Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 9.30.18

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

KanCare
Section 1115 Quarterly Report
Temporary Extension Demonstration Year: 1 (1/1/2018-12/31/2018)
Federal Fiscal Quarter: 4/2018 (7/18-9/18)

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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. The State submitted a one-year temporary extension request of this demonstration to CMS on July 31, 2017. The temporary extension was approved on October 13, 2017.

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 six-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 #77 of the Centers for Medicare & Medicaid Services Special Terms and Conditions (STCs) issued regarding the KanCare 1115(a) Medicaid demonstration program, and in the format outlined in Attachment A of the STCs.

II. Enrollment Information

The following table outlines enrollment activity related to populations included in the demonstration. It does not include enrollment activity for non-Title XIX programs, including the Children's Health Insurance Program (CHIP), nor does it include populations excluded from KanCare, such as Qualified Medicare Beneficiaries (QMB) not otherwise eligible for Medicaid. The table does include members retroactively assigned for the second quarter known as of September 30, 2018.

Demonstration Population	Enrollees at Close of Qtr. (9/30/2018)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	14,837	15,805	968
Population 2: ABD/SD Non-Dual	29,749	30,383	634
Population 3: Adults	48,684	52,322	3,638
Population 4: Children	224,040	235,457	11,417
Population 5: DD Waiver	9,080	9,135	55
Population 6: LTC	19,850	20,729	879
Population 7: MN Dual	1,281	1,398	117
Population 8: MN Non-Dual	965	1,046	81
Population 9: Waiver	4,416	4,559	143
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**352,902**	**370,834**	**17,932**

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 the Section 1115 demonstration and its operation is provided in the interest of transparency and engagement.

The KanCare Advisory Council consists of 13 members: 3 legislators representing the House and Senate, 1 representing mental health providers, 1 representing CDDOs, 2 representing physicians and hospitals, 3 representing KanCare members, 1 representing the developmental disabilities community, 1 former Kansas Senator, 1 representing pharmacists. The 2nd quarter KanCare Advisory Council meeting took place on September 25, 2018 in Curtis State Office building room 530. The agenda was as follows:

- Welcome
- Review and Approval of Minutes from Council Meeting, May 30, 2018
- KDHE Update – Jon Hamdorf, Director and Medicaid Director, Division of Health Care Finance, Kansas Department of Health and Environment
- KDADS Update – Tim Keck, Secretary, Kansas Department for Aging and Disability Services
- Updates on KanCare with Q&A
    - Amerigroup Kansas
    - Sunflower State Health Plan
    - UnitedHealthcare Community Plan

- Next Meeting of KanCare Advisory Council – December 14, 2018, Curtis State Office Building, 2:00 to 4:00 p.m.
- Adjourn

The Tribal Technical Advisory Group (TTAG) did not meet during the 3rd quarter due to scheduling conflicts. The next scheduled TTAG meeting is November 19, 2018.

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

- Autism Advisory Council (quarterly)
- Money Follows the Person (quarterly) – ending this quarter
- PACE Program (quarterly)
- HCBS Provider Forum teleconferences (monthly)
- Long-term Care Roundtable with Department of Children & Families (quarterly)
- Big Tent Coalition meetings to discuss KanCare and stakeholder issues (monthly)
- Interhab (CDDO and I/DD Provider Association) board meetings (monthly)
- KACIL (centers for independent living) board meetings (monthly)
- Presentations, attendance, and information is available as requested by small groups, consumers, stakeholders, providers and associations across Kansas
- Community Mental Health Centers meetings to address billing and other concerns (monthly and quarterly)
- Series of workgroup meetings and committee meetings with the Managed Care Organizations and Community Mental Health Centers
- Regular meetings with the Kansas Hospital Association 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
- State Mental Health Hospital mental health reform meetings (quarterly)
- Medicaid Functional Eligibility Instrument (FE, PD & TBI) Advisory Workgroup
- IDD Functional Eligibility Instrument Advisory Workgroup
- Systems Collaboration with Aging & Disability, Behavioral Health and Foster Care Agencies
- PRTF Stakeholder meeting (quarterly)
- Mental Health Coalition meeting (bi-weekly)
- Kansas Association of Addiction Professionals (monthly)
- Crisis Response & Triage meetings with stakeholders including MCOs to improve timely, effective crisis services for members and improved care coordination post crises (bi-weekly)
- Lunch and Learn biweekly series on a variety of behavioral health topics including prevention and the prevention framework initiative; SUD 101; trauma informed systems of care; recovery and peer support; housing and homeless initiatives; community crisis center development
- Bi-monthly Governor's Behavioral Health Services Planning Council meetings; and monthly meetings with the nine subcommittees such as Suicide Prevention, Justice Involved Youth and Adult, and Rural and Frontier
- Mental Health Excellence and grant project meetings
- Monthly Nursing Facility Stakeholder Meetings
- KDADS-CDDO-Stakeholder Meetings (quarterly)

- WSU-Community Engagement Institute Special Projects (weekly meeting) including HCBS Access Guide, Policy Gap Analysis, and Capacity Building survey
- KDADS-CDDO Eligibility workgroup tasked to update IDD Eligibility policy and Handbook- policy work meetings will start on 11/16/18

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

OneCare Kansas Program
A legislative proviso directed KDHE to implement a health homes program. To avoid the confusion caused by the term health homes, a new name was selected for the program – OneCare Kansas. Authority to spend planning money was received from CMS and a OneCare Kansas Planning council has convened to help plan implementation of the new health homes program. Implementation is currently expected at the end of State Fiscal Year 2019.

MCO Outreach Activities
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:
Marketing Activities**:** Amerigroup participated in 84 events for the third quarter of 2018. This included partner development, sponsorships, member outreach and advocacy.

The Community Relations Representatives primary focus continues to be assisting members with education on all the benefits provided by KanCare program. They constantly look to develop strong community partnerships across the state by enhancing existing relationships and building new ones.

Below is a sampling of activities Amerigroup supported in the third quarter:

- Kansas Special Olympics
- Wichita iCab Bike Camp
- Community Health Council Meeting
- Central Avenue Parade

Outreach Activities**:** Amerigroup's Outreach Care Specialists continued their telephonic outreach efforts and mailings to new members to welcome them and to ensure they have completed their initial health risk assessment. They also reached out to members who appeared to be due for an annual checkup or need other medical services to help schedule their appointment with their provider to help improve their overall health.

The Community Relations Representatives participated in a variety of community events reaching approximately 13,503 Kansans in the third quarter of 2018. Amerigroup highly values the benefits of these activities which give them the opportunity to obtain valuable feedback and to cover current topics that are relevant to their members, such as: KAN Be Healthy screenings, transportation, diabetes, well child visits, employment, dental care, working with your PCPC, and more.

Below is a sampling of some of their outreach efforts this past quarter:

- Community Baby Showers
- Kansas School Nurse Conference

- Back to School at Kickapoo Nation
- Saline County Back to School Fair

Advocacy Activities**:** Amerigroup' s advocacy efforts for third quarter of 2018 continue to be broad based to support the needs of the general population, pregnant women, children, people with disabilities and the elderly. The staff is proactively and engaged at the local level by participating in coalitions, committees, and boards across the state. These commitments help the staff learn the needs of the communities they serve and how they can better serve these communities.

