

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



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

Focused Review Visits Conducted

July 23, 2013 – UnitedHealthcare Community Plan

July 24, 2013 – Amerigroup Kansas

July 25, 2013 – Sunflower State Health Plan

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Background and Summary

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

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

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

I. Customer Service

● AMERIGROUP

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

Desk Review

Policy & Procedure Manuals

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

Selected Call Review

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

Onsite Review

Call Center Resources

- Training

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

- Systems

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

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

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

Customer Service Processes

- Provider Processes

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

- Beneficiary Processes

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

Customer Service Interviews and Call Monitoring

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

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

Issues of Concern

Subcontractor Oversight

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

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

Provider Representative Responsiveness

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

SUNFLOWER

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

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

Desk Review

Policy & Procedure Manuals

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

Selected Call Review

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

Onsite Review

Call Center Resources

- Training

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

- Systems

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

Customer Service Processes

- Provider Processes

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

- Beneficiary Processes

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

Customer Service Interviews and Call Monitoring

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

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

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

Issues of Concern

Subcontractor Oversight

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

Beneficiary Customer Service Call Center

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

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

Provider Representative Responsiveness

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

UNITED

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

Desk Review

Policy & Procedure Manuals

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

Selected Call Review

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

Onsite Review

Call Center Resources

- Training

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

- Systems

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

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

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

Qfiniti is used for call recording and monitoring.

Customer Service Processes

- Provider

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

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

- Beneficiary

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

Customer Service Interviews and Call Monitoring

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

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

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

Issues of Concern

Subcontractor Oversight

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

Provider Representative Responsiveness

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

Summary of findings:

KanCare MCO	Areas of Strength	Areas for Improvement
United	<ul style="list-style-type: none"> • Beneficiary call center is well developed with multiple quality assurance reviews and oversight. • The systems in place support the Customer Service representatives with beneficiary specific information. • Member calls considered to have a negative or inaccurate component are returned the following business day with corrections. • Escalation processes are in place and Spanish speaking representatives are part of the local team. • While provider services calls are routed to a centralized unit in Arizona the representatives there were observed to accurately answer Kansas specific questions about benefits and authorizations. 	<ul style="list-style-type: none"> • The review found instances of poor customer service from subcontractors. The State is concerned that subcontractor calls are not being sampled and policy and procedure manuals are not being reviewed by United. The dental subcontractor is using a copied and poorly edited customer service manual that indicative of an incomplete customer service plan. United receives monthly and quarterly reports from subs including claims turnaround, customer service call metrics and utilization management. Joint operating meetings are held monthly. • With provider reps spread across multiple lines of business KanCare must compete with other priorities for provider issue resolution. Complaints from providers during the review period describe frustration with long turnaround times from field representatives. The lack of a central contact tracking system complicates management and reporting of representative effectiveness. The 20 claim inquiry limit at the call center is reasonable but suggests a volume of claims issues that exceed planned capacity. Progress on claims payment deficiencies would free provider representatives to address other network opportunities.

<p>Amerigroup</p>	<ul style="list-style-type: none"> • Our overall impression of Amerigroup’s customer service activities is of a well planned approach that focuses national and local resources into the hands of the customer service representatives. • Beneficiary customer service representatives are carefully screened, given several weeks of training and continuously reviewed. • Meaningful evaluations focus on resolution and people skills rather than call times. Evaluation results impact the employee’s compensation and future opportunities. • Provider representatives receive training on their systems and meet weekly to review urgent and systemic issues. • The customer service teams are supported by responsive systems that give them efficient access to benefits and beneficiary information allowing them to solve many issues without the need for research and follow up. 	<ul style="list-style-type: none"> • This review found instances of poor customer service from subcontractors. The State is concerned that subcontractor calls are not being sampled and policy and procedure manuals are not being reviewed by Amerigroup. The dental and optical customer care manuals are poorly edited copies of the same document which points to an undeveloped customer service plan. Poor customer service was evident in recorded calls from Access2Care and SCION. Transportation complaints were common with failure to appear, rude driver, inappropriate vehicle and companion not allowed topping the list. • While expectations are high and include a 24 hour turnaround on contacts, the current provider relations network cannot keep pace with provider calls. The suggested sixth field representative is unlikely to mitigate provider concerns. The State’s experience during this time period suggests claims issues are much of this volume and substantial progress in this area will reduce the load on provider representatives to a more manageable level.
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Sunflower	<ul style="list-style-type: none"> • Call center operations are straightforward with information system support and escalation processes in place. • The center is dominated by a tally board that displays the representatives' availability and call metrics. These metrics play an important role in the representative's evaluations. • Representative performance covered the spectrum from highly capable and respectful to disengaged and offensive. • The State is concerned that customer service quality assurance allows unacceptable performance to exist in this department. 	<ul style="list-style-type: none"> • The review found examples of poor customer service from subcontractors. The State is concerned that subcontractor calls are not being sampled and policy and procedure manuals are not being reviewed by Sunflower. The Cenpatico sample was incomplete and included a partial recording that did not include verifying member identification before discussing personal health information. • Some acute examples of poor customer service were evident in the recorded calls and directly observed during the on site visit. Quality oversight and follow up are not in place. An unwillingness to accept State feedback or responsibility for their own or subcontractor inadequacies was apparent in some members of management. • The phone numbers of incoming calls are not captured resulting in lost communication if the call is dropped. Rather than access a network directory with important information like panel availability, Google is used to find contact information for Sunflower medical providers. In some instances the representative did not confirm the beneficiary's identification before discussing personal health information. • Provider representatives report an expectation of 24 hours turnaround on contacts. Ongoing provider commentary describes difficulty meeting this expectation. Provider reps report they are 'hammered by claims and credentialing inquiries' and 'just so swamped' they struggle to meet expectations. • Recorded customer service calls included provider claims inquiries that the customer service representatives cannot resolve. One representative told the provider their claims department should be handling these calls but they are too busy. Progress on claims payment deficiencies would free provider representatives to address other network opportunities.
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II. Provider Credentialing

