuracy of claims paid: Ongoing
- Claims reprocessing – monitoring and reporting on the timeliness and accuracy of major claims reprocessing projects for the MCO's.

As part of the PEI Project, KDHE selected two major reprocessing projects from each MCO to track completion in 45 days (March 21 to May 6).

- Amerigroup will reprocess prior authorization denials in error due to prior authorization coding table and hospital emergency room (ER) down coding logic to all ER claims with diagnosis code of N or S
- Sunflower will reprocess claims denied with EX11 in error and claims denied when primary explanation of benefits is attached.
- United Healthcare will reprocess claims to adjust for the correct PCP payment as well as for those claims processed with incorrect DRG rates.

An update on the completion of the PEI Project will be provided in the next quarterly STC report.

Another targeted outreach activity by the state is the Provider Issue Tracking Log: During the first quarter of 2014, the State developed a web application for HCBS providers to submit their issues to the State for review. Initially, this tool has been limited to only providing access to HCBS-IDD providers and some behavioral health providers to beta test its functionality and effectiveness. With the limited use, the State has identified areas for improvement and added enhancements to the tool to increase its functionality. Providers are able to track their issues by logging into the web application and looking at the status of the response. MCOs are able to access the issue log and provide a response to the State regarding the provider's concerns. KDHE also has access to the log for follow up and review purposes. This helps minimize duplication of efforts as KDHE is able to see what has been added to the log and notify the State if there is a similar or the same issue lodged with KDHE for KanCare.

State staff monitor the Issue Tracking Log and follow up with provider and the MCOs to ensure issues are being addressed and assist in facilitating communication. Most issues are related to billing and claims, prior authorization, AuthentiCare, and denials. These are monitored regularly and have been helpful during the IDD implementation process. The tool's use will be expanded during the second quarter as a tool for all home and community based services, behavioral health services and nursing facility providers to communicate any unresolved issues and ensure they are addressed. Consumer issues are referred to the KanCare Ombudsman for tracking and response.

Kansas also has some innovative program options/expansions underway. An innovative program option Kansas has been developing as part of the KanCare program relates to the use of Health Homes. A summary of that developing option follows:

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

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

- Developing consumer education materials, including a brochure, a booklet and a consumer PowerPoint presentation
- Making presentations at various provider association conferences and meetings about the project
- Holding an educational webinar for interested providers
- Identifying the second target population, approximately 38,000 people who have asthma or diabetes and are at risk for a second chronic condition, including hypertension, substance use disorder, coronary artery disease, or depression
- Deploying the Preparedness and Planning Tool to help providers assess their readiness to become HHPs
- Deploying a provider survey through Kansas Foundation for Medical Care to prioritize providers for assistance in planning to implement electronic health records (EHR)
- Transferring responsibility to WSU's Center for Community Support and Research (CCSR) for convening and facilitating the Health Homes Focus Group, now called the Health Homes Stakeholders Meeting
- Scheduling, through CCSR, twice monthly webinars for providers interested in becoming HHPs to be held from February through June 2014
- Developing a HHP network adequacy report format for the health plans to report their progress in establishing networks of Health Homes, beginning April 15, 2014
- Holding 32 meetings in 16 cities for consumers to introduce the Health Homes program
- Creating a referral form for providers and hospitals to use to refer potential Health Homes members to the MCOs
- Creating an informational brochure to help inform consumers about Health Homes
- Securing funding from the Sunflower Foundation and REACH Foundation to support the Health Homes Learning Collaborative beginning July 2014
- Developing the PMPM rate for SMI Health Homes
- Publishing a draft Program Manual for SMI Health Homes
- Issuing tribal notification to the four recognized American Indian tribes
- Holding six day-long provider training sessions across the state
- Tasks completed since the last report:
 - Publishing a draft Program Manual for Chronic Conditions (CC) Health Homes
 - Developing PMPM rates for CC Health Homes
 - Developing the components the State wants the health plans to include in their contracts with HHPs
 - Consulting with SAMHSA for the second, chronic conditions, SPA
 - Issuing public notice about the SPAs and their fiscal impact
 - Submitting both SPAs to CMS officially on May 7, 2014
- Task still to complete
 - Performing an operational readiness review of the MCOs May 20-22, 2014
 - Reviewing network reports submitted by the MCOs

- Developing reporting requirements
- Completing operational work to receive files from and pay the MCOs for Health Home services

Another state initiative announced this quarter related to the expansion of our PACE programs. PACE Expansion activities will begin in the second quarter of 2014 following the announcement of the expansion of PACE counties from the current eight (8) counties to an additional fifty-nine (59) counties over the next few years. Currently PACE is only offered in the Topeka and Wichita areas and six other counties and serves approximately 380 individuals. The expansion will open up PACE services to an estimated 11,900 individuals in Kansas over the age of 55 who are clinically and financially eligible for the PACE program to live safely in their communities. Individuals who are served by the PACE program are excluded from KanCare while they are in the PACE program

Via Christi which began offering PACE in Wichita in 2002, will be expanding its current program in Sedgwick County to five adjacent counties. Via Christi has also been awarded six counties, including Johnson County, in the Northeast part of Kansas and will be partnering with local providers to offer PACE in this area in 2015. In addition, Via Christi has been awarded 12 counties in the Southeast corner of the state including Parsons, Pittsburg and Independence.

Midland Care, which began offering PACE in Topeka in 2007, will be expanding its current program from seven to 10 counties in the Shawnee County catchment area. Midland Care will be partnering with Kansas City Hospice and Palliative Care to open a new PACE program in 2015 in a five-county area in Northeast Kansas that includes Wyandotte County.

Bluestem Communities of Hesston has been awarded the PACE program for 20 counties that includes Newton, Hutchinson, Salina, Junction City and Manhattan. Bluestem plans to begin offering PACE services in 2015.

The State has completed contracts with the three PACE organizations, and the application process will begin in the second quarter. The PACE expansion applications are expected to be completed by July 2014. The map showing the PACE expansion counties and the service providers in those counties is available on the PACE website found at www.kdads.ks.gov.

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

- HCBS-IDD Provider Lunch and Learn teleconferences (1 hour, twice weekly)
- HCBS-IDD Consumer Lunch and Learn teleconferences (1 hour, weekly)
- CDDO meetings with KDADS and MCOs (weekly during February and March)
- TCM meetings with KDADS and MCOs (weekly during February and March)

- Long-term Care Roundtable with Department of Children and Families for stakeholders
- Big Tent Coalition meetings (monthly) to discuss KanCare and stakeholder issues
- Interhab (CDDO Association) board meetings (as requested)
- Traumatic Brain Injury Association of Kansas meetings (monthly)
- Community Mental Health Centers meetings (monthly) to address billing and other concerns
- KACIL (centers for independent living) board meetings (monthly)
- Series of workgroup meetings and committee meetings with the Managed Care Organizations and Community Mental Health Centers
- Quarterly Meetings with the Association of Community Mental Health Centers, including Managed Care Organizations
- Regular meetings with the Kansas Hospital Association KanCare implementation technical assistance group
- Series of meetings with behavioral health institutions, private psychiatric hospitals, and Psychiatric Treatment Residential Facilities (PRTFs) to address care coordination and improved integration
- KanCare's Provider and Operational Issues Workgroup
- KanCare's Consumer and Specialized Issues Workgroup
- Presentations, attendance, and information is available as requested by small groups, consumers, stakeholders, providers and associations across Kansas

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

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

Amerigroup participated in over 250 events for the first quarter allowing the plan to spread its message regarding education of services and benefits of the KanCare program to thousands of Kansans. Amerigroup continues to keep our focus on building relationships and learning more about the value it can bring to the community especially with the I/DD population and Health Homes implementation coming in July 2014 . Examples of marketing activities include exhibits at conferences, community held events, and meetings with key community partners. A sample of events Amerigroup supported in the first quarter includes (but is not limited to):

- KMOM (Kansas Mission of Mercy)
- KCK7 Project
- Health Homes KanCare statewide tour
- Mother and Child Health Coalition

Outreach Activities: One of Amerigroup's outreach efforts focuses on reaching its newly enrolled members. Amerigroup reaches out to new members to welcome them and to ensure they have completed their initial risk assessment. The plan also takes the time to answer specific member

questions and will remind them about critical services such as EPSDT. This initial outreach is primarily accomplished through phone calls and mailing. Amerigroup also performs targeted outreach to improve member knowledge about the services available to them. For example, Amerigroup will call members to help them understand the benefits of calling their nurse line instead of using the emergency room for non-emergent services. Amerigroup participates in a variety of community events in an effort to show support to community agencies and organization and answer member questions regarding their benefits. These “feet in the street” activities give Amerigroup the opportunity to cover topics such as diabetes, infant car seats, high blood pressure, teenagers and stress, your PCP and you, and others. Their participation at the Youth Health Days; KS ACA Today Fair; and KS Parents and Teachers Teen Resource Day are examples where Amerigroup’s staff participated in community events where they were available to provide general Medicaid information and to answer specific member questions.

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

Marketing Activities: Sunflower Health Plan carried out an advertising campaign in Q1 to highlight the plan's services to members and providers. Sunflower Health Plan

– Paid outreach campaign consisting of TV commercials and print/online ads

- 2,133 TV spots throughout the state including digital, web and ad on Ch. 22 in Wichita, run time Feb 6-9, 2014

- Wichita Eagle, run time Feb 16 - March 2

- Pittsburg Morning Sun, run time Jan 26 – Feb 16, 2014

Outreach Activities: The Member Connections staff were involved in many outreach events throughout the state of Kansas in the first quarter of 2014 such as:

- Head Start screening clinic in the Garden City area
- County health fairs in Sherman and Washington counties, and Ulysses, KS
- Treehouse meetings for pregnant teens in the Wichita area
- The Kansas WORK Employment meeting in Topeka
- The We Learn Together Conference in Wichita
- Community baby showers for safe sleep in Wichita and Kansas City

The Member Connections team has also reached out to new mothers in their areas to help them understand the importance of their post-partum and well child visits. The team helped members with any barriers to these visits such as transportation or access to a phone.

In March, Sunflower had a well-attended Start Smart for Your Baby Shower at The Children's Campus of Kansas City. Plan staff attending included a nurse case manager, social worker case manager, EPSDT coordinator, Cenpatico behavioral health case manager, Member Connections Representative, and a Spanish speaking staff member for translation. Community partners from Project Eagle and the Unified Government of Wyandotte County Health Department staff were also in attendance. Topics covered

included labor and delivery, finding a pediatrician, care after delivery for mom and dad, post-partum depression, WIC, and breastfeeding.

Advocacy Activities: Community Action Team (CAT) meeting – Wesley Medical Center, Wichita, Kansas
The CAT is a community-based coalition, whose goal is to reduce infant mortality in Sedgwick County. The CAT takes recommendations from the Fetal Infant Mortality Review Case Team and develops strategies to engage key stakeholders in programs, policies and initiatives to improve services and resources. There are 5 topic-specific task forces within CAT:

- Access
- Mental Health
- Maternal Smoking
- Preconception/Interconception Education
- “Count the Kicks” Education Sub-Task Force

Dates a Sunflower representative was present: January 22, 2014 (Access Team); February 26, 2014 (Access Team and Mental Health Team); and March 26, 2014 (Access Team and Mental Health Team)

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

Marketing Activities: United’s main activities have been focused on education with regard to the continued emphasis of health and benefit literacy regarding the UnitedHealthcare Community Plan of Kansas members. This is accomplished through attendance at community events that engage United members, member welcome calls, mailings to those who could not be reached by phone, and sending out quarterly Member Newsletter to all members. United has also begun the process of contacting key Medicaid medical provider offices to provide them with education on the benefits that members can achieve by completing their health screenings and by effectively managing their health with wellness activities.

Outreach Activities: United has three outreach specialists focused on activities targeted within a geographic area of Kansas. Their jobs are to conduct educational outreach to members, community based organizations and provider offices about UnitedHealthcare, 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 UnitedHealthcare for members who visit their offices.

- During the first quarter of 2014, UnitedHealthcare staff personally met with 4,378 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 2014, UnitedHealthcare staff personally met with 811 individuals from community based organizations located throughout Kansas. These organizations work directly with our members in various capacities.

- During the first quarter of 2014, UnitedHealthcare staff personally met with 1,052 individuals from provider offices located throughout the State.

Advocacy Activities: United's activities in advocacy are 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 individuals who support Kansans with disabilities.

- United's outreach specialist to the community of people with disabilities personally visited with 10 advocates, providing them with education on KanCare and UnitedHealthcare benefits, and has consistently been meeting with individual members and advocates across the State regarding implementation of I/DD services into managed care. This specialist staff also has been working internally to make sure that all operations of plan activities are focused on making sure that United's members are well represented in all processes.

-That same outreach specialist also worked in conjunction with the Empower Kansas steering committee on collecting more RFP's to award grantees in early 2014.

-Every quarter United holds a Member Advisory Council meeting to educate members on what the plan is working on and receiving feedback on ways to improve processes for members. During the first quarter, the meeting was focused on getting feedback from members on United's Member Handbooks as well as the process for communicating with members about their appeals, grievances and state fair hearing rights.

IV. Operational Developments/Issues

- a. Systems and reporting issues, approval and contracting with new plans: No new plans have been contracted with for the KanCare program; there are contract amendments pending with CMS for review/approval related to the existing MCOs. Through a variety of accessible forums and input avenues, the State is kept advised of any systems or reporting issues on an ongoing basis and worked either internally, with our MMIS Fiscal Agent, with the operating state agency and/or with the MCOs and other contractors to address and resolve the issues. Examples of this include ongoing external work groups with consumer focus and provider focus; technical work groups with key provider associations to resolve outstanding issues impacting timely and accurate reimbursement; and claims projects to assess and correct systemic issues.

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

- b. Benefits: All pre-KanCare benefits continue, and the program includes value-added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value added services used, per KanCare MCO's top three value-added services by reported value and total, January-March 2014, follows:

MCO	Value Added Service	Units	Value
Amerigroup	Adult Dental Care	634	\$86,615.30
	Member Incentive Program	2,331	\$69,370.00
	Mail Order OTC	2,114	\$34,610.02
	<i>Total of all Amerigroup VAS Jan-Mar 2014</i>	<i>6,464</i>	<i>\$230,254.63</i>
Sunflower	CentAccount debit card	10,508	\$210,160.00
	Adult Dental Services	7,438	\$136,585.56
	Start Smart (pregnant mothers, newborn program)	1,093	\$30,767.95
	<i>Total of all Sunflower VAS Jan-Mar 2014</i>	<i>26,226</i>	<i>\$ 447,551.00</i>
United	Additional Vision Services	2,974	\$144,418.29
	Join for Me - Pediatric Obesity Classes	25	\$62,500.00
	Adult Dental Services	381	\$20,341.59
	<i>Total of all United VAS Jan-Mar 2014</i>	<i>34,701</i>	<i>\$304,512.00</i>
Combined Totals	All MCOs - Jan-Mar 2014	67,391	\$982,317.63

- c. Enrollment issues: For the first quarter of calendar year 2014, there were 15 American Indian/Alaska Native people who chose to not be enrolled in KanCare. The table below represents the enrollment reason categories for the first quarter of calendar year 2014 (months January, February and March). All KanCare eligible members are defaulted to a managed care plan if they do not choose a plan during the application process.

Start Reasons	Total
Newborn assignment	3
KDHE - Administrative change	3
WEB - Change Assignment	33
KanCare Default - Case Continuity	114
KanCare Default - Morbidity	419
KanCare Default - 90 Day Retro-reattach	125
KanCare Default - Previous Assignment	173
KanCare Default - Continuity of Plan	244
Choice - Enrollment into KanCare MCO via Medicaid Application	221
Change - Enrollment Form	335
Change - Choice	896
Change - Access to Care - Good Cause Reason	5
Change - Case Continuity - Good Cause Reason	0
Assignment Adjustment Due to Eligibility	4
Total	2,575

d. Grievances, appeals and state hearing information

KDHE Grievance Data Base

Members - CY14 1st quarter report

MCO	Access	Dental Access*	Pharmacy	Benefits & Billing	Quality of Care	Rights and Dignity
Amerigroup	3	0	18	59	0	0
Sunflower	6	0	18	96	0	0
United	4	0	27	37	0	0

Providers - CY14 1st quarter report

MCO	Access	Enrollment	Dental Access*	Pharmacy	Benefits and Billing
Amerigroup	1	3	0	9	20
Sunflower	0	0	0	8	14
United	0	0	0	23	11

* HP is unable to provide numbers for these. HP will submit a change order to allow for this category to be calculated.

MCOs' Grievance Database

Members - CY14 1st quarter report:

MCO	Access to ofc	Avail-ability	QOC	Attitude/ Service of Staff	Bene-fits	Billing/ Fin Issues	Transp-Timely	Transp-Access	Phar	DME	Med Proc	Waiver HCBS Service	Mail/ Other
AMG	1	20	22	50	13	47	14	38	2	4	6	2	3
SUN	2	27	7	35	1	10	28	18	3	4	2	1	6
UHC	0	0	25	17	0	75	46	0	1	0	0	0	0

MCOs' Appeals Database

Members - CY14 1st quarter report

MCO	PA Dental	PA DME/ Ent Feed	PA WORK Hours	PA MRI, CT, Endo)	PA Phar-macy	PA OP/IP Surg	PA Gen Tests	LTSS/ HCBS PCA Hours	HH Hrs	OT/ PT/ ST	Inpt Covg	Ster/ Epid Inj/ Sleep	PCP/ Special-ist	Air Amb	Resid or CBS Trmt
AMG	4	10	2	14	6	2	0	14	0	0	0	0	0	0	0
SUN	0	11	0	10	36	4	3	5	10	13	17	5	0	2	5
UHC	2	6	0	0	9	2	0	30	2	2	0	1	2	1	0

MCOs' Appeals Database

MCO	MCO Auth	MCO Claim/ Billing	MCO Clin/ UM	MCO Phar	MCO Plan Admin/ Other	MCO QOC	MCO Cred/ Cont	Vision Auth	Vision Claim/ Billing	Dent Auth	Dent Claim/ Billing	Dent Plan Admin	Dent Clin/ UM	Cen-patico STRS Auth
AMG	20	8,403	62	0	0	0	0	1	6	1	57	0	0	0
SUN	3	79	36	47	12	23	1	1	54	0	2	17	55	19
UHC	0	744	0	0	0	0	0	1	19	0	26	0	0	0

Providers - CY14 1st quarter report (appeals resolved)

State of Kansas Office of Administrative Fair Hearings:
Members - CY14 1st quarter report

AMG-Red SUN-Green UHC-Purple	Claim Denied	PA Denied	Pharm Denied	Dental Denied	DME Denied	Pt Liab	Waiver Fin Elig (KDHE)	Hos-pice	HCBS PD Wait List	LTSS PCA Hrs
Withdrawn	2									1 1 6
Dismissed MCO paid/Moot	1	1	1 1		1		1			1 5
Default Dismissal Plaintiff no-show				1						1 2 1
Dismissed-Untimely										1
FH in process									1	2 3
OAH upheld MCO decision					1		1			1
OAH reversed MCO decision			1						1	
FH dec pending					1					

Providers - CY14 1st quarter report

AMG-Red SUN-Green UHC-Purple	Claim Denied	PA Denied	Pharm Denied	DME Denied	Pt Liab	Waiver Fin Elig (KDHE)	Hos-pice	Recoup-ment	Home Health Hrs	LTSS PCA Hrs
Withdrawn	10 2						6		2	1
Dismissed MCO paid/Moot	30 1 4	3 1 4		8 2			2		6	
Dismissed-No internal appeal	2 2	3		1					3	
FH in process	2	1			2		3			1
Dismissed-Untimely									6	
OAH upheld MCO decision								4		
FH dec pending	1		1		1	1				

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

f. Access: During the first quarter of 2014, there was a late upswing in requests for changes in plan affiliation outside of the open enrollment period. As discussed in previous reports, members who are not in their open enrollment period are unable to change plans without a

good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs. In the fourth quarter of 2013, KDHE received 156 member requests to change health plans. In the first quarter of 2014, KDHE received 118 member requests in total, with 90 requests in March. Only nine of the 90 requests were ultimately approved. As in previous quarters, GCRs (member “Good Cause Requests” for change in MCO assignment) after the choice period based solely on the member’s preference, when other participating providers with that MCO are available within access standards, are denied as not having good cause. The MCOs are tasked with offering to assist the member in scheduling an appointment with one of their participating providers.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the first quarter of 2014, there were no state fair hearings filed for a denied GCR.