The third quarter advocacy efforts remain similar to those of the previous quarters. Amerigroup continues to educate families, members, potential members, caregivers, providers, and all those who work with the KanCare community. Amerigroup continues to help support their members in resolving issues through the KanCare Ombudsman, the grievance and appeal process with the assistance of the Grievance Specialists on site at the Health Plan.

Amerigroup also met with members who participate in their adult advisory group to help assess their effectiveness and to improve various health related strategies, programs and systems of care.

Here are a few examples of their Advocacy Activities this past quarter:

- Member Advisory Committee
- Latino Coalition Meeting
- Kansas Poverty Conference
- Homeless Taskforce Meeting

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

Marketing Activities: Sunflower Health Plan marketing activities for the 3rd quarter 2018 included attending and/or sponsoring 79 member and provider events. Sunflower sponsored local and statewide member and provider events along with partnership and participation in community activities. Sunflower's marketing material for the third quarter included member postcards and customized letters addressing preventive health care gaps for diabetes screenings, childhood and adolescent immunizations and prenatal care along with member invitations to advisory group meetings. Our social media channels are steadily increasing their reach, and we use those to engage the public and our members with valuable health information, invitations and event notifications.

Noteworthy stakeholder programs and events for marketing during Q3 2018 included:

- Statewide Farmer's Market Voucher Program
- KS Public Health Association Conference & Walk
- Statewide Leading Age Provider Roundtable Meetings
- Johnson County Mental Health Recovery Conference
- Community Outreach to state Health Departments
- Mom & Baby Health Fair
- Baby Jubilee Community Baby Shower

Outreach Activities**:** Sunflower Health Plan's outreach activities for the third quarter of 2018 centered on community outreach, farmers markets and Mother Child Wellness activities. Sunflower also focused on health insurance education for providers and members.

Sunflower's participation at community events resulted in a reach of more than 8,100 members and providers during the third quarter. Examples of member outreach activities this quarter:

- Participated in six Farmers Market member programs across the state.
- Chicken N Pickle- Pickleball Tournament.
- Participated in community baby showers to promote prenatal care and safe sleep initiatives
- Participated in eight community health events serving all populations, including the Baby Jubilee health fair.
- Participated in a variety of ongoing community/public health meetings.
- Held Sunflower Health Plan's quarterly Member Advisory Committee meeting on September 28, in Wichita. The meeting was open forum for all members and the agenda walked through various areas of Sunflower Health Plan insurance including member portal, find a provider, and healthy rewards accounts to solicit member feedback.
- Sunflower staff volunteered at the Open Streets ICT event.

Advocacy Activities**:** Sunflower Health Plan's advocacy efforts for Q3 2018 centered on supports for people with disabilities, employment opportunities and work to help all populations improve individual health literacy. During this reporting period, there was enhanced promotion of employment initiatives with participation in several events focused on those with disabilities. Sunflower participated in the following advocacy activities during Q3 2018:

- Transition Pathways: What's Next
- GKC DisAbility Inclusion Summit
- Employment First Summit
- Self Advocate Coalition of Kansas Conference
- KC Teen Summit STEM Camp
- Wichita Advocacy Council Meeting
- LeadingAge Biannual Regional Roundtable events
- Autism Across the Ages
- Crime Victims' Rights Conference

Information related to UnitedHealthcare Community Plan marketing, outreach and advocacy activities:
Marketing Activities: UnitedHealthcare Community Plan of Kansas continued to focus on member, provider, and community education regarding KanCare benefits and general health education. Plan staff completed new member welcome calls and Health Risk Assessments. New members were sent ID Cards and new member welcome kits in a timely manner. Throughout the quarter, UnitedHealthcare hosted a number of meetings and presentations with key providers, hospitals, Federally Qualified Health Centers (FQHC's) and Community Based Organizations like Butler County Special Education, Consulate of Mexico, Derby Recreation Center, Public Schools, Housing Authorities, March of Dimes, KIDS Network, Head Start and Parents as Teachers as well as providers, health departments and faith based organizations throughout the state with a focus on innovation and collaboration.

Advocacy Activities: UnitedHealthcare continued to support advocacy opportunities to support children and members with disabilities, and the individuals and agencies that support them.

Throughout this quarter, the team also worked closely with Health Plan Care Coordinators who support the waiver population. The Health Plan staff continued to stress to all members, including those with disabilities the desire to help support the members' personal goals and encouraged them to make informed decisions about enrollment in a KanCare plan. Staff will also meet consumers new to KanCare

who are trying to understand their benefits. UnitedHealthcare remains committed to providing ongoing support and education to members and offering support to the consumers of Kansas. Health Plan staff worked with the Kansas Disability Caucus, Topeka Veterans Administration, Kansas Association of Community Action Programs (KACAP), Families Together, Hillcrest Transitional Housing, Catholic Charities, Mexican Consulate, USD #457, DSNWK, and several other organizations and providers to help support individuals in areas of training and job development. UHC advocate also served on the Project SEARCH advisory committee. Staff also participated in Panel Discussion for Inclusion Connection.

Health Plan sponsored several key events including the KAMU Conference. The Health Plan staff supported multiple committees and coalitions surrounding the challenges faced by consumers navigating the health care world.

Below is a sample of the organizations the Health Plan staff interacted with during third quarter:

– Self-Advocate Coalition of Kansas
– Hays Community Service Council
– Pratt County Community Health & Resource Council
– Thomas County Health Coalition
– Great Bend Interagency Committee
– WILCO Interagency Coalition
– Cultural Relations Board
– Ford County Health Coalition
– Kansas Association for the Medically Underserved (KAMU)
– Tobacco Cessation Work Group
– WIC
– Food Pantries
– Jayhawk ADRC
– Johnson County Mental Health Center
– Council on Aging
– KIDS KS Infant Death & SIDS
– ECKAN
– Growing Futures
– Parents as Teachers
– Wesley House
– Consulate of Mexico: Kansas City
– My Family Labette County
– USD 259 Wichita Public Schools & USD 457 Garden City
– Reach Healthcare Foundation
– SafeHome
– My Family Labette County

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

KanCare Amendment 35 was submitted to CMS for review and approval on August 30, 2018. The Amendment adjusts the capitation payment to KanCare MCOs. The Amendment is effective July 1, 2018, pending CMS approval.