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

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

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

Summary of findings:

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

Additional specific findings:

KanCare MCO	Areas of Strength	Areas for Improvement
United	<ul style="list-style-type: none"> • Most core requirements related to credentialing are addressed in United’s policies and procedures. • HCBS providers are credentialed locally with a dedicated provider representative responsible for this group of providers. The provider representative reaches out to the provider if the credentialing documents are incomplete. • Logisticare provider representatives make daily and weekly contact with providers when credentialing documents are incomplete. 	<ul style="list-style-type: none"> • Ensure that SSA death master file and the National Plan and Provider Enumeration System checks are conducted by both United and subcontractors, with results recorded prior to credentialing decision. • Ensure that subcontractors are aware of the contractual requirements regarding program integrity checks for the KanCare program. • Ensure that all records related to a provider credentialing application are available and provided when the state requests information regarding credentialing processes and decisions. • Get engaged in effective ways to access the Medicare Exclusion Database (the MED), which will make screening checks more efficient
Amerigroup	<ul style="list-style-type: none"> • Amerigroup demonstrated overall sound policies, procedures and practices related to provider credentialing. Local plan program is well supported by national credentialing resources and that resource allows leveraging best practices and efficiencies. • Participating in a pilot program with CMS to access the Medicare Exclusion Database (the MED), which will make screening checks more efficient. Amerigroup has been proactive about pursuing this option. 	<ul style="list-style-type: none"> • Ensure that SSA death master file checks are consistently conducted by both Amerigroup and subcontractors, with results recorded prior to credentialing decision. • Ensure that all records related to a provider credentialing application are available and provided when the state requests information regarding credentialing processes and decisions. Storing electronically is fine, but when sample demonstration is requested those materials should be provided by screen shot or otherwise so that you definitively demonstrate compliance.

Sunflower	<ul style="list-style-type: none"> • Most core requirements related to credentialing are addressed in Sunflower’s policies and procedures. • Strong practices regarding outreach to and engagement of providers around credentialing issues; good communication. 	<ul style="list-style-type: none"> • Ensure that SSA death master file checks are conducted by both Sunflower and subcontractors, with results recorded prior to credentialing decision. • Ensure that subcontractors are aware of the contractual requirements regarding program integrity checks for the KanCare program. • Ensure that all records related to a provider credentialing application are available and provided when the state requests information regarding credentialing processes and decisions. • Get engaged in effective ways to access the Medicare Exclusion Database (the MED), which will make screening checks more efficient. • Explore ways to capture and publish areas of practice for providers, when the provider has more than one specialty.
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Action Items – Necessary for All Three MCOs

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

III. Grievances and Appeals

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

● AMERIGROUP

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

Policy and Procedure Review

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

Noted concerns:

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

Selected Sample Review

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

Member Grievance Samples – of note by the reviewers:

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

Member Appeal Samples – no noted concerns.

Provider Appeal Samples – of note by the reviewers:

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

Onsite Review

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

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

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

A few points were noted as weaknesses:

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

details are initially communicated.

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

● SUNFLOWER

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

Policy and Procedure Review

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

Of note by the reviewers:

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

reference State Fair Hearing.