Status	January	February	March
Total GCRs filed	18	10	90
Approved	1	1	9
Denied	8	2	34
Withdrawn (resolved, no need to change)	6	4	32
Dismissed (due to inability to contact the member)	3	3	14
Pending	0	0	0

There are still providers being added to the Plans’ networks with much of the effort still focused upon I/DD service providers. Numbers of contracting providers are as follows (for this table, providers were de-duplicated by NPI):

KanCare MCO	# of Unique Providers as of 6/30/13	# of Unique Providers as of 9/12/13	# of Unique Providers as of 12/31/13	# of Unique Providers as of 3/31/14
Amerigroup	16,706	16,891	17,352	18,897
Sunflower	13,016	14,478	15,404	15,931
UHC	14,738	15,893	18,010	19,872

In March, two issues caused the majority of good cause requests and the largest amount of concern. Both of these issues will continue into the second quarter of 2014. The first issue involved a number of dental practices either closing their panels or refusing entirely to accept patients from one of the plans. The affected plan has implemented remediation measures by switching to another dental sub-contractor.

A second source of concern was a large pediatric clinic which began in late March to give letters to their patients asking them to file good cause requests if the patient was enrolled with a certain plan. The affected plan held high level meetings with the clinic to address concerns. The clinic is still contracted with all plans, but KDHE is still seeing GCRs filed based upon the letters.

g. Proposed changes to payment rates: Effective January 1, 2014, the KanCare capitation rates were adjusted to reflect prospective medical trend to include cost as well as utilization. Rates were also adjusted to reflect program rate changes subsequent to the previous rate change. Effective February 1st, 2014, the KanCare capitation rates were adjusted to reflect the inclusion of long term support services for the I/DD population.

h. MLTSS implementation and operation:

Waitlist Management: In the third quarter of 2013, Kansas added nearly \$18.5 million for fiscal year 2014 to address the PD and IDD waiting lists. \$8.2 million in all funds were added in fiscal year 2013. Additional funds are anticipated to be added to address the waiting lists for fiscal year 2015. 250 individuals with IDD were added to the IDD waiver by the first quarter of 2014. Additionally, Kansas committed to eliminating the IDD “underserved” list by the end of July 2014.

Elimination of IDD “Underserved” List

The IDD request for additional services list (RASL) is commonly referred to as the “underserved” list. Previously maintained by the CDDOs, Kansas is managing the RASL and working with the MCOs to assess the 1740 individuals who were on the RASL as of December 2013. In the first quarter, KDADS received 997 responses for the 1740 individuals who are waiting for additional services. Of those responses, 35% requested services in 30 days; 20% indicate not needing services at all; 40% want future services. During the second quarter, Kansas will work with targeted case managers to ensure individuals who have a request for a service in the future have their requests identified for future planning in the individual’s person-centered support plans. For those who have not responded to the letter verifying their need for additional services, Kansas will conduct outreach activities and engage the CDDOs in the efforts. All individuals on the RASL will be assessed by the end of July 2014, and either be granted additional services or denied and given appeals rights. KDADS will be reviewing disputes related to the scope, duration and type of additional services as they arise.

PD Waiting List Verification process

In November 2013, KDADS attempted to contact 500 individuals on the PD waiting list to offer services to eligible individuals. Of that group, 69 individuals began receiving services, and additional 13 received services due to crisis situations. KDADS was not able to contact over 50% of individuals. Kansas worked with stakeholders to develop a plan to verify all of the individuals on the waiting list had a continued interest in waiting for services. During the first quarter, over 2,700 individuals on the PD waiting list were sent a letter and form to verify continued interest in waiting for services. During the quarter, 36% responded, and 72 individuals have been offered services based on the date they were added to the waiting list. Kansas has worked with stakeholders to reach individuals who have not responded by phone, fax, email or mail to the

letter and forms. Responses are due no later than June 30, 2014. In the first quarter of 2014, Kansas added 150 individuals unto the PD waiver through the waitlist verification process and crisis.

Money Follows the Person

Kansas's Money Follows the Person (MFP), five year demonstration grant, serves four HCBS populations: the Frail Elderly (FE), the Physically Disabled (PD), the Traumatic: Brain Injured (TBI), and the Intellectually/ Developmentally Disabled (I/DD). During the first quarter 2014, 69 individuals were transferred from institutions by the MCOs, and a new quality management specialist was hired. To increase the number of transitions from qualifying institutions to home and community based settings for individuals who would qualify for an HCBS program, the MCOs have identified single contacts for all MFP transitions and contracted with local independent living centers to provide transition coordination. Kansas is taking additional steps to improve the transition of individuals from qualifying institutions to ensure the program meets its goals and objectives. MFP is expected to meet its objectives to move individuals from qualifying institutions and shift them from Medicaid's traditional emphasis on institutional care to a system offering greater choices that include HCBS waiver services offered in a community setting.

- i. Updates on the safety net care pool including DSRIP activities: CMS and the State had a conference call on March 27, 2014, to review State goals for DSRIP and map out timeline for completing DSRIP protocols by May 31, 2014.
- j. Information on any issues regarding the concurrent 1915(c) waivers and on any upcoming 1915(c) waiver changes (amendments, expirations, renewals):

Quality Assurance Amendment Approvals

CMS approved the amendments to the 1915(c) HCBS waivers for incorporation of the new quality performance measures. The Autism, FE, TBI, Technology Assisted, and PD waivers were amended to include new quality measures for performance outcomes for the 1915(c) waivers. Most approvals came in late March, so final quality assurance protocols will be developed and updated in the second quarter. Kansas will also work on updating the Quality Improvement Strategy to reflect the updated protocols and amended waivers.

TBI & IDD 1915(c) Renewal

The Traumatic Brain Injury (TBI) program and the Intellectual/Developmental Disability (IDD) program planned to submit applications for renewal in the first quarter of 2014. The 1915(c) waivers for IDD and TBI expire on June 30, 2014. Submission of 1915(c) renewals for TBI and IDD were due by the end of the first quarter. Submissions were delayed a few days due to pending approvals for the previously submitted quality measures and web application malfunctions that prevented Kansas from completing the necessary changes for submission.

On the TBI renewal, Kansas responded to stakeholder comments related to proposed changes and did not change the limits on how long ago the TBI must have occurred, current policy language that requires a review of continued need or ability to rehab after four years on the program as demonstrated by sufficient progress, the program age limits, or the definition of traumatic brain injury. Kansas has proposed to bolster its policy requirements and change the documentation that is required to obtain TBI services to ensure program integrity.

During this time period, Kansas held several in person and telephonic information sessions in February and March 2014, to accept public comment on the proposed changes in the renewal of the TBI and IDD 1915(c) waivers. Tribal notifications were sent January 31, 2014. The sessions included discussion about proposed changes to the TBI and IDD programs and the CMS HCBS Final Rule, the State's proposal for the transition plan, and the subsequent timeframe for developing a Statewide Transition Plan.

The TBI Public comment period included the addition of an evening teleconference session to increase the opportunity for consumers, friends, family and other stakeholders to participate in the teleconference. The evening teleconference was successful and added to the IDD public comment period as an additional option for increasing public access and transparency during the renewal process. It will be used for other public comment sessions in the future.

On the IDD renewal, Kansas did not propose significant changes to the waiver and clarified conflicting language regarding guardians and legally responsible persons (parents and spouses). It has been explained to stakeholders that this may change in part due to federal rules. Kansas is committed to minimize the impact to families to the extent possible.

The IDD Public comment period included the addition of a formal request for information. This request allowed stakeholders and consumers to provide formal written responses and plans for improving the IDD program. This format had limited use because of the limited timeframe between MLTSS implementation for IDD and the deadline for renewal; however, it provided more detailed and thoughtful responses from consumers, providers, and MCOs related to improvements to the IDD system. This process will be used during the Transition Plan to ensure opportunities for detailed responses from HCBS participants and stakeholders. Responses to the RFI have been posted on the KDADS website for public review.

CMS Final Rule – Effective March 17, 2014

The new final rule, effective March 17, 2014, requires states to evaluate its HCBS settings to ensure compliance with the new rule's definition for home and community based settings. The new Final Rule affects all HCBS settings (residential and nonresidential) that are controlled, owned and operated by providers in which where individuals who receive home and community based services. In Kansas, there are seven HCBS waivers: Frail Elderly (65+), Autism (child who

starts services prior to age 6), Intellectual and Developmental Disabilities (5+), Technology Assisted (0 through 21), Traumatic Brain Injury (16-64), Physical Disability (16-64), and Serious Emotional Disturbance (0-18).

To ensure compliance with the new settings rules, Kansas will develop a transition plan consistent with regulation and the final rule during the second and third quarters of 2014. The Transition plan will be available for 30 days for public review and comments prior to submission to CMS. Additionally, Kansas will follow CMS guidance issued on March 20, 2014, related to recent language added to 42 CFR 431.301 regarding HCBS Transition Plans and required public comment periods for the IDD and TBI renewals.

The Transition Plan will include the State's plans to:

- Analyze all setting where HCBS participants receive services to determine if current settings comply with the Final Rule, Kansas will evaluate whether current settings: (1) Have the effect or isolating an individual from integration, (2) are not compliant, can the setting come into compliance within a specified timeframe or (3) cannot comply but can be replaced by alternatives that comply with the Final Rule.
- Develop and propose remedial strategies and timelines, which give reasonable notice and due process, include a relocation process timeline, assure impacted participants will be relocated to a compliant location, and individuals are informed of their options for alternative settings. The plan will include information about each setting type and the number of participants impacted.
- Provide opportunity for public comment and input for 30 days of the Transition Plan that includes information about the initial review and assessment of settings compliance, the public notice process plan, and information about where the approve Transition Plan will be posted.

Once approved by CMS, the Transition Plan will be added to the appropriate waivers through the amendment or renewal process. Kansas anticipates that the final rule will only affect settings for the IDD, PD, FE, and TBI programs. All other aspects of the Final Rule will be considered for amendments to the HCBS programs in the third and fourth quarters of 2014.

Department of Labor – Companionship Rule

Kansas is evaluating the impact of the Department of Labor's Final Rule related to the application of labor laws to direct service workers. Effective January 1, 2015, most direct care workers will be required to receive federal minimum wage and overtime pay protections. Direct care workers are critical components of HCBS services and perform services such as certified nursing assistants, home health aides, personal care aides, caregivers, and companions. The FMS Workgroup is following the rule because it may have an impact on the number of hours a direct services worker can work (40 hours per week) and the self-directing individual's ability to manage the employer-related responsibilities (anything over 40 hours a week requires

overtime). KDADS will provide additional training and information for consumers and stakeholders in the future. The State is reviewing the fiscal and programmatic impact and will submit appropriate amendments to the waivers and update relevant policies as needed.

Financial Management Services

Kansas has had an on-going workgroup focused on issues related to Financial Management Services (FMS). The FMS Workgroup submitted recommendations in December 2013 to change the model of FMS for individuals self-directing services on the HCBS Programs from the current Agency with Choice model to the Vendor/Fiscal Agent model. The workgroup was formed to address growing concerns about the impact of the Affordable Care Act on FMS providers. With the delay in implementation of the ACA requirements affecting FMS providers until January 2015, the State utilized the first quarter of 2014 to review and consider concerns related to self-direction, impact of vendor fiscal model on participants and agencies, and impact of the ACA and DOL Companionship Rules on administration of FMS under both models. Financial Management Services (FMS) Workgroup resumes work in the second quarter to address responses to the recommendations related to changing the model for FMS providers.

A subcommittee of members from the FMS Workgroup will begin working on next steps based on State responses to the FMS Workgroup's recommendations. Final decisions will be made after the recommendations and responses are posted for public comment. A formal amendment to the FMS model will be made in early fall, if necessary.

Ongoing MLTSS Activities

As part of ongoing program integrity and development the KDADS HCBS staff continues to listen to consumer and provider input and participates in the following workgroups and steering committees to ensure consistency, quality assurance, program integrity, and program improvements including but not limited to:

- Autism Steering Committee
- FMS Workgroup
- IDD KanCare Implementation Workgroup
- CDDO Business Meeting
- Statewide Funding Committee
- Statewide Oversight Committee
- TA Workgroup
- MFP Steering Committee
- MCO Technical Assistance
- HCBS Provider Forum (monthly)
- Friends and Family Advisory Council
- Employment First Committee

CMS 372 Submission Activities

CMS 372 reports have been submitted for the Intellectual and Developmental Disability (I/DD), Physically Disabled (PD) and Traumatic Brain Injury (TBI) programs. KDADS is responding to CMS' follow-up questions for these three reports and will submit responses no later than May 27. Additionally, KDADS is currently working on 372 reports for the Technology Assisted (TA), Severe Emotional Disturbance (SED), Frail Elderly (FE), Physically Disabled (PD) and Autism waiver programs.

- k. *Legislative activity:* The Robert G. Bethell Home & Community Based Services and KanCare Oversight Committee, a statutory joint committee, met twice during the first quarter to finalize its 2013 report and to review the current state of KanCare and the implementation of IDD long-term supports and services into KanCare. The committee received reports from KDHE, KDADS, and the Ombudsman's office and took comments from stakeholders, including providers and beneficiaries. The committee also heard reports from each KanCare managed care organization and testimony from the Kansas Insurance Department regarding implementation of the Federally Facilitated Marketplace.

During the first quarter, the Administration supported legislation to establish statutory penalties for late claims processing by MCOs, similar to a statute that applies to commercial payers. Other legislation introduced and considered included bills related to creating a registry for adult home care licensure and operators, autism insurance coverage, and Medicaid fraud prevention. The next quarterly report will detail the outcome of key legislation, as well as the introduction of a budget amendment to invest additional funds in waiting list reduction.

V. Policy Developments/Issues

I/DD LTSS

The Section 1115 demonstration amendment to provide long term supports and services (LTSS) for individuals with intellectual or developmental disabilities through KanCare managed care plans was approved in January, effective February 1, 2014.

HCBS Quality Assurance Protocols

CMS approved amendments to the 1915(c) waivers to incorporate new quality assurance performance measures consistent with recent CMS guidance. KDADS is currently revising its HCBS Quality Measures protocols and updating its data systems to ensure the collection and availability of meaningful and reliable quality assurance data for all of its HCBS Quality Measures.

Notices of Action

Kansas reviewed public comments and stakeholder feedback regarding the Notices of Action provided by the Managed Care Organizations for the HCBS Programs. Public concerns were related to language in the notices, lack of standardization across MCOs, and timeframes for appeals. To address concerns, Kansas engaged stakeholders in the process of designing a uniform HCBS Notice of Action (NOA). The

uniform language in use by each MCO, effective on or before April 1, 2014, includes:

- Clarity about access to MCO Appeals Process and State Fair Hearings
- Consistent timelines across all three MCOs
- Confirmation that services will continue during 33-day appeal “window”
- Language that member not liable for cost of continued services (exception only for fraud)

General Policy Changes

Kansas addressed policy concerns related to managed care organizations and state requirements through the weekly KanCare Policy Committee and KanCare Steering Committee. Policy changes are also communicated to MCOs through other meetings as necessary to ensure the key leadership and program staff is aware of changes. All policies affecting the operation of the Kansas Medicaid program and MMIS are addressed through a defined and well-developed process that is inclusive (obtaining input from and receiving review by use groups, all affected business areas, the state Medicaid policy team and the state’s fiscal agent) and results in documentation of the approved change. Limited policy changes were made during the first quarter.

Targeted Case Management

Policy changes were implemented for targeted case management during the implementation of IDD long-term supports and services into KanCare. The KMAP Manual was updated to remove language allowing targeted case managers to provide day supports, which is prohibited because it is a direct service. No targeted case managers have reported an adverse impact for this policy change. It was identified as remnant language that needed to be removed through a formal policy update. In addition, the KMAP Manual was updated to correct language allowing partial billing of a 15 minute unit, which could not be accommodated universally by all of the MCOs and is contrary to other policy, which prohibits the billing of partial units and requires whole units at the time of billing. Potential adverse impact was noted by providers. In response, Kansas created a subcommittee of targeted case managers to review the impact of the new billing policy and submit recommendations to the KDADs Secretary for consideration. The subcommittee will begin meeting in the second quarter. The state will continue to monitor any potential financial impact the policy may have on targeted case managers in the interim.

Positive Behavior Supports

Kansas included positive behavior supports services in KanCare on January 1, 2014, and worked during the first quarter of 2014 to develop policy changes to improve billing practices. Previous billing barriers limited the biller to a community developmental disability organization. This limitation has continued to be a barrier to the continued growth and use of the positive behavior support services under managed care. Policy changes were developed to remove this limiting language; however, Kansas was also required to submit a State Plan Amendment for the service. Effective April 1, 2014, PBS can be billed by the independently contracted and credentialed provider. Pending CMS approval, the State is responding to requests for additional information presented by CMS. The final PBS policy is expected to be complete and reported by the second quarter of 2014.

VI. Financial/Budget Neutrality Development/Issues

Budget neutrality: KDHE issues retroactive monthly capitated payments; therefore, the budget neutrality document cannot be reconciled on a quarterly basis to the CMS 64 expenditure report because the CMS 64 reflects only those payments made during the quarter. For the quarter ending March 2014 (DY2-Q1), the State removed the January payment amount/enrollment for December and input the April payment amount/enrollment for March. 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 were carved out from managed care through January 31, 2014, but required to be included in Budget Neutrality reporting.