One State Plan Amendments (SPA) was approved as noted below:

SPA Number	Subject	Submitted Date	Effective Date	Approval Date
18-008	Technical amendment that restores definitions applicable to the inpatient hospital program.	6/26/2018	01/01/2018	7/02/2018

Five State Plan Amendment (SPA) were submitted:

SPA Number	Subject	Submitted Date	Proposed Effective Date	Approval Date
18-0009	Payment for services rendered in an outpatient and inpatient hospital setting will be increased 4%.	8/20/2018	07/01/2018	
18-0010	Yearly rates for NF/NFMH	9/25/2018	07/01/2018	
18-0011	Payment for PRTF reserve days	9/25/2018	07/01/2018	
18-0012	Tobacco Cessation Counseling	9/26/2018	9/21/2018	
18-0013	Revisions to the Medicaid eligibility application	9/26/2018	1/01/2019	

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

b. *Benefits:* All pre-KanCare benefits continue, and the program includes value-added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value-added services utilization, per each of the KanCare MCOs, by top three value-added services and total for January-June 2018, follows:

MCO	Value Added Service Jan.- Sept. 2018	Units YTD	Value YTD
Amerigroup	Member Incentive Program	2,165	$1,190,086
	Adult Dental Care	2,576	$336,837
	Mail Order OTC	5,537	$102,544
	Total of All Amerigroup VAS	**11,290**	**$1,729,641**
Sunflower	CentAccount debit card	53,650	$585,657
	Dental visits for adults	4,183	$250,738
	Comprehensive Medication Review	7,160	$199,380
	Total of all Sunflower VAS	**89,049**	**$1,345,625**
United	Additional Vision Services	8,772	$221,954
	Home Helper Catalog Supplies	4,389	$122,319
	Baby Blocks Program and Rewards	772	$92,640
	Total of all United VAS	**35,895**	**$673,554**

c. *Enrollment issues:* For the third quarter of calendar year 2018 there were 8 Native Americans who chose to not enroll in KanCare and who are still eligible for KanCare.

The table below represents the enrollment reason categories for the second quarter of calendar year 2018. All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Beneficiary placed on Punitive Lock-In	1
Newborn Assignment	1
KDHE - Administrative Change	56
WEB - Change Assignment	21
KanCare Default - Case Continuity	93
KanCare Default – Morbidity	163
KanCare Default - 90 Day Retro-reattach	257
KanCare Default - Previous Assignment	391
KanCare Default - Continuity of Plan	517
AOE – Choice	442
Choice - Enrollment in KanCare MCO via Medicaid Application	1404
Change - Enrollment Form	274
Change - Choice	337
Change - Access to Care – Good Cause Reason	65
Change - Case Continuity – Good Cause Reason	1
Change – Due to Treatment not Available in Network – Good Cause	
Assignment Adjustment Due to Eligibility	9
Total	**4032**

d. Grievances, appeals and state hearing information:

MCOs' Grievance Database
CY18 3rd quarter report

MCO	AMG		SUN		UHC		Total
	HCBS Member	Non HCBS Member	HCBS Member	Non HCBS Member	HCBS Member	Non HCBS Member	
QOC (non HCBS, Non Transportation)	5	14	11	16	12	30	88
QOC - Opioids		3	2	3		2	10
Customer Service	1	2	6	13	8	5	35
Member Rights Dignity		2	4	2			8
Access to Service or Care	3	7		5	2	6	23
Non-Covered Services		4	2	4		5	15
Pharmacy	2	4				7	13
QOC HCBS Provider	7		9		3		19
Value Added Benefits	2		1	3		2	8
Billing/Financial Issues (non-Transportation)	14	30	3	8	9	42	106
Transportation – Billing and Reimbursement	1	3	1	2		4	11
Transportation - No Show	7	8	6	5	5	6	37
Transportation - Late	8	8	8	10	12	16	62
Transportation - Safety	2	4	1	9	7	7	30

No Driver Available	1	1	2	1			5
Transportation - Other	7	14	9	16	10	28	84
Other	3	5		1		2	11
TOTAL	63	109	65	98	68	162	565

MCOs' Appeals Database

Members – CY18 3rd quarter report

Member Appeal Reasons **AMG – Red** **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**	**MCO Determined not Applicable**
MEDICAL NECESSITY/LEVEL OF CARE – Criteria Not Met					
Durable Medical Equipment	1 31 14	 1 1	 11 7	1 19 6	
Inpatient Admissions (Non-Behavioral Health)	6 1 42	4 36	 1	2 1 3	 2
Medical Procedure (NOS)	9 14 4	 2	6 3 1	2 9 3	1
Radiology	3 20		2 9	1 11	
Pharmacy	23 68 73	 4 5	14 48 38	6 16 26	3 4
PT/OT/ST	3			3	
Dental	2 3		1	1 3	
Home Health	2 1	1	1		 1
Out of network provider, specialist or specific provider request	7	1	3	2	1
Inpatient Behavioral Health	12 4 5		1 4	9 4	2 1
Behavioral Health Outpatient Services and Testing	2 1 15		 1 6	2 7	 2
LTSS/HCBS	16 7 5	2 1	10 2	4 4 4	 1
Mental Health	1				1
HCBS (change in attendant hours)	5 1			5 1	
Other	1 11		 8	 3	1
NONCOVERED SERVICE					
Dental	2			2	

	2	1		1	
Pharmacy	1 2		2	1	
OT/PT/Speech	2	1		1	
Durable Medical Equipment	11 1		9	2 1	
Other	23	2	15	6	
Lock In	1 2		1	2	
Billing and Financial Issues					
AUTHORIZATION DENIAL					
Late submission by member/provider rep.	2	1		1	
No authorization submitted	1 1	1 1			
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **84** **203** **177**	 **8** **13** **44**	 **33** **113** **58**	 **36** **77** **62**	 **7** **13**

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

MCO's Appeals Database

Member Appeal Summary – CY18 3rd quarter report

AMG – Red **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**	**MCO Determined Not Applicable**
Total Number of Appeals Resolved	84 203 177	8 13 44	33 113 58	36 77 62	7 13
Percentage Per Category		10% 6% 25%	39% 56% 33%	43% 38% 35%	8% 7%

MCOs' Reconsideration Database

Providers - CY18 3rd quarter report (reconsiderations resolved)

PROVIDER Reconsideration Reasons **AMG – Red** **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**	**MCO Determined Not Applicable**
CLAIM DENIALS					
Hospital Inpatient (Non-Behavioral Health)	294 1154 701		38 583 337	195 506 364	61 65
Hospital Outpatient (Non-Behavioral Health)	638 1591 835		173 642 422	364 853 413	101 96
Dental	64		51	13	
Vision	2		1	1	
Ambulance (Include Air and Ground)	5		1	2	2

	26 157		24 116	2 41	
Medical Professional (Physical Health not Otherwise Specified)	3844 1238 7325		1466 954 4597	1942 276 2728	436 8
Nursing Facilities - Total	296 115		109 99	151 16	36
HCBS	708 671		406 545	225 83	77 43
Hospice	133 69 208		34 63 120	74 6 88	25
Home Health	2			2	
Behavioral Health Outpatient and Physician	996 152 1002		542 34 774	347 98 228	107 20
Behavioral Health Inpatient	24 1 25		9 9	12 1 16	3
Out of network provider, specialist or specific provider	73 1713		9 774	59 939	5
Radiology	575 307 656		224 178 365	302 92 291	49 37
Laboratory	524 672 1185		197 277 655	289 350 530	38 45
PT/OT/ST	2 24 22		 22 3	2 2 19	
Durable Medical Equipment	77 353		29 235	38 100	10 18
Other	20		14	5	1
Total Claim Payment Disputes	8136 6512 13831		3242 3717 8172	3948 2458 5659	946 337
ADMINISTRATIVE DENIAL					
Denials of Authorization (Unauthorized by Members)	474		259	215	
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **8136** **6512** **14305**		 **3242** **3717** **8431**	 **3948** **2458** **5874**	 **946** **337**