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

Selected Sample Review:

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

Member Grievance Samples

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

Member Appeals Samples – no noted concerns

Provider Appeals Samples

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

Onsite Review

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

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

Concerns noted are as follows:

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

UNITED

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

Policy and Procedure Review

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

Of note by the reviewers:

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

Selected Sample Review

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

Member Grievance Samples

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

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

Member Appeals Samples

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

Provider Appeals Samples

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

Onsite Review:

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

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

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

A few points were noted as weaknesses:

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

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

Summary of findings:

KanCare MCO	Areas of Strength	Areas for Improvement
United	<ul style="list-style-type: none"> • All documentation requests were honored with complete, on time and organized information provided. Responsive to onsite requests and adjustments. • Staff managing grievances and appeals are well trained with ample opportunities for continued or refresher training. • Daily 'huddles' presented as a very functional approach to communicating workload, policy/process changes, brief education/training, etc. and seems to be effective. • ETS (Escalated Tracking System) for G&A appears to have great capabilities for tracking and trending. • Nice check and balance system to make sure all grievances/appeals are captured. Gatekeepers in Customer Service review all calls at the end of the day to make sure calls were routed appropriately and member advocate supervisor reviews the following morning to capture any others that may have been missed. • Every case is reviewed and audited. 	<ul style="list-style-type: none"> • Specific errors or omissions in policies and procedures, or in documentation practices, were identified and need to be addressed. • G&A system did not capture issues received from HP or State staff. • Focus seems to be on contractual or pay for performance metrics with little mention of the customer. • Lack of verbal contact with the member who has filed a grievance. • Concern about quality of care issues being redirected to the national quality department with lack of final resolution being captured. It's not necessary that the details of the resolution be captured, but the fact that the case has been resolved and closed by the local quality team would seem to close the loop. Appears there could be a potential for issues to fall through the cracks. • Noted the advocate working on provider grievances has the KanCare account as primary responsibility, but serves as backup to Maryland as well. Is there a potential here for confusion of policies and procedures?

Amerigroup	<ul style="list-style-type: none"> Amerigroup has overall strong performance in the areas of grievances and appeals. Staff managing grievances and appeals work as a collaborative team and connect with customer service staff effectively. Although timeframes are important, they focus on service and making sure the grievance is addressed. Use of daily 'huddles' to communicate trends, changes, etc. Grievance specialists are QA'd every day. All letters are reviewed before sending. Atlas alert system is an effective tool for communicating through management. Grievance staff dedicated to KanCare. 	<ul style="list-style-type: none"> Specific errors or omissions in policies and procedures, or in documentation practices, were identified and need to be addressed. Only one staff member assigned to 'process' grievances Lack of verbal contact with the member who has filed a grievance. Concern about quality of care issues being redirected to the national quality department with lack of final resolution being captured. No formalized process for trending grievances. Reports are created by corporate office – local staff has not run reports from either the grievance or appeals systems. Concerns about keeping a grasp on trends and patterns without the ability to run reports as needed. Although their audit/review process seems to be adequate, one selected sample resolution letter contained several typos.
Sunflower	<ul style="list-style-type: none"> Strong onsite responsiveness, and helpful overview of processes for managing grievances and appeals, helped plug gaps in documentation. Customer service records are routinely reviewed to ensure all calls that were grievances were identified as such. Communication regarding grievances and appeals are generated and mailed in-house. 	<ul style="list-style-type: none"> Struggled to make requested documents available, and once received, the materials were disorganized and inaccessible to reviewers. Specific errors or omissions in policies and procedures, or in documentation practices, were identified and need to be addressed. Cenpatico and NIA grievances and appeals are delegated to the subcontractor and tracked in the respective subcontractor systems. No formal training for grievance and appeal staff. Lack of requested records creates a concern about ability to coordinate information between all of their systems. Lack of verbal contact with the member who has filed a grievance. Concern about quality of care issues being redirected to the national quality department with lack of final resolution being captured, creating fragmentation that leads to poor communication and difficulty with providers and members. Lack of clarity in how they assure trends with subcontractors and providers are adequately addressed. Although all state fair hearing cases are reviewed, audits of grievances and appeals processed is looser than would be expected. A minimum of only five cases per month per coordinator are reviewed. During the interview, it was stated that all HP escalated issues, as well as those from State staff, are recorded in their grievance system. However, during the demonstration, it was clear that only those clearly identified as being from someone wanting to file a grievance are recorded in the database.

IV. Prior Authorizations

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

1. Policies and procedures related to prior authorization practices/standards of both MCO and subcontractors were requested and assessed.
2. Business practice manuals (of whatever name) that guide the staff of the MCO and subcontractors in management of prior authorizations were requested and assessed.
3. A sample of prior authorization requests received during April 14-20, 2013 and May 19-25, 2013, were requested and assessed for each of the following categories, as relevant for each MCO:
 - Physical Health (MCO)
 - Physical Health (Subcontractor)
 - Behavioral Health (MCO)
 - Behavioral Health (Subcontractor)
 - Nursing Facility (MCO)
 - Nursing Facility (Subcontractor)
 - Dental Services (MCO)
 - Dental Services (Subcontractor)
 - Vision (MCO)
 - Vision (Subcontractor)
4. A sample of prior authorization requests received on April 12, April 23 and May 18, 2013, were requested and assessed for the following two categories:
 - Pharmacy (MCO)
 - Pharmacy (Subcontractor)

For items 3 and 4, the following issues were assessed: Whether the information reported to the state and internally tracked was accurate, based upon prior authorization standards for the service involved; and, whether providers in the service area had 24/7 access to all identified receipt modes (phone, portal, fax, and any other).
5. Provider Representative and Provider Advocate staff at each MCO, engaging providers in the PA request process for the specified dates, were identified, and a sample of those staff were selected for interview during the onsite portion of the focused review.