Changes/New Issues: New Calendar Year 2014 rates were effective beginning with the January service payments. The IDD Waiver services were incorporated into the 1115 Waiver as of February 1, 2014. As a result, rates beginning with February service payments increased due to the inclusion of DD services.

General reporting issues: The start of the second demonstration year has brought additional challenges to reporting. (Reports for both DY1 and DY2 are now needed and the fiscal agent needs to identify which DY the expenditure is charged to.) KDHE continues to work with HP, the fiscal agent, to modify reports as needed in order to have all data required in an appropriate format for efficient Section 1115 demonstration reporting. KDHE communicates with the other Medicaid agencies regarding any needed changes.

VII. Member Month Reporting

Sum of Member Unduplicated Count	Member Month			Totals
MEG	2014-01	2014-02	2014-03	Grand Total
Population 1: ABD/SD Dual	17,955	17,931	17,888	53,774
Population 2: ABD/SD Non Dual	29,537	29,390	29,320	88,247
Population 3: Adults	36,287	36,899	37,625	110,811
Population 4: Children	218,714	220,576	222,639	661,929
Population 5: DD Waiver	8,773	8,765	8,761	26,299
Population 6: LTC	21,562	21,550	21,465	64,577
Population 7: MN Dual	1,297	1,250	1,205	3,752

Population 8: MN Non Dual	1,080	1,060	1,071	3,211
Population 9: Waiver	4,263	4,234	4,231	12,728
Grand Total	339,468	341,655	344,205	1,025,328

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

VIII. Consumer Issues

Summary of consumer issues during the first quarter of 2014:

Issue	Resolution	Action Taken to Prevent Further Occurrences
Member spenddown issues – spenddown incorrectly applied by plans, causing unpaid claims and inflated patient out of pocket amounts.	MCO’s work with the State to monitor and adjust incorrect spenddown amounts. Weekly spreadsheets are sent to the State, showing the MCO remediation efforts.	All affected plans have system correction projects completed and reprocessing projects currently in progress. This information is posted on the KanCare Claims Resolution Log for providers and the State to review and monitor.
Member claims denied incorrectly due to Third Party Liability (TPL). Claims are denied due to incorrect member TPL file information.	MCO’s correct the member files and reprocess affected claims. The State monitors member TPL reports and the resolution of those issues through a weekly issue log and the KanCare Claims Resolution log.	All plans have system correction projects under way and reprocessing projects will follow. This information is posted on the KanCare Claims Resolution Log for providers and the State to review and monitor.
Member services denied due to untimely prior authorization responses.	MCO attempted to clarify the policies and the correct method to submit for prior authorization. Appears to be miscommunication issues with provider.	MCO reviewed on-line directory and address information for prior authorization submittal and verified for accuracy and clarity. Will continue outreach as needed.
Member client obligation or patient liability incorrect.	Global system project completed in late February, which fixed a large portion of the issues. Weekly spreadsheets were sent to the state, showing MCO remediation efforts until the main issue was corrected.	All plans have system correction projects underway and reprocessing projects will follow. This information is posted on the KanCare Claims Resolution Log for providers and the State to review and monitor.

Continued eligibility confirmation gaps causing denial of services for members, particularly at pharmacies.	When referred to the State, eligibility was confirmed and the medication dispensed.	Simultaneous to the State referral, the member information is sent to the MCO. They will correct their file information so the situation should not occur again. Systematically, eligibility load times are still an issue, but showing improvement. The plans are continually monitored by the State for progress.
MLTSS Notifications/Notice of Actions: concerns that the Notices were too complicated, too long, and too different for consumers to understand. Notifications were inconsistent	Development of a Standardized Notice of Action and clear notification timeframes for MLTSS actions	A workgroup of stakeholders and the State met to review the language in the Notice of Action and develop a standard NOA. The NOA will be utilized in the second quarter
Billing Issues: Third Party Liability (TPL were common concerns related to billing, claims, and payments including denials	MCOs increased training opportunities for providers to understanding the billing process.	KDHE has taken proactive steps to identify blanket denials and educate providers on how to properly obtain denials. Enhancements to the KS AuthentiCare system will also minimize TPL related issues

In addition, related to consumer issues and supports: Outreach workers at Community Health Clinics across Kansas partner closely with local communities to provide health care education and assistance to KanCare members. Outreach workers also partner with the three KanCare MCO’s to conduct community events such as baby showers for pregnant women and new mothers, community health fairs and WIC clinics. Six of these workers are bilingual Spanish-speakers, enabling effective communication and partnership with the Latino community.

One outreach worker is dedicated to the Native American population, and has regular office hours at all the Kansas Indian Health Clinics. In conjunction with the MCO’s, outreach workers organize events at Haskell Indian Nations University. Any Native American citizen may access health services at the Haskell campus clinic, including an on-sight dental clinic. Cultivating relationships at Haskell provides important access to services for all KanCare members who are of Native American decent.

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. This comprehensive strategy was updated with additional operational details, and the MCO QAPIs for 2013 were finalized and approved in June 2013.

The State values a collaborative, race-to-the-top approach that will allow all KanCare MCOs, providers, policy makers and monitors to maximize the strength of the KanCare program and services. Kansas recognizes that some of the performance measures for this program represent performance that is above the norm in existing programs, or first-of-their-kind measures designed to drive to stronger ultimate outcomes for members, and will require additional effort by the KanCare MCOs and network providers. Therefore, Kansas continues to work collaboratively with the MCOs and provide ongoing policy guidance and program direction in a good faith effort to ensure that all of the measures are clearly understood; that all measures are consistently and clearly defined for 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 the State of 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 2014, some of the key quality assurance/monitoring activities have been:

- Ongoing and at least twice monthly business meetings between KDHE's KICCM team, other state staff as relevant to the subject matter, and cross-function/leadership MCO staff to continue 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, with extensive work on customizing measures for the year two P4P measures which will be validated by the state's EQRO, including integration of care, healthy life expectancy and nursing facility-related measures. Additional focus areas this quarter included addressing provider/association questions regarding HEIDIS data collection and disability/behavioral health performance data validation and reporting progress.

- Ongoing interagency and cross-agency collaboration, and coordination with MCOs, to develop and communicate both specific templates to be used for reporting key components of performance for the KanCare program, as well as the protocols, processes and timelines to be used for the receipt, distribution, review and feedback regarding submitted reports.
- Operationalizing the EQRO work plan for 2014, with the associated deliverables detail. One of the business meetings with the MCOs each month is dedicated to discussing EQRO activities, MCO requirements related to those activities, and timeline/action items to move all EQRO deliverables and related MCO deliverables along apace with good mutual understanding and clarity.
- Ongoing meetings of the KanCare Interagency Monitoring Team, with primary focus areas this quarter being the update of HCBS waiver performance measures and merging them with the KanCare comprehensive quality strategy, developing related HCBS waiver amendments, preparation for the addition of IDD waiver services into the KanCare program, and making optimal use of care management resources of the KanCare structure.
- Work continued during the first quarter of 2014 on the comprehensive annual compliance reviews of the MCOs – which are being done in partnership between Kansas' External Quality Review Organization and the two state agencies (KDHE and KDADS) managing the KanCare program, to maximize leverage and efficiency. Those annual reviews, which address both MCO regulatory requirements and many key state contract requirements, began in the fourth quarter of 2013, onsite components were completed in first quarter of 2014, and reporting is slated to be completed in the second quarter.
- Consistent with the STCs, the State has submitted revisions to the concurrently operating 1915(c) waivers (KS-0476, KS-0304, KS-4165, KS-4164, KS-0320 and KS-0303) to incorporate performance measures that are reflective of services delivered in a managed care delivery system, taking into account a holistic approach to care. The State sought technical assistance from a CMS vendor in the development of the new performance measures. Upon approval of the 1915(c) amendments, the State will revise the Comprehensive Quality Strategy to incorporate the new performance measures. KDADS will be revising the quality assurance protocols consistent with the approved quality assurance measures and in conjunction with the QIS.
- MFCU monthly meetings to address fraud, waste, and abuse cases, referrals to MCOs and State, and collaborate on solutions to identify and prevent fraud, waste and abuse.

- OIG/Program Integrity monthly meetings to build a system of identifying, investigating, and preventing fraud, waste, abuse through interagency and managed care cooperation.
- Facilitation of provider and MCO training to address implementation and programmatic questions for the integration of IDD long-term supports and services into KanCare.
- Review of the performance protocols for quality assurance to incorporate in to the comprehensive Kansas state quality strategy pending CME approval of the new quality assurance performance measures.
- Complex Case staffing of HCBS and Behavioral Health staff from the State with the MCOs. Each MCO brings a few complex cases for State review and consideration, and the State providers critical technical assistance and insight into program policies, integration, and other alternatives to meet an individuals' needs. These are held biweekly and integrated the State's behavioral health and long-term supports and services teams.
- KDHE and KDADS leadership and members of the IMT participate in bi-weekly meetings with the managed care organizations to address emerging and ongoing issues, identify innovative new opportunities, and provide one-one-one discussions.
- KDADS Quality Management Specialists (QMS) KDADS Quality Management Specialists (QMS) continue to provide quality assurance and oversight for the Behavioral Health and Home and Community Services programs.
 - Completion of 50% of the National Core Indicators surveys for a minimum of 400 individuals served by the IDD Program to establish a baseline of consumer satisfaction. The survey is being completed simultaneously as the required review process for the HCBS programs under the 1915(c) requirements. The estimated completion date is the second quarter of 2014.
 - QMS have conducted ride-a-longs with the MCO Care Coordinator for assessments for individuals on the request for additional services ("underserved") list.
 - APS/KDADS monthly meetings to address critical incidents, APS investigations, substantiations and monthly reports and data
 - Continue participation in the long-term care meetings to report quality assurance and programmatic activities to KDHE for oversight and collaboration
 - Publishing a policy memorandum detailing the process for license suspension and revocation following continued or egregious activities by a licensed provider. The revocation and termination policy for quality assurance is outlined by statute and regulation and details the process the State will take to ensure transition and choice following a provider losing their license for failing to perform the duties as required under the licensed.
 - Reviewing crisis, exception and transfer requests to ensure program integrity. Ad hoc reviews are assigned to the QMS to ensure health, safety, and welfare, follow up on a request for access to services, and continue to support program goals and objectives
 - Continuing regular meetings with stakeholders regarding policies, procedures, and practices for each waiver program. These meetings ensure providers and stakeholders

are able to view and comment on new policies and changes to policies before they are finalized.

- o Updating the licensing protocols, forms, and applications to remove language that is no longer applicable, change language in and reformat documents to make them easier to understand and more accessible.

X. Managed Care Reporting Requirements

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

Each MCO submits a monthly network adequacy report. The State uses this report to monitor the quality of network data and changes to the networks, drill down into provider types and specialties, and extract data to respond to requests received from various stakeholders. In addition, each MCO submits 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 viewing:

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 a summary table from each MCO and provides a side-by-side comparison of the access maps for each plan by specialty.
2. HCBS Service Providers by County: http://www.kancare.ks.gov/download/HCBS_Report_Update.pdf, includes a network status table of waiver services for each MCO.

Beginning in September 2013, an additional report was submitted to KanCare administration by each MCO that demonstrates participation of providers who perform I/DD waiver services.

- b. Customer service reporting, including average speed of answer at the plans and call abandonment rates:

KanCare Customer Service Report - Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0.10	2.0%	21,035
Sunflower	0.18	2.2%	31,721
United	5.79	0.4%	23,534
HP – Fiscal Agent	3.30	0.6%	21,503

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0.16	0.6%	16,028
Sunflower	1.17	2.5%	19,963
United	4.75	0.25%	14,951
HP – Fiscal Agent	0.15	0.9%	10,691

- 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 for the first quarter of 2014:

Accessibility

The KanCare Ombudsman was available to members and potential members of KanCare (Medicaid) through the phone, email, letters and in person during the first quarter of 2014. There were 545 contacts through these various means.

1st Qtr 2014 Contacts		MCO related	
January	153	Amerigroup	67
February	195	Sunflower	96
March	197	United Health	51
Total	545	Total	214

The KanCare Ombudsman website was completely revised to include educational resources for members and potential members seeking information. (<http://www.kancare.ks.gov/ombudsman.htm>)

- KanCare Ombudsman’s contact information at the top of the page
- The Role of the Ombudsman (revised based on the Center for Medicaid direction)
- Resource Information
 - KanCare Medicaid Contact Information (how to apply, didn’t get an enrollment packet, didn’t get an ID card)
 - MCO contact information
 - Frequently Asked Questions
 - Grievance/Complaint Process
 - MCO Appeal Process
 - State Fair Hearing/Appeal Process
 - Continuation of Services
 - MCO Member Resources on-line

- Reports
- Meet the KanCare Ombudsman

A link for the Ombudsman page was put on the KanCare Main page in the Consumer section to make it easier for people to locate.

Outreach

- The Ombudsman’s brochure was updated and is in the process of being printed at the state printer. The new brochures will be mailed in packages of 25 along with an introductory letter to Centers for Independent Living, Aging and Disability Resource Centers, Community and Developmental Disability Centers, Community Mental Health Centers, along with others as they are provided to the office.
- The Ombudsman attended the I/DD listening tour sessions across Kansas (March 18, Salina; March 19, Wichita; March 20, Pittsburg; March 21, Topeka).
- Attended and presented at the KanCare Advisory Council meeting, March 26 in Topeka.
- Attended and presented at the Consumer Specialized Issues (CSI) committee meeting, March 28, 2014 in Clay Center.
- The Ombudsman’s office sponsors the KanCare (I/DD) Friends and Family Advisory Council which met three times during first quarter and had several conference calls.
- Hosted Lunch-and-Learn weekly conference calls for the Intellectual/Developmental Disability (I/DD) parents, guardians and other consumers providing a guided question and answer time with a panel from the three Managed Care organizations and the / I DD team from Kansas Department on Aging and Disability Services (KDADS).

Future Outreach

- Ombudsman’s office is in the process of hiring a Volunteer Coordinator to create a volunteer program across Kansas to assist members with questions and issues.

Data

Current Data Info

Contact Method		Contact Method by MCO - Amerigroup		Contact Method by MCO - Sunflower		Contact Method by MCO - United	
phone	343	phone	29	phone	51	phone	24
email	194	email	38	email	39	email	26
letter	5	letter	0	letter	4	letter	1
in person	1	in person	0	in person	0	in person	0
on-line	1	on-line	0	on-line	0	on-line	0
other	1	other	0	other	0	other	0
Total	545	Total	67	Total	94	Total	51

(Emails are not posted in the log individually they are filed by quarter and by MCO for reference.)

Caller Type	
Provider	135
Consumer	384
MCO employee	4
Other	22
Total	545

Caller Type by MCO - Amerigroup	
Provider	16
Consumer	49
MCO employee	1
Other	0
Total	66

Caller Type by MCO - Sunflower	
Provider	21
Consumer	71
MCO employee	1
Other	0
Total	93

Caller Type by MCO - United	
Provider	13
Consumer	35
MCO employee	2
Other	0
Total	50

The issue categories have increased from twelve to twenty from the 4th quarter of 2013 to the 1st quarter of 2014 in order to decrease the number of issues in the “other” category and to better identify the concerns about which people are contacting the Ombudsman’s office. The top four concerns for 1st quarter are: Medicaid Eligibility, HCBS Eligibility, and Billing and Pharmacy.

Issues	
Medicaid Eligibility Issues	81
HCBS Eligibility issues	55
Billing	51
Pharmacy	38
Durable Medical Equipment	25
Appeals, Grievances	22
HCBS Reduction in hours of service	22
Access to Providers	16
Dental	16
Guardianship Issues	16
Medicaid Service Issues	14
Questions for Conf Calls/sessions	13
HCBS General Issues	11

Issues by MCO - Amerigroup	
Medicaid Eligibility Issues	7
HCBS Eligibility issues	3
Billing	7
Pharmacy	7
Durable Medical Equipment	10
Appeals, Grievances	2
HCBS Reduction in hours of service	3
Access to Providers	5
Dental	3
Guardianship Issues	0
Medicaid Service Issues	2
Questions for Conf Calls/sessions	0
HCBS General Issues	0

Issues by MCO - Sunflower	
Medicaid Eligibility Issues	2
HCBS Eligibility issues	12
Billing	15
Pharmacy	17
Durable Medical Equipment	7
Appeals, Grievances	2
HCBS Reduction in hours of service	6
Access to Providers	6
Dental	4
Guardianship Issues	1
Medicaid Service Issues	2
Questions for Conf Calls/sessions	1
HCBS General Issues	3

Issues by MCO - Sunflower	
Medicaid Eligibility Issues	8
HCBS Eligibility issues	4
Billing	6
Pharmacy	3
Durable Medical Equipment	4
Appeals, Grievances	5
HCBS Reduction in hours of service	3
Access to Providers	3
Dental	3
Guardianship Issues	2
Medicaid Service Issues	2
Questions for Conf Calls/sessions	0
HCBS General Issues	2

Transportation	11	Transportation	7	Transportation	0	Transportation	1
Care Coordinators	10	Care Coordinators	3	Care Coordinators	4	Care Coordinators	1
Nursing Facility Issues	8	Nursing Facility Issues	0	Nursing Facility Issues	0	Nursing Facility Issues	0
Change MCO	6	Change MCO	1	Change MCO	2	Change MCO	1
HCBS Waiting List issues	3	HCBS Waiting List issues	0	HCBS Waiting List issues	0	HCBS Waiting List issues	0
Housing issues	3	Housing issues	0	Housing issues	1	Housing issues	0
Other	49	Other	4	Other	6	Other	3
Unspecified	73	Total	64	Total	91	Total	51
Thank you	2						
Total	545						

Future Data Info

Since the 4th quarter of 2013, the Ombudsman’s office has changed its record-keeping process. The data log is undergoing a major overhaul, to be completed the end of April, and now will be used to:

- date the incoming request, modifications and when the request is closed
- calculate time required for assistance
- increase the number of issues to track from 12 to 20
- add three caller types under Consumer (HCBS, long-term care and other)
- add tracking for waiver-related types of services: physical disability (PD), intellectual/developmental disability (I/DD), frail elderly (FE), autism, severe emotional disability (SED), traumatic brain injury (TBI), money follows the person (MFP), program of all-inclusive care for the elderly (PACE), mental health (MH), behavioral health (BH), nursing facility (NF)
- add: Resources/How resolved category:
 - Question/Issue resolved
 - Used Resource/Issue Resolved
 - KDHE resources
 - DCF resources
 - MCO resources
 - HCBS team
 - CSP MH team
 - Other KDADS resources
 - Referred to State/Community Agency
 - Referred to DRC and/or KLS

f. Summary of MCO critical incident report: The Adverse Incident Reporting (AIR) System is the system used for behavioral health and HCBS critical incidents. All behavioral health and HCBS providers submit critical incidents for individuals receiving services. The critical incidents are

reviewed by quality management specialists (field staff) who may make unannounced visits and research critical incidents to determine if additional corrective action and monitoring are required to protect the health, safety and welfare of those served by the programs involved. AIR is not intended to replace the State reporting system for abuse, neglect and exploitation (ANE) of individuals who are served on the behavioral health and HCBS programs. ANE substantiations, therefore, are reported separately to KDADS from the Department of Children and Families (DCF) and monitored by an interagency team. This team ensures individuals with reported ANE are receiving adequate supports and protections available through KDADS programs, KanCare and other community resources. A summary of 1st quarter 2014 AIRS reports follows:

Critical Incidents	1 st Qtr	2 nd Qtr	3 rd Qtr	4 th Qtr	YTD
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	TOTALS
Total # Received	389				
Total # Reviewed	208				
Total # Pending	127				
APS Substantiations*	95				

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

In addition, during the first quarter of 2014, KDHE established the Cross-Agency Adverse Incident Management Team, including representatives from KDHE (the single state Medicaid agency), KDADS (the state operating agency for disability and behavioral health services) and DCF (Department for Children and Families, where adult and child protective services are managed), and for all three KanCare MCOs. The charter and expected outcomes of that team are as follows:

Charter:

The purpose of the Adverse Incident Management Team is to establish a statewide strategy to delineate and structure multi-agency efforts related to critical/adverse incident reporting. Several State agencies including DCF (Department of Children and Family Services), KDADS (Kansas Department of Aging and Disability Services) and KDHE (Kansas Department of Health and Environment) operate systems to receive, respond to manage and resolve incidents with the potential to impact members’ health, welfare and safety. Some adverse incidents may be instances of abuse, neglect or exploitation by another person or the member themselves and some are the result of avoidable and unavoidable accidents such as medication errors and falls. Further, each agency utilizes a different data system to collect and warehouse adverse incident documentation, investigations, remediation and findings and distinct policies and procedures for

numerous State and Federal reporting purposes. With the addition three MCOs (Managed Care Organizations) to these long-standing systems of care, the potential for competing and conflicting strategies to safeguards, monitoring, investigation and resolution is compounded. While there are some identifiable linkages between different state agencies and state agencies and stakeholders; each of these systems works fairly independent of the others.