MCO's Appeals Database

Provider Reconsideration – Denied Claim Analysis – CY18 3rd quarter report

AMG – Red SUN – Green UHC – Purple	Claim Denied-MCO in Error	Claim Denied-Provider Error	Claim Denied – Correctly Billed and Correctly Denied/Paid	Claim Paid – Correctly Billed and Correctly Paid	Total
Provider Reconsiderations					
MCO Reversed Decision on Reconsideration	2378 3206 2174	498 511 2366	332 658	34 2974	3242 3717 8172
MCO Upheld Decision on Reconsideration	11	1795 11 1370	295 1178 2208	1847 1269 2081	3948 2458 5659
Total Claim Payment Disputes	2389 3206 2174	2293 522 3736	627 1178 2866	1881 1269 5055	7190 6175 13831

MCOs' Appeals Database

Provider Appeal Summary – CY18 3rd quarter report (appeals resolved)

PROVIDER Appeal Reasons AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	MCO Determined Not Applicable
CLAIM DENIAL					
Hospital Inpatient (Non-Behavioral Health)	67 141 222	 1 2	5 56 48	53 80 172	9 4
Hospital Outpatient (Non-Behavioral Health)	67 211 139	 2	9 102 10	51 101 129	7 6
Pharmacy	3		1	2	
Dental	2 9		1 7	1 2	
Vision	8 24 2		 21 1	8 3 1	
Ambulance (Include Air and Ground)	8 16		2 9	6 7	
Medical Professional (Physical Health not Otherwise Specified)	211 31 138		72 14 18	117 15 120	22 2
Nursing Facilities - Total	34 9 6		19 5	12 4 6	3
HCBS	35		19	13	3
Hospice	12 2		4 1	8	 1

	2		1	1	
Home Health	1 6 15		1 2 2	 4 13	
Behavioral Health Outpatient and Physician	40 12 17	 1	20 3 2	15 9 14	5
Behavioral Health Inpatient	4 16		 3	4 11	 2
Out of network provider, specialist or specific provider	16		2	12	2
Radiology	19 63 1	 1	6 23	11 36 1	2 3
Laboratory	12 21 11		 12 3	12 9 8	
PT/OT/ST	5 5		5 1	 4	
Durable Medical Equipment	13 42 5	 1	5 16	4 25 5	4
Other	17 6		8 2	8 4	1
Total Claim Payment Disputes	525 636 585	 5 3	161 283 97	309 327 485	55 21
BILLING AND FINANCIAL ISSUES					
Recoupment	1 3			 3	1
ADMINISTRATIVE DENIAL					
Denials of Authorization (Unauthorized by Members)	185 44 3	 1 3	93 17	70 26	22
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **710** **681** **591**	 **6** **6**	 **254** **300** **97**	 **379** **353** **488**	 **77** **22**

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

MCO's Appeals Database
Provider Appeal Summary – CY18 3rd quarter report

AMG – Red **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**	**MCO Determined Not Applicable**
Reconsideration	**8136** **6512**	**0**	**3242** **3717**	**3948** **2458**	**946** **337**

	14305		8431	5874	
Resolved at Appeal Level	710 681 591	0 6 6	254 300 97	379 353 488	77 22
TOTAL	8846 7193 14896	0 6 6	3496 4017 8528	4327 2811 6362	1023 359
Percentage Per Category		<1% <1%	40% 56% 57%	49% 39% 43%	11% 5%

MCO's Appeals Database

Provider Appeal – Denied Claim Analysis – CY18 3rd quarter report

AMG – Red SUN – Green UHC – Purple	Claim Denied-MCO in Error	Claim Denied-Provider Error	Claim Denied – Correctly Billed and Correctly Denied/Paid	Claim Paid – Correctly Billed and Correctly Paid	Total
Provider Appeals					
MCO Reversed Decision on Appeal	103 8	17 22 87	32 212 10	8 41	160 283 97
MCO Upheld Decision on Appeal	0 0 173	19 2	21 291	130 34	300 327 173
Total Claim Denials	103 8 173	166 24 87	53 503 10	138 75	460 610 270

State of Kansas Office of Administrative Fair Hearings

Members – CY18 3rd quarter report

AMG-Red SUN-Green UHC-Purple	Number Resolved	Withdrew	OAH Affirmed MCO Decision	OAH Reversed MCO Decision	Dismiss Moot MCO Reversed	Dismiss Moot Duplicate	Dismiss Untimely	Dismiss Not Ripe/ No MCO Appeal	Dismiss No Adverse Action	Dismiss No Auth.	Dismiss Appellant Verbally Withdrew	Dismiss Failure to State a Claim	Default Appellant Failed to Appear	Default Respondent Failed to Appear	Default Respondent Failed to File Agency Summary
MEDICAL NECESSITY/LEVEL OF CARE – Criteria Not Met															
Durable Medical Equipment	4				4										
Inpatient Admissions (Non-	1				1										

Behavioral Health)														
Medical Procedure (NOS)	2 1				1 1				1					
Pharmacy	6	1						4	1					
PT/OT/ST	3				1			2						
Dental	1							1						
Home Health	1							1						
Out of network provider, specialist or specific provider request	1													1
Inpatient Behavioral Health	2		1		1									
Behavioral Health Outpatient Services and Testing	1		1											
LTSS/HCBS	6 2	2	3		1							2		
Other	1		1											
BILLING AND FINANCIAL ISSUES	2				2									
TOTAL **AMG-Red** **SUN-Green** **UHC-Purple**	 13 12 9	 2 1	 6		 4 6 2			 4 4	 1 1			 2		 1

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

State of Kansas Office of Administrative Fair Hearings

Providers – CY18 3rd quarter report

AMG-Red **SUN-Green** **UHC-Purple**	**Number Resolved**	**Withdrew**	**OAH Affirmed MCO Decision**	**OAH Reversed MCO Decision**	**Dismiss Moot MCO Reversed**	**Dismiss Moot Duplicate**	**Dismiss Untimely**	**Dismiss Not Ripe/ No MCO Appeal**	**Dismiss No Adverse Action**	**Dismiss No Auth.**	**Dismiss Appellant Verbally Withdrew**	**Dismiss Failure to State a Claim**	**Default Appellant Failed to Appear**	**Default Respondent Failed to Appear**	**Default Respondent Failed to File Agency Summary**
CLAIM DENIAL															
Hospital Inpatient	16 17	2 15			10 1		3	1 1							

(Non-Behavioral Health)	22	15			5			2							
Pharmacy	2	1						1							
Medical (Physical Health not Otherwise Specified)	5				3			2							
Nursing Facilities – Total	3				3										
HCBS	4 1	1		1	3										
Hospice	1						1								
Behavioral Health Outpatient and Physician	1				1										
Laboratory	1							1							
PT/OT/ST															
Durable Medical Equipment	3 1				3 1										
BILLING AND FINANCIAL ISSUES															
Recoupment	5 3	2	2	1	1 1			1							
TOTAL **AMG-Red** **SUN-Green** **UHC-Purple**	 38 18 29	 5 15 16	 2	 1 1	 24 2 6		 4 	 4 1 4							

**The Category – RESOLVED WITHOUT SUBSTANTIVE CHANGES TO ORIGINAL CLAIM will be reported starting CY2018 4th Qtr.*
** We removed categories from the above table that did not have any information to report for the quarter.*

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

f. *Changes in provider qualifications/standards:* None.

g. *Access:* As noted in previous reports, members who are not in their open enrollment period are unable to change plans without a good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs. In Q3 2018, the number dropped to 52 from 144 requests in Q2.