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

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

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

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

Summary of findings:

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

KanCare MCO	Areas of Strength	Areas for Improvement
United	<ul style="list-style-type: none"> Documentation presented reflects that processes are being followed. Layered approach to training whereby all staff get the national PA training then additional specialized training total 4-5 months. Open to additional state training related LTSS transitions and state workgroup opportunities. 	<ul style="list-style-type: none"> Recommend that UCSMM. 06.16 INITIAL REVIEW TIMEFRAMES – include the requirement that members have access to emergency services without prior authorization. Language regarding the below RFP requirement is not found in UCSMM.06.16 Initial Review Timeframes but is found in UCSMM.04.11 Consumer Safety. Suggest it be in this P&P as well. 2.2.40.3 Members shall have access to emergency services without PA, even if the emergency services provider does not have a subcontract with the CONTRACTOR. Should provide all documentation utilized to make decisions (i.e. KCPC, Lucidity) Provide all the resources United uses for training during the annual review.
Amerigroup	<ul style="list-style-type: none"> Strong policy, clearly addressing urgent and routine requests. Numerous resources for staff to utilize desk aids, SharePoint, etc. Documentation presented reflects that processes are being followed. 	<ul style="list-style-type: none"> Amerigroup did not provide the clinical information needed (only provided screen shots of authorization database). In future reviews, need to provide complete records. Herceptin and Neulasta are not in the pharmacy regulation and cannot be on PA. Lidoderm reviewed using unapproved criteria step for Kansas (gabapentin failure).
Sunflower	<ul style="list-style-type: none"> Policies are clear. Received KCPC training from a RADAC and stated they continue to learn about this system and feel comfortable with Lucidity as well. Documentation presented reflects that processes are being followed. Will have a web-based system up and running, soon. 	<ul style="list-style-type: none"> Sunflower did not make all randomly selected PA staff available during the onsite. The Sample included 10 employees were chosen from the list provided and titled, 'Employees Handling PA' and 10 employees were chosen from the 'BH – Staff Created Auths' list. The only employees available were from US Script but not all employees from that sample were available, either. PA authorizations only submitted, need all documentation in the file to make determinations in the future. Several questions and recommendations related to pharmacy prior authorizations were identified and communicated during the review.

Action Items – Necessary for All Three MCOs

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

V. Third Party Liability, Spend Down and Client Obligation

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

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

Summary of findings:

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

KanCare MCO	Areas of Strength	Areas for Improvement
United	<ul style="list-style-type: none"> • Very good letters/notifications to providers and members regarding client obligation (CO), and willing to add CO amount to member letter. • Provider notification contains necessary information. Sample clearly showed how United is applying CO correctly. 	<ul style="list-style-type: none"> • Included only claims payment instructions, no policies or procedures for CO process or notification to members/providers. Only have informal workflows at this point as this has been a process under development with the state. More complete procedures should be available for review at annual onsite review.

Amerigroup	<ul style="list-style-type: none"> • LTSS HCBS Claims document contains a detailed set of instructions for a manual claims process, with process underway to automate. 	<ul style="list-style-type: none"> • Initial policies are fine; however, guidance sent to MCO's in February 2013 regarding need to notify members/providers of CO assignments, and this appears to have not happened until 7.1.13. Amerigroup states they will have more complete procedures for CO by the time of the annual onsite review as these processes have been under development with the state. • 8 of 30 (27%) CO records did not withhold CO appropriately. Amerigroup is remedying this by developing an automation process to minimize opportunity for human error. In the 3rd quarter will do look back and recoup.
Sunflower	<ul style="list-style-type: none"> • Sunflower has the CO process built into an automated system which makes their process efficient and accurate (other than SED waiver being erroneously excluded). 	<ul style="list-style-type: none"> • Included only claims payment instructions, no policies or procedures for CO process or notification to members/providers. We recommend they develop procedures that incorporate the medical management process involved with CO as well as their automated claims process. • Sunflower/Cenpatico is not taking CO out of SED waiver members' claims. This will have to be fixed by Sunflower and a process undertaken to recoup these amounts from any affected providers.

Action Items – Necessary for All Three MCOs

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