Expected Outcomes:

- Agreed upon mutual understanding of the current adverse incident systems and natural linkages to develop a statewide strategy.
- Policy and Procedure development to delineate and structure multi-agency efforts.
- Monitoring process to evaluate the effectiveness of the statewide strategy.

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 attached Safety Net Care Pool Report identifies pool payments to participating hospitals, including funding sources, applicable to the first quarter of 2014. Disproportionate Share Hospital payments continue, as does support for graduate medical education.

XII. Demonstration Evaluation

The entity selected by KDHE to conduct KanCare Evaluation reviews and reports is the Kansas Foundation for Medical Care (KFMC). The draft KanCare evaluation design was submitted by Kansas to CMS on April 26, 2013. CMS conducted review and provided feedback to Kansas on June 25, 2013. Kansas reviewed that feedback worked internally and with the external evaluator, MCOs and others to address that feedback. The final design was completed and submitted by Kansas to CMS on August 23, 2013. On September 11, 2013, Kansas was informed that the Evaluation Design had been approved by CMS with no changes. Since then, KFMC has developed and submitted an evaluation report for the 4th Quarter of 2013 (regarding the subset of measures reported quarterly), and the first annual evaluation report for all of 2013.

For the 1st quarter of 2014, KFMC’s quarterly report is attached. As with the previous evaluation design reports, the State will review Quarterly Report, with specific attention to the related recommendations, and will take responsive action designed to accomplish real-time enhancements to the state’s oversight and monitoring of the KanCare program, and to improve outcomes for members utilizing KanCare services.

XIII. Other (DD Pilot, IDD MLTSS Implementation, PD Waitlist Management, RASL, Claims Adjudication Statistics)

a. KanCare I/DD Pilot Program

The KanCare IDD Pilot ended January 31, 2014. WSU-CCSR is working with the State and the EQRO to complete the Pilot Program’s evaluation. The final evaluation report will be available during the second quarter of 2014. The KanCare IDD Pilot Workgroup ended met through the first quarter to ensure the project evaluation was completed. The workgroup will transition during the second quarter into an advisory workgroup to the State regarding the CMS Final Settings Rule and DOL Companionship Rule. The group will continue to meet bi-weekly and is composed of a diverse group of IDD providers.

b. IDD Long-Term Supports and Services Integration into KanCare – February 1, 2014

Beginning on February 1, 2014, HCBS services and targeted case management for individuals in the Kansas IDD waiver program were integrated into KanCare following a one month delay in implementation. There are approximately 8,500 individuals on Kansas’ IDD waiver who were affected by this change. Their medical and behavioral health services have been delivered through KanCare since January 1, 2013. There are 12 services provided under the I/DD program, including residential and day supports, assistive services, medical-alert rental, financial management services, personal assistance services, overnight respite, sleep-cycle supports, specialized medical care, supportive employment, supportive home care and wellness monitoring.

In addition, CMS has agreed to Kansas’ plan for eliminating the IDD waiver program’s “underserved” waiting list, which has existed for more than a decade. The “underserved” list comprises Kansans with developmental disabilities who are already receiving Medicaid services necessary to allow them to continue to live independently, but who have requested additional services. Plans of care for all of these individuals will be reassessed to ensure that all consumers get the care they need. All individuals who are requesting additional services will be assessed by July 31, 2014.

MCO Contracting and Credentialing Report for IDD

Note: All information contained in the three tables below is as of March 30, 2014 as reported on the KKMAR reports dated 4/1/14. IDD HCBS and TCM Contracting status as of 3/31/14.

HCBS/IDD Providers

	Amerigroup	Sunflower	United
Contract Sent To Provider	308	299	396
Contracting Complete	207	241	200
Credentialing Complete	220	241	200

Declined To Contract/Unresponsive	62	39	91
Only Contracting with other MCO(s)	5	16	0

IDD TCM Providers

	Amerigroup	Sunflower	United
Contract Sent To Provider	118	115	125
Contracting Complete	101	101	80
Credentialing Complete	103	101	80
Declined To Contract/Unresponsive	10	7	8
Only Contracting with other MCO(s)	0	0	0

Lunch and Learn Teleconferences

The IDD Lunch and Learn Sessions were hosted during the 1st Quarter of 2014 to provide consumers, self-advocates, providers, and stakeholders with an open forum for information, discussion, questions and answers with the managed care organizations and the State. This format, started in December 2013, allows the state to be responsive to questions and concerns and provide a forum for the MCOs to interact with consumers and stakeholders in real time.

The Provider Lunch and Learn session were facilitated by WSU-CCSR twice weekly on Mondays and Fridays from 11:00 am to 12:00 pm. Stakeholders participated in the bi-weekly discussions, which included topics like the CMS Final Rule for HCBS settings, Department of Labor companionship rule, billing/claims, care coordination expectations, MCO notification, client obligation, and third party liability. Providers registered to attend the sessions in advance on the KDADS website, and questions were submitted by email to providerforum@kdads.ks.gov. This model has been very successful at engaging the providers and stakeholders. It will be expanded in the second quarter to include all HCBS providers and will include discussions about the Transition Plans for all of the HCBS programs.

The Consumer Lunch and Learn sessions were facilitated by WSU-CSSR on Wednesdays from 12:00 pm to 1:00 pm to allow consumers, guardians, family and friends to attend during a lunch hour. Consumers participated in the weekly discussion, which included topics like the CMS Final Rule for HCBS settings, Department of Labor companionship rule, the school-to-life transition, guardianship issues, shared living and alternatives to traditional day and residential, care coordination and health risk assessments, and how to request additional services. Consumers registered to attend the session in advance on the KDADS website, and questions were submitted by email to KanCare.Ombudsman@kdads.ks.gov. The KanCare Ombudsman also asked the MCO and State questions that were submitted for other reasons to ensure consumers had an opportunity to hear the responses and learn from these sessions. This model has been

very successful at engaging consumers, friends and family members. It will be continued in the second quarter on a bi-weekly basis and include all HCBS consumers, family, and friends. The discussions will include the MCOs and State and cover current topics like Health Homes, Self-Direction, HCBS settings rule, DOL companionship rule, and other upcoming changes and question and answer sessions.

Stakeholder Engagement

In February and March, 2014, the State met with stakeholders regularly to ensure they had an opportunity to connect with the State and share their comments, questions, and concerns on a regular basis. These one (1) hour teleconferences allowed stakeholders across Kansas to participate in the discussion and provide feedback.

Weekly Engagement meetings were held every Tuesday for targeted case managers. The TCM Program Manager, MCOs and TCMs met to discuss common practices and concerns. The regular meetings led to discussion about rounding and billing practices related to partial units and billing increments, the need for possible updates to the IDD Needs Assessment, standardization of the Person Centered Support Plan, and other opportunities to improvement and discussion. Small groups to address billing concerns, the needs assessment and the person-centered plan were created. These groups will continue to meet regularly in the second quarter. The TCM calls will move from weekly to bi-weekly in the second quarter and additional training opportunities will be created.

Weekly engagement meetings were held every Thursday for the community developmental disability organizations (CDDOs). The regular meetings allowed the CDDOs to meet with the State on a regular basis and discussion issues related to billing, communication, notification, crisis, access, and requests for additional units. Also, some of the weekly one hour meetings were expanded to include the MCOs and discuss areas of importance for ensure timely access and services for individuals with IDD. The CDDO meetings will continue during the second quarter on a less frequent basis and as needed to ensure the lines of communication stay open between all of the parties.

Targeted Case Manager/Care Coordinator Summits

In addition to routine meetings continued by state staff with a broad range of providers, associations, advocacy groups and other interested stakeholders, Kansas held multiple Summits across the state for targeted case managers and managed care organization care coordinators. The training for case managers and care coordinators for the IDD programs included a 3 hours session of information and examples for the two groups to work through in small groups. The training slides can be found online at: http://www.aging.ks.gov/HCBSProvider/Documents/TCM-CC_Summit_01_21_2014.pdf.

Summary of the summits

- 3 Locations across Kansas – Salina, Wichita, Overland Park
- Held January 22nd, 23rd, and 24th
- Facilitated by Wichita State University – Community Services and Supports Research
- PowerPoint was posted on website and emailed to attendees
- Over 405 attendees (including care coordinators ~ 125)

During the 1st quarter of 2014, Kansas also hosted Open House sessions for HCBS-IDD participants

- 3 Locations across Kansas – Salina, Wichita, Overland Park
- Hosted by WSU-CSSR (including snacks) following the TCM/CC Summits
- Approximately 100 consumers, friends, and family members attended the Open Houses
- No formal presentations were given, face-to-face meetings with Care Coordination

Post-summit surveys were collected by WSU-CSSR and analyzed to identify areas of improvement and training requests for future summits. Generally the attendees appreciated the summit and learning format. Some requested more detailed information and different topics for future trainings.

This model will be used in the future for other Care Coordinator and stakeholder summits to foster conversation and collaboration in small group settings with a large number of participants. Following the training sessions with Open House opportunities for Care Coordinators to meet with those they serve in an informal environment helped to increase communication and decrease concerns and fears.

Summary of Stakeholder Engagement and Communication

- Letters & Memoranda
- Public Information Sessions
- TCM/CC Summits
- IDD Provider Bulletins
- Lunch and Learn Calls (started the week of December 9th)
 - Consumer calls are held weekly at noon on Wednesdays
 - Provider calls held twice weekly at 11:00 on Mondays and Fridays

Consumer Engagement:

- Increased Consumer engagement activities in the first quarter by using Open House sessions following training events (Meet and Greet, no presentations) and teleconference Lunch and Learn sessions (1 hour over lunch with the Ombudsman and MCOs)
- Consumer notifications of elimination of the “underserved” list and implementation of IDD long-term supports and services into KanCare

Provider Engagement:

- Contracting and credentialing reporting is due weekly to KDADS.
- Targeted Case Management
- Community Developmental Disability Organizations
- Provider Trainings
- Weekly provider bulletins and rearranging the provider section of the website to make it easier to view policy changes and access recently added information

Billing and Claims - IDD KKMAR (KanCare Key Management Activities Report)

IDD Claim/Payment Status Reporting Date: 3/28/14 Data Period Ending: 3/26/14

Below you will find billing/payment data through 03/26/14. KDADS actively monitored the IDD KKMAR, which was submitted by MCOs twice weekly during the first quarter of implementation. Billing and claims issues were reviewed and followed up with by each MCO for issues that were included in the reason for denial list.

- A total of \$36,572,832 was billed for HCBS/IDD, and a total of \$32,545,545 was paid.
- A total of \$1,013,359 has been billed for IDD/TCM, and a total of \$967,128 has been paid.
- TCM/IDD payments increased to 967K by the 3/26 the reporting periods.
- There are 1,794 denials for duplicate claims.
- There were 669 denials for “Error in billing (procedure code, NPI, etc.)”. These denials are being identified primarily as issues with providers billing with the incorrect ID numbers or using an incorrect procedure code. This appeared to be largely an issue around MCOs rejecting or denying claims without an NPI number.

HCBS/IDD	Amerigroup	Sunflower	United	Total
HCBS/IDD Claims Lines in Received	37,273	65,062	30,630	132,965
HCBS/IDD Claims Lines in Process/Pending	5,845	8	3,967	9,820
HCBS/IDD Claims Lines Paid	32,255	64,052	25,422	121,729
HCBS/IDD Claims Lines Denied	796	1002	1241	3039
HCBS/IDD Billed Amount	\$10,231,586	\$18,118,357	\$8,222,889	\$36,572,832
HCBS/IDD Amount in Process/Pending	\$1,581,349	\$151,577	\$1,040,752	\$2,773,678
HCBS/IDD Amount Paid	\$8,617,010	\$17,262,127	\$6,666,408	\$32,545,545
HCBS/IDD Amount Denied	\$296,751	\$298,259	\$515,729	\$1,110,738

TCM/IDD	Amerigroup	Sunflower	United	Total
HCBS/IDD Claims Lines in Received	2,774	5,090	2,095	9,959
HCBS/IDD Claims Lines in Process/Pending	310	0	73	383

HCBS/IDD Claims Lines Paid	2,482	5,060	1,949	9,491
HCBS/IDD Claims Lines Denied	98	30	73	201
HCBS/IDD Billed Amount	\$274,858	\$508,316	\$230,185	\$1,013,359
HCBS/IDD Amount in Process/Pending	\$29,121	\$0	\$8,864	\$37,986
HCBS/IDD Amount Paid	\$245,288	\$506,419	\$215,420	\$967,128
HCBS/IDD Amount Denied	\$4,881	\$2,859	\$5,900	\$13,640

Denial of Claims – Top Reasons

Top HCBS/TCM Denial Reasons	Amerigroup	Sunflower	United	Total
1. Non-covered service/item	17	15	24	56
2. Service not authorized	84	0	9	93
3. Service limit exceeded without PA	0	95	19	114
4. Member not eligible	16	0	26	42
5. Provider not contracted for service	17	0	9	26
6. Duplicate Claim	468	892	434	1794
7. Error in billing (procedure code, NPI, etc.)	49	28	592	669
8. Date of service not covered	0	0	0	0
9. Exceeds filing time limit	0	0	0	0
10. Claim and PA not matching	0	0	2	2
11. Denial required from primary insurance	24	0	112	136
12. Other	219	2	87	308

Turnaround Times

HCBS/IDD	Amerigroup	Sunflower	United	State Average*
HCBS/IDD Average Days Age Clean	4.7	5.0	7.0	5.3
HCBS/IDD Average Days Age All Claims	4.7	5.0	7.0	5.3
TCM/IDD	Amerigroup	Sunflower	United	State Average*
HCBS/IDD Average Days Age Clean	5.2	5.0	7.0	5.5
HCBS/IDD Average Days Age All Claims	5.2	5.0	7.0	5.5
*This is a weighted average based on the portion of MCO claims.				

Early Billing and Claims Issues

Issues resolved during the first quarter include:

- Access to KMAP was temporarily down, which caused minor problems for providers trying to bill. The service functions on the KMAP website were limited until functions were restored.

Claims issues related to KMAP problems resulted in one provider have higher than normal denials from the MCOs. The issue was corrected, proactive steps were taken to notify affected providers, and shortly providers resumed billing as normal without further interruption.

- Denials for Third Party Liability (TPL) were resolved with additional education and posting a Q & A document online. The TPL Frequently Asked Questions are available online for providers to review at the following link: http://www.aging.ks.gov/HCBSProvider/IDD_Provider_Index.html.
- Plans of Care that spanned pre-KanCare and post-KanCare implementation were managed by the MCOs and State staff. The need to manually handle plans of care that have errors or need changes should decrease in the second quarter, and cease to be a problem by the third quarter of 2014.

Summary of Billing and Claims

Steps taken to minimize concerns or issues related to potential billing problems included

- Reminding providers who were using the KMAP/EDI front-end billing and the MCO billing portals to wait a few days after submitting a claim for them to appear in the MCO system for review in the MCO web portal and contact the MCO through the Member Representative. The Care Coordinator Education activities continued to ensure limited billing concerns. Failing to wait a few days to see the claims in the MCO portal could result in multiple duplicate claims, which would be properly denied.
- Instructing providers who did not previously have an NPI listed with KMAP but have an NPI now, to contact KMAP Provider Enrollment by email or mail to update the NPI information in KMAP. The issue was resolved within a few weeks. The process to obtain an NPI did not take long, and most providers needed to be reeducated to use the correct information when billing
- Hosting training and Lunch and Learn sessions related to Third Party Liability including information on how to obtain it, how to submit it to MCOs and why it is required.

c. Request for Additional Services List (RASL)

On January 31, 2014, KDADS sent a letter to all HCBS-IDD program participants who are currently receiving HCBS services and have asked for additional services in the past. The forms were initially due to KDADS by Saturday, March 1, 2014; however, KDADS has continued to accept forms after this date. Individuals could submit forms to KDADS by mail to 503 S. Kansas Ave, Topeka, KS 66603, by fax to 785-296-0256 or by email to HCBS-KS@kdads.ks.gov. They could also work with their care coordinator and targeted case manager to complete the form and submit it to the state. The letter and confirmation form has been made publically available on the KDADS website at:

http://www.kdads.ks.gov/CSP/IDD/KanCare_Imp/2014_01_31_RASL_Consumer_Letter_Form.pdf.

The “underserved” list is composed of those individuals who are receiving HCBS services, but at some time in the past, they requested an additional service or additional units of service. They were then added to the BASIS data system, from which was created a list that consists of those who requested an additional service.

The waiting list is composed of those individuals who are not receiving any HCBS services, but they may be receiving targeted case management, which is a State Plan service. Those individuals are considered “unserved” and are waiting for access to HCBS-IDD services. This process does not include those who are still waiting for access to HCBS-IDD services.

Only those on the “underserved” list would have received a letter and form. Individuals have the opportunity to report whether services are needed within 30 days, within 12 months, in more than 12 months or no additional services are needed. For those who did not need services within 30 days, the targeted case manager will work with the individual to update the person-centered plan and document future requests for additional services. At any time a person’s needs change, the individual can request an assessment for additional services.