Most of good cause requests (GCRs) are due to members mistakenly believing that they can file good cause requests because they prefer a provider outside of their assigned MCO's network. GCRs still occur due to providers advising patients to file GCRs to switch plans. And as in previous quarters, GCRs filed after the choice period are denied as not reflective of good cause if the

request is based solely on the member's preference, when other participating providers are available within access standards. In these cases, the MCOs are tasked with offering to assist the member in scheduling an appointment with one of their participating providers. The previous quarter had usually large numbers of approved requests due to a single provider dropping out of a MCO's network. This large provider specializes in traumatic brain injury waiver treatment. The Secretary of Kansas Department of Health and Environment and the State Medicaid Director opted to approve any Good Cause Requests filed for these vulnerable waiver members who expressed a desire for continuity of care with this provider. Those requests were isolated to Q2, thus explaining the dramatic drop in requests for Q3.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the third quarter of 2018, there was one state fair hearing filed for a denied GCR, and the decision was affirmed. A summary of GCR actions this quarter is as follows:

Status	July	August	Sept
Total GCRs filed	18	20	14
Approved	1	3	3
Denied	7	9	7
Withdrawn (resolved, no need to change)	3	6	3
Dismissed (due to inability to contact the member)	7	2	0
Pending	0	0	1

Providers are constantly added to the MCOs' networks, with much of the effort focused upon HCBS service providers. All three MCOs have made a concerted effort to review, revise and update their network adequacy reports based upon State feedback. The networks are not changing significantly, but the network reports generated still require updates.

The chart below indicates unique providers by name, locale and NPI. Providers who serve multiple physical locations will be counted more than once:

KanCare MCO	# of Unique Providers as of 12/31/17	# of Unique Providers as of 3/31/17	# of Unique Providers as of 6/30/18	# of Unique Providers as of 9/30/18
Amerigroup	27,107	29,066	26,544	33,230
Sunflower	31,168	27,441	27,433	30,886
UHC	31,247	31,259	30,819	38,196

h. *Payment rates:* Changes were made to payment rates to reflect policy changes and service reimbursement increases (see Section IV. Operational Developments/Issues, a. Systems and reporting issues, approval and contracting with new plans).

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

j. *MLTSS implementation and operation:* In August 2018, Kansas offered services to 450 people on the HCBS PD waiting list. Of the 450 offers, 236 individuals accepted waiver services and 2 individuals declined as of 09/30/2018. Combined, 238 individuals have responded, resulting in a

53% initial response rate. There were several individuals from this offer round that accepted waiver services after the end of this quarter.

During this quarter, the Money follows the Person (MFP) program continued its transition to sustainability services. New referrals to MFP concluded on June 30, 2017 KDADS sought input from stakeholders and MCO on a proposed policy to continue to encourage supports designed to move members to community based services. Effective July 1, 2017, rather than being referred to the MFP program, persons seeking to transition from institutions to HCBS are referred to their assigned MCO and applicable waiver program manager for review and approval. Members of the MFP program prior to June 30, 2017 will continue to receive supports during the 365 days post-transition.

k. *Updates on the safety net care pool including DSRIP activities:* Currently there are two hospitals participating in the DSRIP activities. They are Children's Mercy Hospital (CMH) and Kansas University Medical Center (KU). CMH has chosen to do the following projects: Complex Care for Children, and Patient Centered Medical Homes. KU will be completing STOP Sepsis, and Self-Management and Care Resiliency for their projects. Kansas Foundation for Medical Care (KFMC) is working with the State on improving healthcare quality in KanCare. The hospitals continued identifying community partners, creating training for community partners, and working toward reaching the project milestones for the DY6.

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

- The State has submitted a technical amendment to the Serious Emotional Disturbance Waiver (SED). The technical amendment addresses the Wraparound facilitator/targeted case manager planning for the initial plan of care meeting. KDADS received an informal request for additional information from CMS and has submitted answers to the questions. Currently the State awaits feedback for the technical amendment and IRAI questions.
- The IDD waiver expires on 7/1/19, and CMS has requested that the renewing waiver be submitted for review 180 days in advance of the termination date. IDD waiver will be submitted on 1/1/19. From September 10, 2018-September 17, 2018, KDADS hosted an HCBS forum on the renewing waivers to provide information and seek feedback from providers and stakeholders. The IDD waiver renewal will be posted for the public comment period from 11/1/18 to 11/30/18, as well as for the 60-day tribal notice period. An in-person meeting at the Prairie Band Potawatomi Government Center has been scheduled for 11/20/18 to discuss the waiver renewal with tribal members

m. *Legislative activity*: The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight met August 20 and 21, 2018. The committee was provided a program update, information about KanCare Meaningful Measures Collaborative, a presentation of the KanCare audit report, an update on the procurement activities for the 2019 KanCare managed care contracts, and information on HCBS waivers and the waiting lists. In addition, the KanCare Ombudsman provided a report and testimony was provided by the three managed care organizations, several individuals, and associations who are stakeholders of the KanCare program.

n. *Other Operational Issues*: None

V. Policy Developments/Issues

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

VI. Financial/Budget Neutrality Development/Issues

Budget neutrality: Attached is the current budget neutrality document. The expenditures contained in the document reconcile to Schedule C from the CMS 64 report for QE 9 30 2018.

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

VII. Member Month Reporting

We have updated this section to reflect member months reporting for each month by DY.