To assist individuals who had questions about the “underserved list,” KDADS posted an FAQ for those on the “underserved” list. The key points include:

1. If someone is on the underserved list and decides that they do not need services now, they can indicate that and wait until services are needed in the future. This is NOT the only opportunity for an individual’s needs to be addressed.
2. If needs change in the future, the TCM and Care Coordinator will conduct the assessment process and may update the ISP to include supports and services required to meet assessed needs.

The MCOs are working with the Targeted Case Managers to assess all individuals on the “underserved” list (1740) and ensure all needs are identified and appropriate supports and services are provided. By July 31, 2014, all individuals who are waiting for one service and requesting an additional service as of December 31, 2014, will either receive needed additional supports and services or receive a notice of action denying additional units that includes information about the right to appeal the decision and how to file a grievance and/or an appeal.

d. Claims adjudication statistics: KDHE’s summary of the numerous claims adjudication reports for the KanCare MCOs, covering January-March 2014, is attached.

XIV. Enclosures/Attachments

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

Section 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.

Section XII refers to the KFMC’s 2014 KanCare Evaluation Quarterly Report related to the assessment of KanCare performance measures reported quarterly. That report is attached.

Section XIII(d) refers to KDHE’s Summary of KanCare MCO Claims Adjudication Statistics – 1st Quarter 2014, and that summary is attached.

XV. State Contacts

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XVI. Date Submitted to CMS

May 30, 2014

DY 2

Start Date: 1/1/2014
End Date: 12/31/2014

Quarter 1

Start Date: 1/1/2014
End Date: 3/31/2014

	Total Expenditures	Total Member-Months
Jan-14	189,932,005.96	348,481
Feb-14	229,825,306.46	347,591
Mar-14	215,162,730.88	350,588
PCP	(3,945,991.03)	
Q1 Total	630,974,052.27	1,046,660

	Population 1: ABD/SD Dual	Population 2: ABD/SD Non Dual	Population 3: Adults	Population 4: Children	Population 5: DD Waiver	Population 6: LTC	Population 7: MN Dual	Population 8: MN Non Dual	Population 9: Waiver
Jan-14									
Expenditures	3,398,402.15	32,327,803.26	25,069,460.06	45,651,426.15	9,021,398.60	59,735,646.87	1,551,475.12	2,148,092.90	11,028,300.85
Member-Months	18,752	30,721	39,068	220,692	9,070	22,696	1,546	1,441	4,495
Feb-14									
Expenditures	3,331,672.34	32,081,660.76	21,220,011.03	45,373,133.74	53,498,379.58	59,782,782.80	1,402,247.30	2,155,070.25	10,980,348.66
Member-Months	18,388	30,029	39,070	221,688	8,982	22,227	1,396	1,395	4,416
Mar-14									
Expenditures	3,392,421.34	32,465,604.16	19,782,038.64	45,773,793.74	38,812,273.11	60,071,173.06	1,537,709.21	2,311,584.08	11,016,133.54
Member-Months	18,837	30,601	38,516	223,634	9,055	22,525	1,486	1,473	4,461
PCP									
Expenditures	(11,663.34)	(631,494.34)	(194,779.78)	(2,772,811.49)	(79,141.03)	(125,484.28)	(1,152.71)	(35,266.94)	(94,197.12)
Q1 Total									
Expenditures	10,110,832.49	96,243,573.84	65,876,729.95	134,025,542.14	101,252,910.26	179,464,118.45	4,490,278.92	6,579,480.29	32,930,585.93
Member-Months	55,977	91,351	116,654	666,014	27,107	67,448	4,428	4,309	13,372
DY 2 - Q1 PMPM	180.6248	1,053.5580	564.7190	201.2353	3,735.3049	2,660.7775	1,014.0648	1,526.9158	2,462.6523

Note:

- 1) DY 2, quarter 1 total expenditures are significantly less than DY 1, quarter 4 due to one time reporting of retroactive delivery payments in quarter 4.
- 2) CHIP and refugee populations are not included in the BN member months or expenditures.
- 3) Share of cost is excluded from expenditures.

Safety Net Care Pool Report
Demonstration Year 2 - QE March 2014

Large Public Teaching Hospital\Border City Children's Hospital Pool
Paid 03/28/14

Provider Name	1st Qtr Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	2,491,034.00	1,073,386.55	1,417,647.45
University of Kansas Hospital	7,473,103.00	3,220,160.08*	4,252,942.92
Total	9,964,137.00	4,293,546.63	5,670,590.37

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

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 2 - QE March 2014

Health Care Access Improvement Pool

Paid 5-09-2014

Hospital Name	HCAIP DY/QTR: 2014/1	Provider Access Fund 2443	Federal Medicaid Fund 3414
Bob Wilson Memorial Hospital	46,146.00	19,884.31	26,261.69
Children's Mercy Hospital South	183,833.00	79,213.64	104,619.36
Coffey County Hospital	11,460.00	4,938.11	6,521.89
Coffeyville Regional Medical Center, Inc.	68,275.00	29,419.70	38,855.30
Cushing Memorial Hospital	106,293.00	45,801.65	60,491.35
Galichia Heart Hospital LLC	79,677.00	34,332.82	45,344.18
Geary Community Hospital	132,386.00	57,045.13	75,340.87
Hays Medical Center, Inc.	313,378.00	135,034.58	178,343.42
Hutchinson Hospital Corporation	204,892.00	88,287.96	116,604.04
Kansas Medical Center LLC	75,092.00	32,357.14	42,734.86
Kansas Rehabilitation Hospital	1,589.00	684.70	904.30
Labette County Medical Center	72,833.00	31,383.74	41,449.26
Lawrence Memorial Hospital	285,420.00	122,987.48	162,432.52
Memorial Hospital, Inc.	44,817.00	19,311.65	25,505.35
Menorah Medical Center	156,072.00	67,251.42	88,820.58
Mercy - Independence	60,200.00	25,940.18	34,259.82
Mercy Health Center - Ft. Scott	95,683.00	41,229.80	54,453.20
Mercy Hospital, Inc.	5,341.00	2,301.44	3,039.56
Mercy Reg Health Ctr	133,915.00	57,703.97	76,211.03
Miami County Medical Center	67,245.00	28,975.87	38,269.13
Morton County Health System	23,195.00	9,994.73	13,200.27
Mt. Carmel Medical Center	218,236.00	94,037.89	124,198.11
Newman Memorial County Hospital	139,086.00	59,932.16	79,153.84
Newton Medical Center	192,431.00	82,918.52	109,512.48
Olathe Medical Center	300,858.00	129,639.71	171,218.29
Overland Park Regional Medical Ctr.	611,996.00	263,709.08	348,286.92
Pratt Regional Medical Center	51,979.00	22,397.75	29,581.25
Providence Medical Center	446,753.00	192,505.87	254,247.13
Ransom Memorial Hospital	86,279.00	37,177.62	49,101.38
Saint Catherine Hospital	183,279.00	78,974.92	104,304.08
Saint Francis Health Center	315,942.00	136,139.41	179,802.59
Saint John Hospital	102,201.00	44,038.41	58,162.59
Saint Luke's South Hospital, Inc.	92,753.00	39,967.27	52,785.73
Salina Regional Health Center	128,672.00	55,444.76	73,227.24
Salina Surgical Hospital	2,929.00	1,262.11	1,666.89
Select Specialty Hospital - Kansas City	21,642.00	9,325.54	12,316.46
Shawnee Mission Medical Center, Inc.	616,117.00	265,484.82	350,632.18
South Central KS Reg Medical Ctr	46,073.00	19,852.86	26,220.14
Southwest Medical Center	112,968.00	48,677.91	64,290.09
Stormont Vail Regional Health Center	873,799.00	376,519.99	497,279.01
Summit Surgical LLC	150,738.00	64,953.00	85,785.00
Sumner Regional Medical Center	34,084.00	14,686.80	19,397.20
Susan B. Allen Memorial Hospital	132,727.00	57,192.06	75,534.94
Via Christi Hospital St Teresa	103,783.00	44,720.09	59,062.91
Via Christi Regional Medical Center	1,727,054.00	744,187.57	982,866.43
Via Christi Rehabilitation Center	54,123.00	23,321.60	30,801.40
Wesley Medical Center	1,178,379.00	507,763.51	670,615.49
Western Plains Medical Complex	141,655.00	61,039.14	80,615.86
Prairie View Inc.	9,903.00	4,267.20	5,635.80
Marillac Center, Inc.	1,907.00	821.73	1,085.27
	10,246,088.00	4,415,039.32	5,831,048.68

2014 KanCare Evaluation Quarterly Report

Year 2, CY2014, Quarter 1, January - March

Contract Number: 11231

Program(s) Reviewed: KanCare Demonstration

Submission Date: May 23, 2014

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Prepared for:

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Year 2, CY2014, Quarter 1, January – March

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2014 KANCare EVALUATION QUARTERLY REPORT **Year 2, CY2014, Quarter 1, January – March** **MAY 23, 2014**

BACKGROUND/OBJECTIVES

The Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF), submitted the KanCare Evaluation Design to the Centers for Medicare & Medicaid Services (CMS) on August 24, 2013, and it was approved on September 11, 2013. The Kansas Foundation for Medical Care, Inc., (KFMC) is conducting the evaluation. KFMC also serves as the External Quality Review Organization (EQRO) for Kansas Medicaid managed care.

The KanCare Evaluation Design includes over 100 annual performance measures developed to measure the effectiveness and usefulness of the five-year KanCare demonstration managed care Medicaid program. Annual performance measures include baseline and cross-year comparisons; the first year of the KanCare demonstration, calendar year (CY) 2013 serves as a baseline year. Data sources for assessing annual performance measures include administrative data, medical and case records, and consumer and provider feedback.

A subset of the annual performance measures was selected to be assessed and reported quarterly. The quarterly measures for the first quarter (Q1) CY2014 report include the following:

- Timely resolution of customer service inquiries.
- Timeliness of claims processing.
- Grievances
 - Track timely resolution of grievances.
 - Compare/track the number of access-related grievances over time, by population categories.
 - Compare/track the number of grievances related to quality over time, by population.
- Ombudsman's Office
 - Track the number and type of assistance provided by the Ombudsman's office.
 - Evaluate for trends regarding types of questions and grievances submitted to the Ombudsman's office.
- Systems - Quantify system design innovations implemented in Kansas such as Person Centered Medical Homes (PCMH), Electronic Health Record (EHR) use, Use of Telehealth, and Electronic Referral Systems.

KanCare health care services are coordinated by three managed care organizations (MCOs): Amerigroup of Kansas, Inc., (Amerigroup), Sunflower State Health Plan

(Sunflower), and UnitedHealthcare Community Plan of Kansas (United). For the KanCare Quarterly and Annual Evaluations, data from the three MCOs are combined wherever possible to better assess the overall impact of the KanCare program.

Preliminary review of the following findings has occurred with KDHE, and they will be working to remedy the issues addressed. Interagency/MCO work group meetings are being scheduled in Q2 CY2014 to modify reporting templates and to clarify grievance definitions to promote greater consistency in reporting.

TIMELY RESOLUTION OF CUSTOMER SERVICE INQUIRIES

Quarterly tracking and reporting of timely resolution of customer service inquiries in the KanCare Evaluation is based on the MCOs' contractual requirements to resolve 95% of all inquiries within 2 business days of inquiry receipt, 98% of all inquiries within five (5) business days, and 100% of all inquiries within 15 business days.

DATA SOURCES

Data sources for the Q1 CY2014 KanCare Quarterly Evaluation Report are monthly KanCare Key Management Activities Reports (KKMAR). In the KKMAR reports, MCOs report the monthly and cumulative percentage of member and provider inquiries resolved within 2, 5, 8, 15, and greater than 15 days and the percentage of inquiries pending. MCO staff provided KFMC with the monthly counts that correspond to the KKMAR reported percentages. In CY2013, MCOs reported the customer service inquiry counts on the Pay for Performance (P4P) reports. As timeliness of resolution of customer service inquiries was a P4P measure only in CY2013, the P4P report does not report customer service data for CY2014. In Table 1 below, the quarterly counts of member and provider customer service inquiries for Q1-Q4 of CY2013 are based on P4P report data, and the quarterly counts for Q1 CY2014 are based on monthly data reported to KFMC by MCO program managers. Percentages reported in the KKMAR were then used to calculate the number of inquiries resolved and not resolved within 2, 5, and 15 business days.

Table 1 - Timeliness of Resolution of Customer Service Inquiries					
	CY2013				CY2014
	Q1	Q2	Q3	Q4	Q1
Number of Inquiries Received	261,286	181,427	157,547	146,374	141,964
Number of Inquiries Resolved Within 2 Business Days	260,859	180,903	157,185	146,299	141,907
Number of Inquiries Not Resolved Within 2 Business Days	298	524	362	75	57
Percent of Inquiries Resolved Within 2 Business Days	99.84%	99.71%	99.77%	99.95%	99.96%
Number of Inquiries Resolved Within 5 Business Days	261,286	181,427	157,458	146,349	141,951
Number of Inquiries Not Resolved Within 5 Business Days	0	0	89	25	13
Percent of Inquiries Resolved Within 5 Business Days	100%	100%	99.94%	99.98%	99.99%
Number of Inquiries Resolved Within 15 Business Days	261,286	181,427	157,547	146,374	141,964
Number of Inquiries Not Resolved Within 15 Business Days	0	0	0	0	0
Percent of Inquiries Resolved Within 15 Business Days	100%	100%	100%	100%	100%

Beginning in January 2014, detailed customer service data began to be reported in the Member and Provider Services Phone Line reports. The Member and Provider Services Phone Line reports track the total number of calls “offered,” “handled,” and “abandoned,” the average length of calls, and the top five reasons for calls placed not only to the MCOs directly, but to each of their vendors as well.

While Member and Provider Service Phone Line report tracks call volume, transfers, and call length, the KKMAR report tracks calls by customer service inquiry category. KKMAR customer service inquiry categories include: claim or billing question; coordination of benefits; ordering an ID card; eligibility questions; disenrollment; find/change the member’s PCP or specialist; update demographic information; need for transportation; concerns about access to services; questions about letters or calls received; benefit inquiry; emergent or crisis calls; and requests for member materials. The number of “inquiries” will always be greater than the number of calls received/handled, since some calls are related to several members within a family. One call to change PCP for three children in a family would count as three “inquiries” in the customer service inquiry tracking.

CURRENT QUARTER AND TREND OVER TIME

As shown in Table 1, the number of customer service inquiries received by the MCOs has decreased significantly over time. In Q1 CY2013, the MCOs received a total of 261,286 inquiries; in Q1 CY2014, the MCOs received 141,964 inquiries, a 46% decrease over time.

In Q1 CY2014, 99.96% of the customer service inquiries received by the MCOs were resolved within two business days. During each quarter to date, the two-day resolution rate exceeded 99.7%. In Q1 CY2014, 57 of the 70 inquiries not resolved within two business days were resolved within 5 business days, and all were resolved within 15 business days. The 70 inquiries not resolved within two business days were from members; all provider inquiries were identified as resolved within two business days.

CONCLUSIONS

The customer service inquiry reports show that the MCOs have consistently met contractual and P4P standards for resolving inquiries within 2 to 5 business days in each quarter throughout CY2013. The number of inquiries received has also decreased significantly over time.

RECOMMENDATIONS

- The KKMAR report includes monthly percentages of inquiries resolved within 2, 5, 8, and 15 days, but the report does not include the number of inquiries that the percentages are based on. Including the denominators (for member and provider inquiries received) in the report would better facilitate validation and comparison with data in other reports and would provide a clearer description of the distribution of customer inquiries by members and by providers.
- The current tracking system could be improved by including the number of individual members and providers that have contacted the MCOs with customer service inquiries to better identify the scope of the customer service inquiries. It may be

helpful to identify whether the 888,598 customer service inquiries to date represent calls from most members or represent a much smaller fraction of members contacting the MCOs.

- Tracking of the customer service inquiries reported to date have included only those calls that were placed to the MCOs. KFMC recommends that the number of customer inquiries received by vendors and the timeliness of resolution of these calls be tracked and reported as well.
- Additional clarification should be provided as to the definition of “resolved.” Does “resolved” indicate that the member’s question has been answered, or does “resolved” mean that the member was referred to another source within the MCO or a subcontractor of the MCO? Tracking and reporting of multiple calls by individual members could also help identify whether calls have been “resolved.”

TIMELINESS OF CLAIMS PROCESSING

Because of a two-month claims lag built into the reporting structure, complete data for Q1 CY2014 are not available as of this report date. This quarterly report will focus on Q4 CY2013 and comparison with previous CY2013 quarter data.

DATA SOURCES

Quarterly tracking and reporting of timely resolution of claims processing for CY2013 in the KanCare Evaluation were to be based on the MCOs’ contractual requirements to process 100% of clean claims within 30 days, 99% of non-clean claims within 60 days, and 100% of all claims within 90 days. The only MCO reports on timeliness of claims processing available to KFMC for the Q4 CY2013 evaluation were the P4P reports, which report the percentage of clean claims processed within 20 days (instead of 30), the percentage of non-clean claims processed within 45 days (instead of 60), and the percentage of all claims processed within 60 days (instead of 90 days).

During Q2 CY2014, KDHE will be working with the MCOs to revise the claims reporting format. Revisions in the claims reporting will also consider and incorporate recommendations made in the KanCare Quarterly Evaluation Reports and input from CMS.

“Clean claim” is defined on the P4P reporting template as “one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. For purposes of the P4P measure, a clean claim is a claim that can be paid or denied with no additional intervention required and does not include adjusted or corrected claim; claims that require documentation (i.e., consent forms, medical records) for processing; claims from out-of-network providers that require research and setup of that provider in the system; claims from providers where the updated rates, benefits, or policy changes were not provided by the State 30 days or more before the effective date (these claims may be pended until rates are loaded so the appropriate amounts can be paid).”

Claims that are excluded from the measures include “claims submitted by providers placed on prepayment review or any other type of payment suspension or delay for potential enforcement issues” and “any claim which cannot be processed due to outstanding questions submitted to KDHE.”

CURRENT QUARTER COMPARED TO PREVIOUS QUARTERS

In Q4 CY2013, there continues to be different interpretation of the method for calculating the P4P timely claims processing measure. As a result, data for the three MCOs cannot yet be combined, and each MCO’s claims report is again presented separately in Table 2, Table 3, and Table 4 below for Q1 to Q4 of CY2013.

In each of the claim categories described below, it is unclear whether all vendor claims are included in the calculations reported.

AMERIGROUP. Data reported by Amerigroup (Table 2 below) again appear to be the most easily understood and analyzable without additional clarification required. For each month, “Number Received” refers to the number of claims received during that particular month. “Number Not Excluded from Measure” is determined by subtracting the “Number Excluded from Measure” from the “Number Received.” The “Number Processed Within x Days” (20 days for “clean claims,” 45 days for “non-clean claims,” and 60 days for “all claims”) plus the “Number Not Processed Within x Days” equals the “Number Not Excluded from Measure.” The “Percentage of Claims Processed within x Days” and the “Number of days” measures are based on the number of claims received that month, whether or not they were processed in that month or a later month.