Jul 2018 DATA		Aug 2018 DATA		Sep 2018 DATA	
DY/MEG	**Member Months**	**DY/MEG**	**Member Months**	**DY/MEG**	**Member Months**
2016	**(19)**	**2016**	**(24)**	**2016**	**(4)**
MEG 1 - ABD/SD DUAL	34	MEG 1 - ABD/SD	29	MEG 1 - ABD/SD	(7)
MEG 2 - ABD/SD NON	(68)	MEG 2 - ABD/SD	(47)	MEG 2 - ABD/SD	(4)
MEG 3 - ADULTS		MEG 3 - ADULTS	-	MEG 3 - ADULTS	1
MEG 4 - CHILDREN	12	MEG 4 - CHILDREN	(1)	MEG 4 - CHILDREN	3
MEG 5 - DD WAIVER	(3)	MEG 5 - DD	-	MEG 5 - DD	
MEG 6 - LTC	8	MEG 6 - LTC	4	MEG 6 - LTC	3
MEG 7 - MN DUAL	11	MEG 7 - MN DUAL	(1)	MEG 7 - MN DUAL	6
MEG 8 - MN NON DUAL	(18)	MEG 8 - MN NON	(8)	MEG 8 - MN NON	(9)
MEG 9 - WAIVER	5	MEG 9 - WAIVER		MEG 9 - WAIVER	3
2017	**(68)**	**2017**	**(135)**	**2017**	**57**
MEG 1 - ABD/SD DUAL	162	MEG 1 - ABD/SD	122	MEG 1 - ABD/SD	3
MEG 2 - ABD/SD NON	(426)	MEG 2 - ABD/SD	(184)	MEG 2 - ABD/SD	(37)
MEG 3 - ADULTS	16	MEG 3 - ADULTS	(1)	MEG 3 - ADULTS	3
MEG 4 - CHILDREN	125	MEG 4 - CHILDREN	26	MEG 4 - CHILDREN	84
MEG 5 - DD WAIVER	(13)	MEG 5 - DD	16	MEG 5 - DD	(1)
MEG 6 - LTC	34	MEG 6 - LTC	(97)	MEG 6 - LTC	(2)
MEG 7 - MN DUAL	32	MEG 7 - MN DUAL	(6)	MEG 7 - MN DUAL	27
MEG 8 - MN NON DUAL	(47)	MEG 8 - MN NON	(14)	MEG 8 - MN NON	(33)
MEG 9 - WAIVER	49	MEG 9 - WAIVER	3	MEG 9 - WAIVER	13
2018	**347,599**	**2018**	**341,178**	**2018**	**342,668**
MEG 1 - ABD/SD DUAL	15,668	MEG 1 - ABD/SD	15,019	MEG 1 - ABD/SD	14,829

MEG 2 - ABD/SD NON	29,996	MEG 2 - ABD/SD	29,760	MEG 2 - ABD/SD	29,937
MEG 3 - ADULTS	50,929	MEG 3 - ADULTS	50,384	MEG 3 - ADULTS	50,127
MEG 4 - CHILDREN	214,602	MEG 4 - CHILDREN	210,220	MEG 4 - CHILDREN	211,923
MEG 5 - DD WAIVER	9,127	MEG 5 - DD	9,145	MEG 5 - DD	9,090
MEG 6 - LTC	20,170	MEG 6 - LTC	19,891	MEG 6 - LTC	19,986
MEG 7 - MN DUAL	1,426	MEG 7 - MN DUAL	1,240	MEG 7 - MN DUAL	1,268
MEG 8 - MN NON DUAL	1,010	MEG 8 - MN NON	965	MEG 8 - MN NON	998
MEG 9 - WAIVER	4,671	MEG 9 - WAIVER	4,554	MEG 9 - WAIVER	4,510
Grand Total	347,512	Grand Total	341,019	Grand Total	342,721

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

VIII. Consumer Issues

Consumer issues remain static. A summary of second quarter 2018 consumer issues remains:

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.	MCOs 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 and reprocessing projects continuing in progress. This information is posted on each plan's Issue logs, and the KanCare Claims Resolution Log for providers and the State to review and monitor. MCOs must report spenddown files to the State that track the spenddown files. Unfortunately, this has been a difficult system issue to resolve.
Delays in HCBS services when the member transitions from one MCO to another, or from one setting to another.	There are many reasons this can occur. If the provider must report transition (like a nursing facility) sometimes they fail to turn in the correct forms. We require certain forms before we can switch the level of care coding in MMIS. Sometimes KDADS or KDHE failed to do something to switch the MMIS coding. Finally, the MCOs could fail to transfer service plans and other information when a member switches from one MCO to another.	The State has tasked the MCOs with working together on a common process to effectively transfer member plans of care to another MCO. The data transfer files and processes will be streamlined in the future to more effectively transition members
Members sometimes find it difficult to find providers with open panels.	MCOs are working to correct provider network directory database issues. Also educating providers to reach out to MCOs when their directory information changes or if they add/subtract providers to the practice.	MCOs are instructed to report Open/Closed panels for all provider types. MCOS have begun to report this information in 2017, and to actively collect and report this data in the quarterly reporting template. The State is also developing guidelines for the provider directory to be implemented soon as mandated by CMS.

Retroactively eligible members are denied authorizations or claims denied for timely filing.	Members are denied authorization, services and care coordination due to retroactive eligibility.	Some of the MCO processes require manual intervention, which may lead to errors. Also, some MCOs require a claim to be submitted and denied before they can implement the retroactive eligibility protocol. All authorization and customer service employees receive frequent updates on how to deal with retro authorizations.

During the third quarter of 2018, support and assistance for consumers in the state for KanCare was provided by KDHE's 28 out-stationed eligibility workers (OEW). OEW staff assisted in determining eligibility for 4,050 consumers. OEW also assisted in resolving 1,492 issues involving urgent medical needs, obtaining correct information on applications, addressing gaps or errors in pending applications/reviews with the KanCare Clearinghouse. These OEW staff assisted with 1,906 consumer phone calls.

During the third quarter of 2018, OEW staff participated in 44 community events providing KanCare program outreach, education and information for the following agencies/events: State of Kansas School Nurse Conference, Local Health Departments/WIC clinics, FQHC clinics, Latino and Asian Wellness groups, Parents as Teachers, State Wide Head Start Conference, Prairie Band Potawatomie, Kickapoo, Sax and Fox Tribal Health Summit, Salvation Army, Homeless Shelters, Veterans Homeless Resource Fair, Circles Out of Poverty consumer groups, Community Health Fairs, Back to School events, health care providers, advocates, and consumers.

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. The KDHE and KDADS leadership team makes sure that KanCare activity is consistent with the managed care contract and approved terms and conditions of the KanCare 1115(a) Medicaid demonstration waiver. This group directs the policy initiatives of the KanCare Steering Committee, which includes both executive and operational leadership from both KDHE and KDADS.

The following 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/onsite reviews and other KanCare contract monitoring results; external quality review findings and reports; feedback from governmental agencies, the KanCare MCOs, Medicaid providers, Medicaid members/consumers, and public health advocates; and leadership's review of and feedback regarding the overall KanCare quality plan. This combined information assists the leadership team and the MCOs to identify and recommend quality initiatives and metrics of importance to the Kansas Medicaid population.

The State Quality Management Strategy – The QMS is designed to provide an overarching framework for the State to allocate resources in an efficient manner with the objective of driving meaningful quality improvement (QI). Underneath the QMS lies the State's monitoring and oversight activities, across KDHE and KDADS, that act as an early alert system to more rapidly address MCO compliance issues and reported variances from expected results. Those monitoring and oversight activities represent the State's ongoing

actions to ensure compliance with Federal and State contract standards. The framework of the QMS has been redesigned to look at the KanCare program and the population it serves in a holistic fashion to address all physical, behavioral, functional and social determinants of health and independence needs of the enrolled population. The QMS serves as the launch pad from which the State will continue to build and implement continuous QI principals in key areas of the KanCare program. The State will continue to scale the requirements of the QMS to address and support ongoing system transformation.

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

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

During 2018 Quarter 3, the State participated in the following activities:

- Quality Management Strategy revisions to comply with the CMS final rule were finalized, sent for tribal input and posted for a public comment period. Responses were incorporated into the strategy and will drive some of the implementation steps of the strategy.
- Business meetings between KDHE's MCO Management team and cross-function/leadership MCO staff to continue to further develop operational details regarding the KanCare State Quality Strategy. Specific attention was paid to development of the performance measures, pay-for-performance measures and performance improvement projects in the KanCare program.
- Ongoing automated report management, review and feedback between the State and the MCOs. Reports from the MCOs consist of a wide range of data reported on standardized templates.
- 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 ongoing receipt, distribution, review and feedback regarding submitted reports. The process of report management, review and feedback is now automated to ensure efficient access to reported information and maximum utilization/feedback related to the data.
- Implementation and monitoring of the External Quality Review Organization (EQRO) work plan.

- Meetings with the EQRO along with the MCOs, KDADS and KDHE to discuss EQRO activities and concerns.
- Dissemination of the 2017 annual compliance reviews of the MCOs – which are done in partnership with KDADS, to review areas of State concern. Onsite audits are performed yearly, but the subsequent review and monitoring of any findings continue through the year.
- Medicaid Fraud Control Unit 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.
- Continued state staff participation in cross-agency long-term care meetings to report quality assurance and programmatic activities to KDHE for oversight and collaboration.
- Continued participation in weekly calls with each MCO to discuss ongoing provider and member issues, and to troubleshoot operational problems. Progress is monitored through these calls and through issue logs. Additionally, top management staff from KDADS, KDHE and the three MCOs meet monthly face-to-face to discuss issues and improvements to KanCare.
- Monitor large, global system issues through a weekly log issued to all MCOs and the State's fiscal agent. The resulting log is posted out on the KanCare website for providers and other interested parties to view. Continue monthly meetings to discuss trends and progress.
- Two-day implementation planning meeting for new components of the KanCare QMS
- Monitor member or provider specific issues through a tracking database that is shared with MCOs and KDADS for weekly review.
- Attend various provider training and workshops presented by the MCOs. Monitor for accuracy, answer questions as needed.
- For the programs administered by KDADS: The Quality Assurance (QA) process is designed to give continuous feedback to KDADS, KDHE and stakeholders regarding the quality of services being provided to KanCare members. KDADS quality assurance staff are integrated in the Survey, Certification and Credentialing Commission (SCCC) to align staff resources for efficient and timely performance measurement. QA staff review random samples of individual case files to monitor and report compliance with performance measures designated in Attachment J of the MCO contracts.
- Also for the programs administered by KDADS: These measures are monitored and reviewed in collaboration with program staff in the Community Services and Programs Commission and reported through the Financial and Information Services Commission at KDADS. This oversight is enhanced through collaboration with the Department of Children and Families and the Department of Health and Environment. During this quarter, HCBS performance measures were reported to CMS via the 372 reporting process. A quality assurance protocol and interpretative guidelines are utilized to document this process and have been established with the goal of ensuring consistency in the reviews.
- Below is the timeline that the KDADS Quality Review Team follows regarding the quality review process.

HCBS Quality Review Rolling Timeline							
	FISC/IT	**SCC**	**MCO/Assess**	**SCC**	**FISC**	**SCC**	**CSP**
Review Period (look back period)	Samples Pulled *Posted to QRT	Notification to MCO/Assessor Samples posted	MCO/Assessor Upload Period *(60 days)	Review of MCO data *(90 days)	Data pulled & Compiled (30days)	Data & Findings Reviewed at LTC Meeting ***	Remediation Reviewed at LTC Meeting

01/01 – 03/31	4/1 – 4/15	4/16	4/16 – 6/15	5/16 – 8/15	9/15	October	November
04/01 – 06/30	7/1 – 7/15	7/16	7/16 – 9/15	8/16 – 11/15	12/15	January	February
07/01 – 09/30	10/1 – 10/15	10/16	10/16 – 12/15	11/16 – 2/15	3/15	April	May
10/01 – 12/31	1/1 – 1/15	1/16	1/16 – 3/15	2/16 – 5/15	6/15	July	August

X. Managed Care Reporting Requirements

a. A description of network adequacy reporting including GeoAccess mapping: Each MCO submits a quarterly network adequacy report. The State uses this report to monitor the quality of network data and changes to the networks, drill down into provider types and specialties, and extract data to respond to requests received from various stakeholders. In addition, each MCO submits quarterly network reports that serve as a tool for KanCare managers to monitor accessibility to certain provider types. KDHE uploads the provider raw data from the MCOs into a monitoring dashboard (still under construction) which has multipurpose report options and user configurable reporting. Currently, data supplied by the MCOs are used to generate two reports are published to the KanCare website monthly for public viewing: http://www.kancare.ks.gov/policies-and-reports/network-adequacy. KDHE hopes to post additional reports and dashboards for users to look at network information once we get the dashboard ready for public use.

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

b. Customer service reporting, including total calls, average speed of answer and call abandonment rates, for MCO-based and fiscal agent call centers, July-September 2018:

KanCare Customer Service Report – Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:29	3.03%	132,450
Sunflower	0:17	1.43%	125,463
United	0:16	0.79%	128,387
DXC – Fiscal Agent	0.05	0.47%	24,500

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:24	1.30%	88,371
Sunflower	0:21	1.76%	69,114
United	0:13	0.64%	67,843
DXC – Fiscal Agent	0.08	0.45%	29,005

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

MCOs' Grievance Trends
Members – CY18 3rd Quarter

Amerigroup 3rd Qtr. Grievance Trends		
Total # of Resolved Grievances	172	
Top 5 Trends		
Trend 1: Billing and Financial Issues (Non-Transportation)	44	26%
Trend 2: Transportation – Other	21	12%
Trend 3: Quality of Care (non HCBS)	19	11%
Trend 4: Transportation – Late	16	9%
Trend 5: Transportation – No Show	15	9%

Amerigroup Member Grievances:

- There are 44 member grievances categorized as Billing and Financial Issues (Non-Transportation) in CY2018 Quarter 3 which is a significant increase of 10 from CY2018 Quarter 2.
- There are 172 member grievances in CY2018 Quarter 3 which is an increase of 29 (20%) from 143 member grievances in CY2018 Quarter 2.
- There are 64 transportation grievances in CY2018 Quarter 3 which is an increase of 8 (14%) from 56 transportation grievances in CY2018 Quarter 2.