Table 2 - Timeliness of Claims Processing - Amerigroup					
	Amerigroup				
	CY 2013				
Clean Claims	Q1	Q2	Q3	Q4	Total
Number Received	913,408	1,131,783	1,164,331	1,233,952	4,443,474
Number Excluded from Measure	558	43	23	1,249	1,873
Number Not Excluded from Measure	912,850	1,131,740	1,164,308	1,232,703	4,441,601
Number Processed (Sunflower only)					
Number Processed Within 20 Days	909,984	1,129,792	1,163,880	1,229,665	4,433,321
Percent Processed Within 20 Days (P4P =100%)	99.7%	99.8%	99.96%	99.8%	99.8%
Number Not Processed Within 20 Days	2,866	1,948	428	3,038	8,280
Non-Clean Claims	Q1	Q2	Q3	Q4	Total
Number Received	34,023	10,676	8,291	7,810	60,800
Number Excluded from Measure	5	0	0	0	5
Number Not Excluded from Measure	34,018	10,676	8,291	7,810	60,795
Number Processed (Sunflower only)					
Number Processed Within 45 Days	33,884	10,676	8,291	7,810	60,661
Percent Processed Within 45 Days (P4P =100%)	99.6%	100%	100%	100%	99.8%
Number Not Processed Within 45 Days	134	0	0	0	134
All Claims	Q1	Q2	Q3	Q4	Total
Number Received	947,431	1,142,459	1,172,622	1,241,762	4,504,274
Number Excluded from Measure	563	43	23	1,249	1,878
Number Not Excluded from Measure	946,868	1,142,416	1,172,599	1,240,513	4,502,396
Number Processed (Sunflower only)					
Number Processed Within 60 Days	946,757	1,140,713	1,172,344	1,240,544	4,500,358
Percent Processed Within 60 Days (P4P =100%)	100%	99.9%	99.98%	100%	99.95%
Number Not Processed Within 60 Days	111	1,746	278	51	2,186

Rates for processing clean claims, non-clean claims, and all claims were comparable in all quarters. In CY2013, 99.8% of Amerigroup’s clean claims were processed within 20 days; 99.8% of non-clean claims were processed within 45 days; and 99.95% of all claims were processed within 60 days. The number of clean claims received increased each quarter (ranging from 913,408 in Q1 to 1,233,952 in Q4); the number of clean claims processed also increased incrementally (ranging from 909,984 in Q1 to 1,229,665 in Q4). The number of non-clean claims received dropped each quarter (ranging from 34,023 in Q1 to 7,810 in Q4).

UNITED. In United’s reports (Table 3 below), “Number Received” minus the “Number Excluded from Measure” does not equal the “Number Not Excluded from Measure.”

For clean claims (and all claims), the “Number Not Excluded from Measure” is actually a higher number of claims than the “Number Received” in 8 of the 12 months of CY2013, including January (2013), the month that the KanCare program was implemented. (February, July, September, and November were the only months where the “Number not Excluded from Measure” was less than the “Number Received.”) In CY2013, the “Number of All Claims Processed within 60 Days” (4,286,997) was higher than the “Number of All Claims Received” (4,233,408). Specific reasons for a higher number of claims processed than received are unclear.

Table 3 - Timeliness of Claims Processing - United					
	United				
	CY 2013				
	Q1	Q2	Q3	Q4	Total
Clean Claims					
Number Received	963,050	983,713	967,104	1,166,094	4,079,961
Number Excluded from Measure	1	0	4	25	30
Number Not Excluded from Measure	955,074	1,029,434	960,993	1,164,599	4,110,100
Number Processed (Sunflower)					
Number Processed Within 20 Days	890,256	998,516	959,854	1,164,332	4,012,958
Percent Processed Within 20 Days (P4P =100%)	93.2%	97.0%	99.9%	99.98%	97.6%
Number Not Processed Within 20 Days	64,818	30,918	1,139	267	97,142
Non-Clean Claims					
Number Received	55,245	47,660	33,922	39,005	175,832
Number Excluded from Measure	167	157	81	228	633
Number Not Excluded from Measure	52,294	48,986	33,774	39,112	174,166
Number Processed (Sunflower)					
Number Processed Within 45 Days	51,973	48,313	33,774	39,088	173,148
Percent Processed Within 45 Days (P4P =99%)	99.4%	98.6%	100%	100%	99.4%
Number Not Processed Within 45 Days	321	673	0	24	1,018
All Claims					
Number Received	995,826	1,031,373	1,001,026	1,205,183	4,233,408
Number Excluded from Measure	168	157	85	253	663
Number Not Excluded from Measure	1,012,150	1,078,420	994,767	1,203,795	4,289,132
Number Processed (Sunflower)					
Number Processed Within 60 Days	1,011,860	1,076,622	994,765	1,203,750	4,286,997
Percent Processed Within 60 Days (P4P =100%)	100%	99.8%	100%	100%	99.95%
Number Not Processed Within 60 Days	290	1,798	2	45	2,135

In CY2013, 97.6% of United’s clean claims were processed within 20 days; 99.4% of non-clean claims were processed within 45 days; and 99.4% of all claims were processed within 60 days. The number of clean claims received dropped slightly in Q3 (16,609 less claims than in Q2), but then increased by 198,990 in Q4, more than a 20% increase in claims received. The number of non-clean claims dropped from Q1 (55,245) to Q2 (47,660) to Q3 (33,922), and then increased slightly in Q4 (39,005).

In Q2 and Q3, the numbers reported for number received, excluded, and not excluded are equal to adding the numbers of clean claims and non-clean claims for these quarters. For Q1, Q4, and the annual totals, these numbers are not equal to the sums of clean and non-clean claims as reported.

SUNFLOWER. Sunflower also reports a higher number of clean claims processed than the “# received” minus the “# excluded from measure” for 8 months in CY2013. No explanation is provided in these reports to explain why the number of claims processed is greater than the number received. Sunflower’s Timely Claims Processing reports do not have the “Number Not Excluded from Measure,” but instead report the “Number Processed.” (See Table 4 below.)

Table 4 - Timeliness of Claims Processing - Sunflower					
	Sunflower				
	CY 2013				
Clean Claims	Q1	Q2	Q3	Q4	Total
Number Received	899,806	1,193,952	1,246,877	1,553,710	4,894,345
Number Excluded from Measure	1	20	5	0	26
Number Not Excluded from Measure (Amerigroup & United)					
Number Processed	898,534	1,230,035	1,237,637	1,583,229	4,949,435
Number Processed Within 20 Days	884,805	1,199,749	1,214,377	1,562,510	4,861,441
Percent Processed Within 20 Days (P4P =100%)	98.5%	97.5%	98.1%	98.7%	98.2%
Number Not Processed Within 20 Days	13,729	30,286	23,260	20,719	87,994
Non-Clean Claims	Q1	Q2	Q3	Q4	Total
Number Received	74,563	45,751	41,567	29,999	191,880
Number Excluded from Measure	1	1	1	1	4
Number Not Excluded from Measure (Amerigroup & United)					
Number Processed (Sunflower)	54,399	46,343	43,711	26,813	171,266
Number Processed Within 45 Days	52,266	43,041	39,090	22,401	156,798
Percent Processed Within 45 Days (P4P =99%)	96.1%	92.9%	89.4%	83.5%	91.6%
Number Not Processed Within 45 Days	2,133	3,302	4,621	4,412	14,468
All Claims	Q1	Q2	Q3	Q4	Total
Number Received	974,369	1,239,703	1,288,444	1,583,709	5,086,225
Number Excluded from Measure	2	1	6	1	10
Number Not Excluded from Measure (Amerigroup & United)					
Number Processed	952,933	1,276,378	1,281,348	1,610,042	5,120,701
Number Processed Within 60 Days	952,521	1,272,346	1,275,943	1,600,822	5,101,632
Percent Processed Within 60 Days (P4P =100%)	100%	99.7%	99.6%	99.4%	99.6%
Number Not Processed Within 60 Days	412	4,032	5,405	9,220	19,069

Comparable to United’s reports, but differing from Amerigroup’s reporting, the “Number Received” minus the “Number Excluded from Measure” does not equal the “Number

Processed.” In Q2, Q4, and for the CY2013 annual total, the “Number of Clean Claims Processed” and “Number of All Claims Processed” are higher than the “Number Received.” Sunflower reports, for example, that 4,949,435 clean claims were processed in CY2013, but reports that they received only 4,894,345 clean claims.

In CY2013, Sunflower reported 98.2% of clean claims were processed within 20 days; 91.6% of non-clean claims were processed within 45 days; and 99.6% of all claims were processed within 60 days. The number of clean claims received and processed increased each quarter of CY 2013. The number of clean claims received ranged from 899,806 in Q1 to 1,553,710 in Q4. The number of non-clean claims received dropped each quarter, ranging from 74,563 in Q1 to 29,999 in Q4.

CY2014 CLAIMS REPORTS

Beginning in CY2014, MCOs are reporting claims data on two additional templates.

- In the monthly Adjusted Claims Reports, MCOs are reporting the number of claims processed, the total value of claims, the number of claims adjusted up and down, and the dollar amounts of the adjustments. Data is reported by hospital inpatient, hospital outpatient, pharmacy, dental, vision, transportation, medical, nursing facilities, HCBS, and behavioral health.
- In the monthly Claims Processing Turn Around Time (TAT) Denied Claims by Category and Month Reporting, MCOs are reporting the number and value of denied clean claims and all claims by the same categories as listed above in the Adjusted Claims Reports. The top ten denial reasons are also reported for these same categories, along with details on the number and dollar amounts.

While the reporting and calculation method used by Amerigroup results in more clearly understood results and methodology, the method used by Sunflower and United is actually more in line with the template instructions that “claims are reported in the month they are processed/adjudicated.” The reason for the two month lag time, as indicated in the template instructions is “to allow time for claims processing.” The example given is that “the report submitted on April 30 will include claims received in January.” KFMC agrees with the two month lag time for claims processing, but recommends that claims received in January, but processed in a later month, be reported for January, the month the claim was received. Basing the processing time on the number of claims processed that month instead of the month the claims are received can potentially make it more difficult to verify that difficult or high cost claims are not being carried forward for extended periods of time. In the current report format, there is no requirement to explain the reason for a higher number of claims processed than were received that month, as is reported by Sunflower and United in Q2, Q3, and Q4.

In response to recommendations in the Q4 CY2013 KanCare Quarterly Evaluation Report, KDHE has begun scheduling agency and interagency (including State, MCOs, and EQRO) work group meetings to revise reporting on timeliness of claims processing.

CONCLUSIONS

Due to differences in reporting data, data for the three MCOs cannot be combined. No explanations were provided as to why the numbers of claims processed by United and

Sunflower exceed the number of claims received in some months and quarters. The State is aware of these issues and is working with the MCOs to address these issues in future MCO reporting templates.

RECOMMENDATIONS

- Reporting of timeliness of claims processing should be reported in consistent ways by three MCOs, and monthly reports should be reviewed for consistency when submitted to the State.
- Monthly reports should include data on the number and percentage of claims processed within the required 20, 45, or 60 days in the month that the claims were initially received.
- Monthly quality review is recommended to identify potential errors (example: monthly data where the total number of “all claims” does not equal the sum of clean claims plus non-clean claims).
- The timeliness of claims processing would be more complete if MCOs also reported the timeliness of claims processing by each of their vendors.

GRIEVANCES

Performance measures for grievances include: Track the Timely Resolution of Grievances; Compare/Track the Number of Access-Related Grievances over time, by population categories; and Compare Track the Number of Quality Related Grievances over time, by population.

Grievances are reported and tracked on a quarterly basis by MCOs in two separate reports:

- The Special Terms and Conditions (STC) Quarterly Report tracks the number of grievances received in the quarter; the total number of the grievances received in the quarter that were resolved; and counts of grievances by category type. The report includes space for MCOs to provide a brief summary for each of these types of grievances of trends and any actions taken to prevent recurrence.
- The Grievance and Appeal (GAR) report tracks the number of grievances received in the quarter; the number of grievances for which an acknowledgement letter was sent within 10 days; the number of grievances closed in the quarter; the number of grievances resolved within 30 business days; and the number of grievances resolved within 60 business days. The GAR report also provides detailed descriptions of each of the grievances, including narratives of grievance description and resolution, date received, Medicaid ID, number of business days to resolve, etc. Categories of the grievances received during the quarter are further summarized by count in a Reason Summary Chart in the report.

In reviewing the counts reported on the number of grievances received during each quarter, KFMC found that counts are still varying slightly not only between reports, but within reports. In one of the MCO’s quarterly GAR report for Q1 CY2014, for example, the MCO reports receiving 80 grievances in the quarter, but the Reason Summary of the GAR report categorizes 165 grievances; in the STC report, the MCO reports that

they received 165 grievances in the quarter. In the STC report, MCOs report the number of grievances received in the quarter and the number of those received in the quarter that were resolved. In the GAR report, MCOs report in the Member Grievance Timeliness Compliance table the number of grievances received during the current quarter and, in the same table, the number of grievances resolved in the quarter, including those from the previous quarter that were resolved in the current quarter. To improve quality review, it may be beneficial to include within the Member Grievance Timeliness Compliance table an additional field that reports the number of grievances that were resolved during the quarter of those received in the quarter.

The STC and GAR reports each have lists of specific grievance categories that have only a few categories with similar category names. The STC report includes 11 grievance categories, and the GAR Reason Summary Table has 20 categories. (See Table 5.) Only four of the categories overlap clearly. The GAR report includes detailed descriptions of the grievances that were resolved within the quarter. In reviewing these detailed grievances, KFMC found many of the grievances did not appear to be based on specific or consistent criteria or seemed misclassified.

Table 5 - Comparison of Grievance Report Categories Q1 CY2014						
	Report categories		STC Report		GAR Report	
	STC Report	GAR Report	#	% of total received in Q1	# Summary Chart	% of total received in Q1
Transportation	√		226	45.4%		
Claims/Billing Issues	√	√	106	21.3%	125	25.1%
Quality of Care or Service	√	√	44	8.8%	48	9.6%
Customer Service	√		38	7.6%		
Access to Service or Care	√	√	24	4.8%	0	0.0%
Health Plan Administration	√		20	4.0%		
Benefit Denial or Lmitation	√		13	2.6%		
Service or Care Disruption	√		6	1.2%		
Member Rights/Dignity	√		1	0.2%		
Clinical/Utilization Management	√		0	0.0%		
Other	√	√	20	4.0%	26	5.2%
Attitude/Service of Staff		√			106	21.3%
Timeliness		√			85	17.1%
Availability		√			80	16.1%
Pharmacy		√			6	1.2%
Lack of Information from Provider		√			4	0.8%
Criteria Not Met - Medical Procedure		√			4	0.8%
Criteria Not Met - Durable Medical Equipment		√			3	0.6%
Prior or Post Authorization		√			3	0.6%
Accessibility of Office		√			3	0.6%
HCBS		√			2	0.4%
Level of Care Dispute		√			2	0.4%
Quality of Office, Building		√			1	0.2%
Criteria Not Met - Inpatient Admissions		√			0	
Sterilization		√			0	
Sleep Studies		√			0	
Overpayments		√			0	
Total			498		498	

As further described in the KanCare Ombudsman update section later in the report, the reporting system being implemented for tracking calls, emails, and face-to-face contacts is also categorizing these contacts. As criteria are further defined for the grievances tracked in these systems, Kerrie Bacon, the KanCare Ombudsman, has expressed interest in coordinating her tracking categories with these as well.

It should also be noted that some grievance “resolutions,” particularly those related to billing issues and transportation, involve repeated contacts. Grievance resolution details in the GAR report indicated, for example, that several providers were contacted by the MCO multiple times regarding balance billing of members.

RECOMMENDATIONS

- Data in the GAR and STC grievance reports should be reviewed and compared to ensure consistent reporting of the quarterly number of grievances received.
- KFMC recommends that grievances categories within these reports be clearly defined, and that, wherever possible, grievances categories in different reports be consistently named and defined.
- Grievances related to balance billing of members should be reviewed to identify providers that have been contacted multiple times to identify patterns that may warrant additional communication to the providers to reduce future balance billing of members.

TRACK TIMELY RESOLUTION OF GRIEVANCES

Quarterly tracking and reporting of timely resolution of grievances in the KanCare Evaluation is based on the MCOs’ contractual requirements to resolve 98% of all grievances within 30 business days and 100% of all grievances within 60 business days.

DATA SOURCE

Timeliness of resolution of grievances is reported by each MCO in the quarterly GAR report described above.

CURRENT QUARTER COMPARED TO PREVIOUS QUARTERS

As shown in Table 6 below, 100% of the grievances closed in each quarter of CY2013 were resolved within 30 business days. In Q1 of CY2014, 99.6% (499 of 501) of grievances were resolved within 30 business days, and 100% were resolved within 60 business days. (The number of grievances reported as resolved in a quarter includes some grievances from the previous quarter. As a result, the number of grievances reported as “received” each quarter does not equal the number of grievances “resolved” during the quarter.)

The number of grievances closed each quarter remained consistent throughout CY2013. In the second half of the year, the MCOs received 96 fewer grievances than

were received in the first half of CY2013. In Q1 of CY2014, the number of grievances received continued to decrease.

CONCLUSIONS

In each quarter of CY2013, 100% of the grievances closed each quarter were resolved within 30 business days. In Q1 CY2014, 99.6% of grievances were resolved within 30 business days. The two grievances not resolved within 30 days were resolved within 60 days.

Table 6 - Timeliness of Resolution of Grievances						
	CY2013				CY2014	Total to Date
	Q1	Q2	Q3	Q4	Q1	
Number of Grievances Received in Quarter	445	496	422	423	498**	1,786
Number of Grievances Closed in Quarter*	422	462	412	427	501	2,224
Number of Grievances Closed in Quarter Resolved Within 30 Business Days*	422	462	412	427	499	2,222
Percent of Grievances closed in Quarter Resolved Within 30 Business Days*	100%	100%	100%	100%	99.6%	99.9%
Number of Grievances Closed in Quarter Resolved Within 60 Business Days*	422	462	412	427	501	2,224
Percent of Grievances Closed in Quarter Resolved Within 60 Business Days*	100%	100%	100%	100%	100%	100%
*The number of grievances closed in the quarter, and the number and percent of grievances resolved in the quarter include grievances received in the previous quarter.						
**As reported in the GAR report "Grievance Resolution Timeframe" section, the Number of Grievances Received in the Quarter is 413 instead of 498). This is due to an apparent error by United, who reported receiving 80 grievances in the Grievance Resolution Timeframe table, but reported receiving 165 grievances this quarter in the GAR Reasons Summary Chart and in the STC report.						

COMPARE/TRACK THE NUMBER OF ACCESS-RELATED AND QUALITY-RELATED GRIEVANCES OVER TIME, BY POPULATION CATEGORIES.

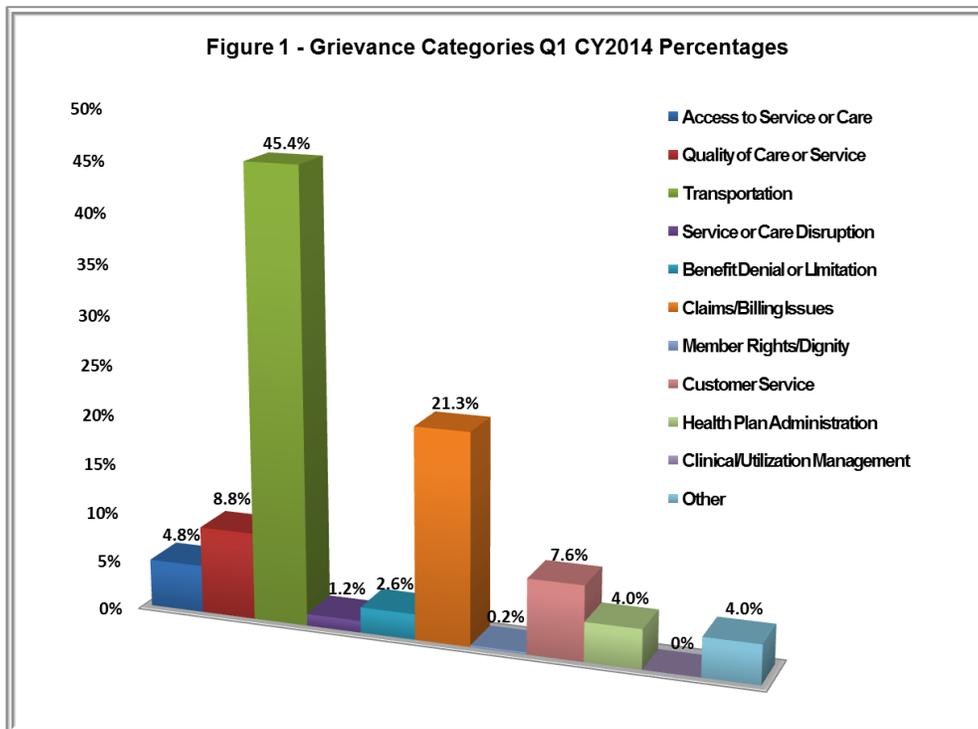
DATA SOURCES

The data sources used for comparing and tracking over time the access-related and quality-related grievances, by population, are the quarterly STC reports described above. The GAR reports were also reviewed, as they include additional detail for each specific grievance resolved during the quarter.

ALL GRIEVANCES

Table 7 summarizes the quarterly numbers and types of grievances to date for the combined MCO populations. In Q1 CY2014, there was an increase in grievances compared with the previous two quarters. The grievance types that increased the most in Q1 were Transportation and Claims/Billing Issues. As displayed in Figure 1, over 45% of the grievances in Q1 were related to transportation.

Table 7 - Number of Grievances by Category						
	CY2013				CY2014	Total to date
	Q1	Q2	Q3	Q4	Q1	
Transportation	271	261	183	182	226	1,123
Claims/Billing Issues	35	87	48	72	106	348
Quality of Care or Service	19	34	30	56	44	183
Customer Service	52	52	34	25	38	201
Access to Service or Care	16	13	13	27	24	93
Health Plan Administration	17	31	26	27	20	121
Benefit Denial or Limitation	16	4	7	10	13	50
Service or Care Disruption	3	11	16	7	6	43
Clinical/Utilization Management	4	10	14	5	0	33
Member Rights/Dignity	4	5	10	6	1	26
Other	13	3	18	3	20	57
Total Grievances Received in Quarter	450	511	399	420	498	2,278
Total Grievances Resolved of those Received in Quarter	407	453	344	385	474	2,063



When KanCare was first launched, grievances were monitored in significant detail, and the types of service/member issues involved were clear. The State monitored for any trends, and there were none that indicated any specific member type needed to be addressed separately. Now that the Intellectually/Developmentally Disabled (I/DD)

members are being included, they are being monitored separately. Going forward, all HCBS waivers, by type, will be monitored separately to detect any programmatic trends.

Beginning in Q1 CY2014, KDHE added a field to the detailed grievances template in the GAR report for tracking the “type of waiver member (if applicable).” Table 8 below reports the types of grievances resolved in Q1 CY2014 and available information on waiver types. Of the 509 grievances resolved in Q1 CY2014, 116 (22.8%) were reported by members receiving waiver services.

Table 8 - Comparison of Grievance Categories by Waiver for Grievances Resolved in Q1 CY2014*							
	Total - all members	Grievances by Waiver Type					
		Waiver Members Subtotal	FE	I/DD	PD	SED	TBI
Billing and Financial Issues	129	19	8	2	4	2	3
Quality of Care or Service	42	13	3		6	1	3
Access to Service or Care	15	1			1		
Attitude/Service of Staff	100	29	8	5	11	2	3
Timeliness	90	22	3	1	15	1	2
Availability	85	26	8	1	14	1	2
Pharmacy	6	1					1
Lack of Information from Provider	4						
Criteria Not Met - Medical Procedure	8	2		1			1
Criteria Not Met - Durable Medical Equipment	3	1		1			
Prior or Post Authorization	3						
Accessibility of Office	2						
HCBS	2	1			1		
Level of Care Dispute	2						
Quality of Office, Building	1						
Other	17	1	1				
Total	509	116	31	11	52	7	15

* Includes grievances received in Q4 CY2013 that were resolved in Q1 CY2014

Table 9, which delineates the percentages of grievances within each quarter, shows that over 60% of the grievances in Q1 CY2013 were transportation related, compared with 45.4% of the grievances in Q1 CY2014. Claims/Billing Issues increased as a percentage of quarterly grievances; in Q1 CY 2013 only 7.8% of the grievances were related to claims/billing, compared with 21.3% of the grievances in Q1 CY2014. Customer Service Grievances showed a decreasing trend over time, decreasing each quarter from 11.6% of the Q1 CY 2013 grievances to 7.6% of the Q1 CY2014 grievances.

Table 9 - Percentage of Grievances by Category Within Each Quarter and To Date						
	CY2013				CY2014	Total to date
	Q1	Q2	Q3	Q4	Q1	
Total Grievances Received	450	511	399	420	498	2,278
	% of 450	% of 511	% of 399	% of 420	% of 498	% of 2,278
Transportation	60.2%	51.1%	45.9%	43.3%	45.4%	49.3%
Access to Service or Care	3.6%	2.5%	3.3%	6.4%	4.8%	4.1%
Quality of Care or Service	4.2%	6.7%	7.5%	13.3%	8.8%	8.0%
Claims/Billing Issues	7.8%	17.0%	12.0%	17.1%	21.3%	15.3%
Customer Service	11.6%	10.2%	8.5%	6.0%	7.6%	8.8%
Health Plan Administration	3.8%	6.1%	6.5%	6.4%	4.0%	5.3%
Benefit Denial or Llimitation	3.6%	0.8%	1.8%	2.4%	2.6%	2.2%
Service or Care Disruption	0.7%	2.2%	4.0%	1.7%	1.2%	1.9%
Member Rights/Dignity	0.9%	1.0%	2.5%	1.4%	0.2%	1.1%
Clinical/Utilization Management	0.9%	2.0%	3.5%	1.2%	0.0%	1.4%
Other	2.9%	0.6%	4.5%	0.7%	4.0%	2.5%
Total Quarter Percentage	100%	100%	100%	100%	100%	100%

ACCESS-RELATED GRIEVANCES

Of the 498 grievances received in Q1 CY2014, 24 (4.8%) were categorized in the STC report as “access to care.” (See Table 7 and Table 9 above.) Access-related grievances increased during each quarter of CY2013 (ranging from 16 in Q1 to 27 in Q4) and decreased slightly in Q1 CY2014.

As described in the STC report, the “access to service or care” grievances included:

- Difficulty obtaining services or supplies
- Inability to see their preferred provider due to a closed panel
- Denial of an appointment due to confusion surrounding ID cards
- Inability to seek therapy services from an out-of-network provider

The GAR report provides additional details on 509 grievances resolved during Q1 CY2014. Beginning this quarter, the detailed grievance descriptions include type of waiver (as applicable). As indicated in Table 8 above, there were 15 grievances resolved during Q1 CY2014 that were categorized as “Access to Service or Care.” The grievance descriptions indicate that all 15 of these “Access to Service or Care” grievances were related to transportation. One of the 15 grievances was a member receiving PD (physical disability) waiver services.

In reviewing the grievance descriptions in the GAR report, other categories that could be related to “access” include “Accessibility of Office” (2 grievances) and “Availability” (85 grievances; 57 of the 85 were transportation related). Also, KFMC found at least 10 additional grievances in different categories that could potentially be considered access related.

KDHE is scheduling interagency/MCO work group meetings this quarter to review the criteria being used by the MCOs in categorizing grievances in the STC and GAR reports. Clarification of these criteria, and inclusion of comparable category types in both reports, would improve the ability to assess trends over time in reporting of access-related grievances, as well as other grievance categories.

QUALITY-RELATED GRIEVANCES

Of the 498 grievances received in Q1 CY2014, 44 (8.8%) were categorized in the STC report as being related to “Quality of Care” (QOC). To date, there have been 183 grievances categorized in the STC report as being related to QOC. The number of QOC grievances increased during each quarter of CY2013, ranging from 19 in Q1 CY2013 to 56 in Q4 CY2013. Q1 CY2014 was the first quarter to date where the number of QOC grievances decreased.

As described in the STC report, the QOC grievances included:

- Members reporting that they received inappropriate treatment from their treating providers;
- Unprofessional behavior by a provider’s office staff;
- Potential fraudulent behavior of a home health aide; and
- Care managers not being attentive to member needs.

As indicated in Table 8 above, there were 42 grievances resolved during Q1 CY2014 that were categorized as QOC. Of the 42 grievances, 13 were members receiving waiver services: three were members receiving TBI (traumatic brain injury) waiver services; six were members receiving PD services; three were members receiving FE services; and one was a member receiving SED (seriously emotionally disturbed) waiver services.

In reviewing the grievance descriptions in the three MCOs’ GAR reports for Q1, KFMC found at least 21 additional grievances that could potentially be considered to be related to QOC that were categorized as “Availability,” “Billing and Financial Issues,” “HCBS,” “Level of Care Dispute,” “Other,” and “Pharmacy.” Many of these additional 21 grievances were referred to as “QOC issue” in the GAR report grievance summaries.

As indicated above, KDHE is scheduling interagency/MCO work group meetings this quarter to review the criteria being used by the MCOs in categorizing grievances in the STC and GAR reports. Clarification of these criteria, and inclusion of comparable category types in both reports, would improve the ability to assess trends over time in reporting of grievances related to quality of care, as well as other grievance categories.

CONCLUSIONS

Grievances categorized as “Access to Services or Care” and “Quality of Care” increased during each quarter of CY2013, but decreased somewhat in Q1 CY2014. Based on the grievance descriptions in the GAR reports, a number of additional grievances may be related to “Access to Services or Care” or “Quality of Care.” Developing standardized category criteria, and ensuring consistent use of categories

and criteria in the GAR and STC reports, would improve the ability to assess the number of access-related and QOC-related grievances and to assess trends over time.

RECOMMENDATIONS

- Clearer definitions and criteria for categorizing “Access to Service or Care,” “Quality of Care,” and other grievance categories in the GAR and STC reports are recommended.
- For access-related grievances, tracking and reporting of the residential region of the members could potentially better identify areas of Kansas where focus on increasing the number of PCPs and/or specialists should be increased.
- Reports should be reviewed for quality and completeness to ensure information such as “type of waiver” are accurately reported by all three MCOs.

OMBUDSMAN’S OFFICE

- **TRACK THE NUMBER AND TYPE OF ASSISTANCE PROVIDED BY THE OMBUDSMAN’S OFFICE.**
- **EVALUATE TRENDS REGARDING TYPES OF QUESTIONS AND GRIEVANCES SUBMITTED TO THE OMBUDSMAN’S OFFICE.**

DATA SOURCES

KFMC staff met with Kerrie Bacon, the KanCare Ombudsman, on 5/06/2014 to discuss the types of questions and grievances that were received by her office in Q1 CY2014, other types of assistance she and her staff are providing, and revisions of the tracking systems implemented this quarter and planned for implementation in Q2. Another major source of data is the KanCare Ombudsman Update report presented by Ms. Bacon on 4/29/2014, to the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight.

CURRENT QUARTER AND TREND OVER TIME

The Ombudsman’s Office has a current staffing of two individuals – the Ombudsman and a part-time assistant. Plans are in place to hire a full-time volunteer coordinator who will recruit volunteers statewide to provide information and assistance to KanCare members, and referral, as needed, to the Ombudsman or other State agency staff.

Contact with the Ombudsman’s Office is primarily by phone and email, but also includes face-to-face contacts. A primary task for the Ombudsman’s Office has been to provide information to KanCare members and assist them in reaching MCO staff that can provide additional information and assistance in resolving questions and concerns.

In CY2013, the primary tracking mechanism used by the Ombudsman’s Office was a log record of voicemail messages. Over the past year, particularly with the addition of the part-time assistant, a greater number of calls are answered directly rather than through voicemail response. In CY2013, the Ombudsman log did not track other contacts, such as email, outgoing phone calls by the Ombudsman staff, and in-person meetings. In CY2014, the Ombudsman log is being replaced by an Oracle-based

tracking system that allows multiple users to access the system at the same time, and allows real time electronic tracking of the caller’s contact information, reason for the call (by category), follow-up contact needs, transfer advice, and space to add notes specific to the call. The system categories can be revised by the Ombudsman or by other staff as needs or criteria change over time. Due to periodic difficulty accessing the agency server, the Ombudsman also tracked calls and voicemails in notebooks. Information recorded in the notebooks must then be re-entered in the tracking system. According to Kerrie Bacon, a new server will soon be in place that should allow consistent access to the electronic tracking system. As the tracking system becomes fully implemented this quarter and the new server is installed, and less reliance is placed on recording contacts in notebooks, efficiency of tracking contacts is anticipated to continue to improve.

As delineated in the CMS Kansas STC, revised in January 2014, data that will now be tracked include the date of the incoming request (and date of any change in status); the volume and type of requests for assistance; the time required to receive assistance from the Ombudsman (from initial request to resolution); the issue(s) presented in requests for assistance; the health plan involved in the request, if any; the geographic area of the beneficiary’s residence; waiver authority if applicable (I/DD, PD, etc.); current status of the request for assistance, including actions taken by the Ombudsman; and the number and type of education and outreach events conducted by the Ombudsman.

As a result of the changes in the tracking system in Q1 CY2014, the Ombudsman has been able to give a more accurate accounting of the number of calls received, the contact method, and the type of caller. Table 10 summarizes the number and type of contacts received and caller types in Q1CY2014.

Table 10 - Ombudsman Contacts Q1 CY2014			
Contact Method		Caller Type	
Phone	344	Consumer	386
Email	194*	Provider	135
Letter	5	MCO employee	4
In person	1	Other	21
Online	1		
Other	1		
Total	546**	Total	546
*Does not include an additional 615 emails to respond to the 194 initial emails.			
**Includes 79 calls that were unspecified, returned calls, and "thank you" calls to the ombudsman.			

Phone contacts comprised 63% of the 546 contacts; however, the 194 contacts by email actually comprised 809 total emails to respond to the contacts. As the tracking system in CY2013 only tracked voicemails, the number of contacts this quarter using the improved tracking system cannot reasonably be compared to previous quarters. Changes in the tracking system will, however, greatly improve the ability from this point

forward to assess quarterly trends in the number and types of contacts with the Ombudsman’s office.

As shown in Table 11 below, the Ombudsman’s Office received a wide variety of questions and requests for assistance in Q1 CY2014. Some of the categories are similar to those being tracked by the MCOs and reported to the State on a monthly or quarterly basis. As grievance categories and criteria are further defined and revised by the State and MCOs, the Ombudsman should be updated so that she can adapt the Ombudsman tracking system to provide an additional resource for tracking comparable grievances and issues being submitted to the Ombudsman’s Office and/or the MCOs.

Table 11 - Types of Issues and Questions Submitted to Ombudsman's Office in Q1 CY2014		
Issues	Number	Percent
Medicaid Eligibility Issues	61	13.1%
Medicaid Service Issues	4	0.9%
Access to Providers	59	12.6%
HCBS Eligibility Issues	55	11.8%
HCBS Reduction in Hours of Service	23	4.9%
HCBS General Issues	7	1.5%
HCBS Waiting List Issues	2	0.4%
Billing	50	10.7%
Other	49	10.5%
Pharmacy	39	8.4%
Durable Medical Equipment	24	5.1%
Appeals, Grievances	23	4.9%
Dental	16	3.4%
Guardianship Issues	15	3.2%
I/DD Conference Call Questions	12	2.6%
Transportation	11	2.4%
Care Coordinators	7	1.5%
Change MCO	6	1.3%
Nursing Facility Issues	6	1.3%
Housing Issues	3	0.6%
Total	467	

CONCLUSIONS

The KanCare Ombudsman has been making considerable progress in improving the tracking system. In addition to tracking voicemail messages, the Ombudsman now also tracks emails and face-to-face contacts with members. The tracking system, when fully implemented, will allow the Ombudsman to generate reports and efficiently track contacts by category of call and by category of caller. When grievance category criteria are defined and revised in MCO reporting templates, comparable categories in the

Ombudsman's tracking system categories can be revised, which may potentially improve tracking of individual member grievances and improve overall understanding of grievance types and trends of time.

RECOMMENDATIONS

- Involvement of the Ombudsman in the interagency work group that is defining grievance criteria could improve MCO grievance tracking systems and the Ombudsman tracking system currently being implemented. At a minimum, the Ombudsman should be informed of the grievance criteria as they are revised, so that she can review the criteria and adapt the Ombudsman tracking categories to mirror revised MCO grievance categories, where appropriate.
- Addition of a tracking field on the grievance detail report to identify grievances forwarded to the MCOs by the Ombudsman could assist in tracking resolution of grievances initially reported to and tracked by the Ombudsman.

QUANTIFY SYSTEM DESIGN INNOVATIONS IMPLEMENTED IN KANSAS

The KanCare quarterly evaluations include updates on system design innovations implemented in Kansas such as: person centered medical homes, electronic health record use, use of telehealth, and electronic referral systems.” Some of these systems may be created by KanCare such as Health Homes, and some are dependent upon the providers in the program to initiate, such as electronic health records. Related initiatives are also led by other entities in Kansas. To isolate the effects of the KanCare demonstration from other initiatives occurring in Kansas, KFMC will first complete a cataloguing of the various related initiatives occurring in Kansas. KFMC will reach out to the various provider associations and state agencies to identify, at a minimum, initiatives with potential to affect a broad KanCare population. KFMC will collect the following information about the other initiatives to help determine overlap with KanCare initiatives:

- Consumer and provider populations impacted,
- Coverage by location/region,
- Available performance measure data, and
- Start dates and current stage of the initiative.

KDHE is on track to implement Health Homes for two target populations on 7/01/2014. The first population will be KanCare beneficiaries with “one serious and persistent mental health condition” and the second target population will be KanCare beneficiaries with “one chronic condition and at risk for a second.” All beneficiaries who meet the definitions for these populations will be assigned to a Health Home, but may opt out if they choose not to participate. The Health Home model expands upon patient centered medical home models to include links to community and social supports. Caregivers in Health Homes will communicate with one another so that beneficiary needs are addressed in a comprehensive manner.

KanCare Health Home Partners (HHPs) and the Lead Entities (MCOs) are required to implement an Electronic Health Record (EHR) to facilitate the sharing of patient

information across health settings. Health Home Partners must commit to the use of an interoperable EHR through the following timeframes:

- Submission of an EHR implementation plan to the MCO within 90 days of contracting as a HHP;
- Full implementation of the EHR within a timeframe approved by the MCOs; and
- Connection to one of the two certified State Health Information Exchanges (Kansas Health Information Network [KHIN] or Lewis and Clark Information Exchange [LACIE]) within a timeframe approved by the MCOs.

MCOs and Health Home Partners must both demonstrate a capacity to use health information technology to link services; facilitate communication among team members and between the health team and individual and family caregivers; provide feedback to practices, as feasible and appropriate; and demonstrate the ability to report required data for both State and Federal monitoring of the program. The KanCare MCOs are required to support Health Home Partners' capacity for Health Information Technology (HIT) by various methods such as provider education and training on implementing health information systems, promoting access to MCO Provider Portals and Dashboards, and deployment of software programs to support providers without the resources to engage with a Kansas Health Information exchange.

KDHE has provided a Preparedness and Planning Tool on their website for potential Health Home Partners to complete. The tool is designed to help providers determine their understanding of Health Home services and requirements and serve as a roadmap for providers looking to become HHPs. The tool will be provided to the MCOs, which will help them in their discussion with interested providers. The tool asks if the provider uses an interoperable EHR. If not, there are follow-up questions regarding timeframes around EHR implementation and connection with one of the State HIEs. The responses to these questions could be used to monitor progress towards EHR adoption.

There are a number of organizations in Kansas who have or are currently involved in efforts to help healthcare providers become Patient Centered Medical Homes (PCMHs) and be recognized by the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Committee (URAC). Below is a summary of these organizations and the work they are doing:

- The Kansas Primary Care Medical Home Initiative, which was discussed in the previous quarterly report, has been able to continue its work due to some funding left from Phase 1. KAFP, the lead organization, has contracted with KFMC to assist four of the remaining five pilot clinics to achieve PCMH recognition. Work days with physician clinic staff, KAFP, and KFMC are planned in May and September, and a strategic planning meeting will be held in July.
- KFMC's Regional Extension Center (REC) Patient-Centered Medical Home Partnership (PCMHP) continues to assist six physician practices in becoming PCMH certified through strategic use of an electronic health record system. All six PCMHP pilot clinics plan to submit to NCQA for PCMH recognition before March 2015, an increase of one from last quarter's report. KFMC has two NCQA PCMH Certified Content Experts (CCEs) who have been participating in various outreach activities that included speaking at education conferences sponsored by the Kansas Hospital

Association and Kansas Association of Healthcare Executives. The CCEs will have a break-out session at KFMC's Quality Forum in June 2014.

- Blue Cross/Blue Shield of Kansas (BCBSKS) continues their Quality Based Reimbursement Program (QBRP) in 2014. The QBRP is designed to promote improved quality, patient care, and outcomes. Contracting BCBSKS providers have an opportunity to earn additional revenue through increased allowances for meeting defined quality metrics that include PCMH recognition.
- The Kansas Association for the Medically Underserved (KAMU), the Primary Care Association of Kansas, whose membership includes the Federally Qualified Health Centers (FQHCs), Primary Care Clinics, Free Clinics, Safety Net Dental Clinics, and Community Mental Health Centers, has two current initiatives to assist members in PCMH transformation efforts.
 - The Medicare Advanced Primary Care Practice (APCP) Demonstration is a three year project that ends 10/31/2014. Two Kansas FQHCs are engaged in this initiative, and one has achieved Level 3 PCMH Recognition.
 - The Kansas Health Foundation PCMH Initiative, which began in 2012 and continues through CY2014, includes nine safety net clinics. Three of the clinics have achieved PCMH Recognition, one has submitted their information to NCQA for review (results are pending), and five clinics continue with their transformation efforts.
 - Of the 17 designated FQHCs in Kansas, seven have achieved PCMH recognition.

The American Recovery and Reinvestment Act (ARRA) signed into law in February 2009 included the Health Information Technology for Economic and Clinical Health Act (HITECH Act). HITECH includes provisions to promote the meaningful use of health information technology to improve the quality and value of American health care. The Office of the National Coordinator for Health Information Technology (ONC) within the Department of Health and Human Services (HHS) was given the responsibility of coordinating the effort to implement a nationwide health information network (NwHIN) infrastructure that allows for the use and exchange of electronic health information in electronic format. In recognition that small physician clinics would need technical assistance to adopt and implement electronic health records, ONC is providing technical assistance to over 100,000 priority primary care physicians through 62 RECs located across the country. KFMC is the REC for Kansas and will continue to provide these services through February 2015.

CMS has provided funds to each state to develop health information exchange (HIE) capabilities. Kansas has two certified HIE organizations, the Kansas Health Information Network (KHIN) and the Lewis and Clark Information Exchange (LACIE). Both of these HIEs are operational and are actively sharing electronic clinical information with each other and their participants.

KDHE contracted with KFMC to provide technical assistance to Medicaid providers who have not yet reached MU of an EHR. KFMC will also conduct an EHR readiness assessment, vendor selection, and implementation services for Health Home Partners contracted with KanCare. This contract and the continuation of the REC program

through February 2015 should have a positive effect on the availability of health information exchange. In February 2014, KFMC conducted a Health Information Technology (HIT) survey to approximately 100 organizations identified by KDHE as potential HHPs. There were 61 surveys returned; 28 of the organizations reported having an EHR implemented; four reported being currently implemented with the HIE; and 23 responded that they are interested in receiving grant-funded assistance with selection of a certified EHR vendor.

Telehealth and telemedicine are important to states such as Kansas that have large rural areas with limited access to healthcare providers, particularly specialists. The University of Kansas Center for Telemedicine & Telehealth (KUCTT) provides services to more than 100 sites throughout the State and has provided specialty clinical consults to patients across Kansas in a variety of settings for more than 30 medical specialties, including: Autism Diagnosis, Cardiology, Diet and Nutrition, Oncology/Hematology, Pain Management, Pediatrics, Psychiatry, and Psychology. In addition to clinical consultations, KUCTT is investigating the use of technology to assist chronically ill, elderly Kansans stay in their homes. Telehealth technology can help manage health issues that might otherwise require admission to a hospital or nursing facility. By partnering with local home-care providers, KUCTT has shown that daily monitoring of health indicators such as blood pressure, pulse, weight, and blood glucose can help people better manage their illnesses and prevent unnecessary emergency department visits and hospitalizations. Home telehealth also provides health care professionals with opportunities to educate patients on health and wellness techniques specific to their individual needs. Many of the home monitoring systems incorporate advancements in miniaturization and wireless technology and use of two-way video and audio capabilities to respond quickly to certain health events. KUCTT uses a variety of devices such as digital stethoscopes, otoscope cameras, general examination cameras or “dermascopes,” and intra-oral scopes. KUCTT also hosts education events for health professionals, teachers, students, and the public across the network. The Heartland Telehealth Resource Center (HTRC) is one of several, federally designated telehealth resource centers supported by the Telehealth Resource Center Grant Program administered through the Office for the Advancement of Telehealth (OAT) in the Office of Health Information Technology. KUCTT is the leading organization of HTRC.

In April 2014, Stormont-Vail HealthCare in Topeka became a network member of the Mayo Clinic Care Network. This is the Mayo Clinic’s first care network partnership in Kansas. Through this network Stormont-Vail and Cotton-O’Neil Clinic physicians can access “eConsults,” where they can connect electronically with Mayo Clinic specialists for consultations on specific patient treatment options, including electronic review of medical records and images sent through secured connections in their systems. Kansas physicians can also access AskMayoExpert, an online tool on disease management, treatment recommendations, care guidelines, and medical condition reference materials.

OVERALL CONCLUSIONS

A number of templates and reports were added or are being revised in CY2014 to improve efficiency, consolidate reporting where possible, and to provide more detailed information where indicated. Phone contacts to MCOs and their vendors, for example, are now being tracked individually and in greater detail. Beginning in Q1 CY2014, much greater detail is being reported to the State on denied and adjusted claims. Work group meetings are being scheduled to further streamline reporting and to respond to recommendations made in the KanCare Quarterly and Annual Evaluation Reports.

TIMELY RESOLUTION OF CUSTOMER SERVICE INQUIRIES

Customer service inquiries continue to have prompt resolution, with over 99.9% reported to be resolved within 2 days. The revised customer service reporting templates, which were implemented in Q1 CY2014, provide a great level of detail by type of caller (member or provider) and program type (physical health, behavioral health, dental, etc.), and now include details by vendor.

TIMELINESS OF CLAIMS PROCESSING

Reporting of claims processing focused on Q4 CY2013 due to the need to allow adequate time for “claims lag” (i.e., up to 90 days for some claims). Claims processing could not be aggregated due to differing ways MCOs reported data. New reporting templates are being developed to promote more consistent reporting.

GRIEVANCES

- Since implementation of KanCare, over 99.5% of grievances have been reported by all three MCOs as resolved within 30 business days, and 100% within 60 business days.
- Tracking of grievances has been improved through the addition of tracking the number and types of grievances by waiver.
- Categories of grievances continue to differ by report. A work group that includes representatives of MCOs, various State programs, and the EQRO will be meeting to establish more consistent grievance categories and criteria to provide greater consistency in reporting.
- The grievance category with the highest number of grievances continues to be those related to transportation, followed by those related to billing or claims issues.
- Grievances categorized as “Access to Services or Care” and “Quality of Care” increased during each quarter of CY2013, but decreased somewhat in Q1 CY2014.

OMBUDSMAN’S OFFICE

The Ombudsman’s Office has greatly improved their tracking system, which now tracks multiple types of contact sources, types, outcomes, and continued follow-up needs.

SYSTEMS DESIGN INNOVATIONS

Through KanCare and other health care agency efforts, progress continues in implementing and increasing the use of EHR, increasing the number of PCMHs, and expanding the scope of telehealth in Kansas.

RECOMMENDATIONS SUMMARY

TIMELY RESOLUTION OF CUSTOMER SERVICE INQUIRIES

- The KKMAR report includes monthly percentages of inquiries resolved within 2, 5, 8, and 15 days, but the report does not include the number of inquiries that the percentages are based on. Including the denominators (for member and provider inquiries received) in the report would better facilitate validation and comparison with data in other reports and would provide a clearer description of the distribution of customer inquiries by members and by providers.
- The current tracking system could be improved by including the number of individual members and providers that have contacted the MCOs with customer service inquiries to better identify the scope of the customer service inquiries. It may be helpful to identify whether the 888,598 customer service inquiries to date represent calls from most members or represent a much smaller fraction of members contacting the MCOs.
- Tracking of the customer service inquiries reported to date have included only those calls that were placed to the MCOs. KFMC recommends that the number of customer inquiries received by vendors and the timeliness of resolution of these calls be tracked and reported as well.
- Additional clarification should be provided as to the definition of “resolved.” Does “resolved” indicate that the member’s question has been answered, or does “resolved” mean that the member was referred to another source within the MCO or a subcontractor of the MCO? Tracking and reporting of multiple calls by individual members could also help identify whether calls have been “resolved.”

TIMELINESS OF CLAIMS PROCESSING

- Reporting of timeliness of claims processing should be reported in consistent ways by the three MCOs, and monthly reports should be reviewed for consistency when submitted to the State.
- Monthly reports should include data on the number and percentage of claims processed within the required 20, 45, or 60 days in the month that the claims were initially received.
- Monthly quality review is recommended to identify potential errors (example: monthly data where the total number of “all claims” does not equal the sum of clean claims plus non-clean claims).
- The timeliness of claims processing report would be more complete if MCOs also reported the timeliness of claims processing by each of their vendors.

GRIEVANCES

- Data in the GAR and STC grievance reports should be reviewed and compared to ensure consistent reporting of the quarterly number of grievances received.
- KFMC recommends that grievances categories within these reports be clearly defined, and that, wherever possible, grievances categories in different reports be consistently named and defined.

- For access-related grievances, tracking and reporting of the residential region of the members could potentially better identify areas of Kansas where focus on increasing the number of PCPs and/or specialists should be increased.
- Reports should be reviewed for quality and completeness to ensure information such as “type of waiver” is accurately reported by all three MCOs.
- Grievances related to balance billing of members should be reviewed to identify providers that have been contacted multiple times to identify patterns that may warrant additional communication to the providers to reduce future balance billing of members.

OMBUDSMAN’S OFFICE

- Involvement of the Ombudsman in the interagency work group that is defining grievance criteria could improve MCO grievance tracking systems and the Ombudsman tracking system currently being implemented. At a minimum, the Ombudsman should be informed of the grievance criteria as they are revised, so that she can review the criteria and adapt the Ombudsman tracking categories to mirror revised MCO grievance categories, where appropriate.
- Addition of a tracking field on the grievance detail report to identify grievances forwarded to the MCOs by the Ombudsman could assist in tracking resolution of grievances initially reported to and tracked by the Ombudsman.

End of report.

KDHE Summary of Claims Adjudication Statistics – January through March 2014 – KanCare MCOs

AMG- YTD Claim Type	Claims Processed	Total \$ Value of Claims Processed	Total claim count - YTD cumulative	total claim count \$ value YTD cumulative	# claims denied – YTD cumulative	\$ value of claims denied YTD cumulative	% claims denied – YTD cumulative	Average TAT - YTD cumulative
Hospital Inpatient	7,536	\$31,635,765.32	11,769	\$364,741,821.97	2,451	\$71,059,048.56	20.80%	7
Hospital Outpatient	54,430	\$7,118,761.64	99,676	\$262,161,788.97	17,780	\$30,781,183.65	18.64%	4
Pharmacy	253,395	\$17,221,924.92	439,178	\$25,998,494.39	92,506	Not Applicable	21.06%	Same Day
Dental	20,414	\$3,087,096.73	31,716	\$8,658,569.89	3,821	\$1,019,319.07	12.05%	14
Vision	12,910	\$896,250.26	19,268	\$4,494,631.39	5,740	\$1,461,830.84	29.79%	8
NEMT	26,977	\$962,160.97	43,358	\$1,612,773.81	47	\$1,802.50	0.11%	17
Medical (Physical health not otherwise specified)	8,614	\$1,297,227.54	447,921	\$181,274,638.94	60,799	\$30,560,715.47	13.89%	4
Nursing Facilities	21,824	\$29,937,240.11	30,867	\$77,980,009.08	3,986	\$6,931,632.16	12.89%	5
HCBS	68,276	\$19,411,944.52	31,633	\$19,087,006.81	2,736	\$1,747,408.78	8.99%	5
BH	64,782	\$11,414,133.68	153,695	\$18,539,040.26	16,607	\$2,183,732.23	10.99%	4
Total	560,982	\$152,919,745.80	1,309,081	\$964,548,775.51	206,473	\$145,746,673.26	15.77%	7

SUN-YTD Claim Type	Claims Processed	Total \$ Value of Claims Processed	Total claim count - YTD cumulative	total claim count \$ value YTD cumulative	# claims denied – YTD cumulative	\$ value of claims denied YTD cumulative	% claims denied – YTD cumulative	Average TAT - YTD cumulative
Hospital Inpatient	6,489	\$22,518,817.35	3,962	\$28,616,890.43	965	\$6,272,164.44	24.36%	6
Hospital Outpatient	51,320	\$6,782,923.35	41,189	\$16,124,441.02	5,465	\$2,938,879.78	13.27%	5
Pharmacy	132,802	\$22,736,347.00	713,265	\$42,647,982.00	148,886	\$7,363,807.00	20.87%	Same Day
Dental	22,439	\$3,157,777.72	38,105	\$9,325,092.16	3,523	\$1,108,174.07	8.00%	3
Vision	19,567	\$1,106,008.39	21,730	\$4,750,898.53	2,542	\$628,499.63	11.70%	12
NEMT	20,866	\$616,978.32	32,301	\$925,828.82	241	\$6,763.49	0.75%	11
Medical (Physical health not otherwise specified)	326,176	\$23,840,578.56	232,814	\$56,040,345.17	25,463	\$7,287,633.37	10.94%	5
Nursing Facilities	37,105	\$53,355,906.63	15,957	\$30,669,324.34	1,380	\$3,368,890.50	8.65%	5
HCBS	66,633	\$23,424,591.88	55,210	\$16,379,764.36	1,505	\$749,586.97	2.73%	4
BH	105,025	\$10,258,219.22	107,696	\$13,215,225.55	4,062	\$1,158,438.59	3.77%	4
Total	825,527	\$221,154,055.05	1,262,229	\$218,695,792.38	194,032	\$30,882,837.84	15.37%	6

UHC-YTD Claim Type	Claims Processed	Total \$ Value of Claims Processed	Total claim count - YTD cumulative	total claim count \$ value YTD cumulative	# claims denied – YTD cumulative	\$ value of claims denied YTD cumulative	% claims denied – YTD cumulative	Average TAT - YTD cumulative
Hospital Inpatient	2,068	\$6,771,944.15	7,636	\$227,419,245.01	1,559	\$52,826,771.40	20.41%	16
Hospital Outpatient	18,885	\$2,625,520.61	70,882	\$173,859,741.17	10,085	\$31,234,183.34	14.22%	10
Pharmacy	216,446	\$15,033,905.62	421,966	\$27,848,753.40	139,110	\$17,330,359.71	32.97%	Same Day
Dental	22,481	\$3,047,208.69	33,598	\$8,705,305.59	5,076	\$716,443.37	15.11%	16
Vision	6,795	\$438,454.95	17,136	\$3,352,369.26	3,440	\$707,633.65	20.07%	12
NEMT	18,988	\$567,392.44	29,065	\$831,070.42	265	\$7,882.16	0.91%	11
Medical (Physical health not otherwise specified)	111,419	\$10,189,783.06	394,114	\$135,050,916.71	49,417	\$20,957,719.83	12.53%	9
Nursing Facilities	7,202	\$10,163,610.04	25,489	\$53,306,613.46	1,955	\$5,020,916.95	7.67%	9
HCBS	14,640	\$3,234,643.54	62,691	\$17,934,550.23	3,952	\$1,131,569.66	6.30%	12
BH	31,932	\$3,378,574.88	112,729	\$26,753,945.84	10,519	\$5,846,698.32	9.33%	8
Totals	458,058	\$65,614,648.02	1,175,306	\$675,062,511.09	225,378	\$135,780,178.39	19.18%	9