Sunflower 3rd Qtr. Grievance Trends		
Total # of Resolved Grievances	163	
Top 5 Trends		
Trend 1: Quality of Care (non HCBS)	27	17%
Trend 2: Transportation – Other	25	15%
Trend 3: Customer Service	19	12%
Trend 4: Transportation – Late	18	11%
Trend 5: Billing and Financial Issues / Transportation – No Show	11	7%

Sunflower Member Grievances:

- There are 163 member grievances in CY2018 Quarter 3 which is a decrease of 40 (20%) from 203 member grievances in CY2018 Quarter 2.
- There are 70 transportation grievances in CY2018 Quarter 3 which is a decrease of 23 (31%) from 93 transportation grievances in CY2018 Quarter 2.

United 3rd Qtr. Grievance Trends		
Total # of Resolved Grievances	230	
Top 5 Trends		
Trend 1: Billing and Financial Issues (Non-Transportation)	51	22%
Trend 2: Quality of Care (non HCBS)	42	18%
Trend 3: Transportation – Other	38	17%
Trend 4: Transportation – Late	28	12%
Trend 5: Transportation – Safety	14	6%

United Member Grievances:

- There are 230 member grievances in CY2018 Quarter 3 which is a decrease of 25 (10%) from 255 member grievances in CY2018 Quarter 2.
- There are 97 transportation grievances in CY2018 Quarter 3 which is a decrease of 6 (6%) from 103 transportation grievances in CY2018 Quarter 2.

MCO's Reconsideration Trends
Provider – CY2018 3rd Quarter

Amerigroup 3rd Qtr. Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	8136	
Top 5 Trends		
Trend 1: Medical Professional (Physical Health not Otherwise Specified)	3844	47%
Trend 2: Behavioral Health Outpatient and Physician	996	12%
Trend 3: HCBS	708	9%
Trend 4: Hospital Outpatient (Non-Behavioral Health)	638	8%
Trend 5: Radiology	575	7%

Amerigroup Provider Reconsiderations

- There are 638 provider reconsiderations categorized as Hospital Outpatient (Non-Behavioral Health) in CY2018 Quarter 3 which is a significant increase of 306 from CY2018 Quarter 2.
- There are 3,844 provider reconsiderations categorized as Medical Professional (Physical Health not Other Specified) in CY2018 Quarter 3 which is a significant increase of 119 from CY2018 Quarter 2.
- There are 296 provider reconsiderations categorized as Nursing Facilities – Total which is a significant increase of 10 from CY2018 Quarter 2.
- There are 133 provider reconsiderations categorized as Hospice in CY2018 Quarter 3 which is a significant increase of 27 from CY2018 Quarter 2.
- There are 524 provider reconsiderations categorized as Laboratory which is a significant increase of 92 from CY2018 Quarter 2.

Sunflower 3rd Qtr. Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	6512	
Top 5 Trends		
Trend 1: Hospital Outpatient (Non-Behavioral Health)	1591	24%
Trend 2: Medical Professional (Physical Health not Otherwise Specified)	1238	19%
Trend 3: Hospital Inpatient (Non-Behavioral Health)	1154	18%
Trend 4: Laboratory	672	10%
Trend 5: HCBS	671	10%

Sunflower Provider Reconsiderations

- There are 1,154 provider reconsiderations categorized as Hospital Inpatient (Non-Behavioral Health) in CY2018 Quarter 3 which is a significant increase of 13 from CY2018 Quarter 2.
- There are 1,591 provider reconsiderations categorized as Hospital Outpatient (Non-Behavioral Health) in CY2018 Quarter 3 which is a significant increase of 593 from CY2018 Quarter 2.
- There are 64 provider reconsiderations categorized as Dental in CY2018 Quarter 3 which is a significant increase of 49 from CY2018 Quarter 2.

- There are 1,238 provider reconsiderations categorized as Medical Professional (Physical Health not Otherwise Specified) in CY2018 Quarter 3 which is a significant increase of 111 from CY2018 Quarter 2.
- There are 115 provider reconsiderations categorized as Nursing Facilities – Total in CY2018 Quarter 3 which is a significant increase of 47 from CY2018 Quarter 2.
- There are 152 provider reconsiderations categorized as Behavioral health Outpatient and Physician in CY2018 Quarter 3 which is a significant increase of 32 from CY2018 Quarter 2.
- There are 73 provider reconsiderations categorized as Out of network provider, specialist or specific provider in CY2018 Quarter 3 which is a significant increase of 73 from CY2018 Quarter 2.
- There are 307 provider reconsiderations categorized as Radiology in CY2018 Quarter 3 which is a significant increase of 49 from CY2018 Quarter 2.
- There are 353 provider reconsiderations categorized as Durable Medical Equipment in CY2018 Quarter 3 which is a significant increase of 14 from CY2018 Quarter 2.

United 3rd Qtr. Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	14305	
Top 5 Trends		
Trend 1: Medical Professional (Physical Health not Otherwise Specified)	7325	51%
Trend 2: Out of network provider, specialist or specific provider	1713	12%
Trend 3: Laboratory	1185	8%
Trend 4: Behavioral Health Outpatient and Physician	1002	7%
Trend 5: Hospital Outpatient (Non-Behavioral Health)	835	6%

United Provider Reconsiderations

- There are 157 provider reconsiderations categorized as Ambulance (include Air and Ground) in CY2018 Quarter 3 which is a significant increase of 69 from CY2018 Quarter 2.
- There are 7,325 provider reconsiderations categorized as Medical Professional (Physical Health not Otherwise Specified) in CY2018 which is a significant increase of 898 from CY2018 Quarter 2.
- There are 208 provider reconsiderations categorized as Hospice in CY2018 Quarter 3 which is a significant increase of 29 from CY2018 Quarter 2.
- There are 1,713 provider reconsiderations categorized as Out of network provider, specialist or specific provider in CY2018 Quarter 3 which is a significant increase of 412 from CY2018 Quarter 2.
- There are 1,185 provider reconsiderations categorized as Laboratory in CY2018 Quarter 3 which is a significant increase of 87 from CY2018 Quarter 2.

MCOs' Appeals Trends

Member/Provider – CY18 3rd Quarter

Amerigroup 3rd Qtr. Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	84		**Total # of Resolved Provider Appeals**	710	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Criteria Not Met – Pharmacy	23	27%	Trend 1: Medical Processional (Physical Health not Otherwise Specified)	211	30%
Trend 2: Level of Care – HCBS/LTSS	16	19%	Trend 2: Denials of Authorization (Unauthorized by Members)	185	26%
Trend 3: Criteria Not Met – Inpatient Behavioral Health	12	14%	Trend 3: Hospital Inpatient (Non-Behavioral Health)	67	9%

Trend 4: Criteria Not Met – Medical Procedure (NOS)	9	11%	Trend 4: Hospital Outpatient (Non-Behavioral Health)	67	9%
Trend 5: Criteria Not Met – Inpatient Admissions (Non-Behavioral Health)	6	7%	Trend 5: Behavioral Health Outpatient and Physician	40	6%

Amerigroup Provider Appeals:

- There are 67 provider appeals categorized as Hospital Inpatient (Non-Behavioral Health) in CY2018 Quarter 3 which is a significant increase of 21 from CY2018 Quarter 2.
- There are 34 provider appeals categorized as Nursing Facilities – Total in CY2018 Quarter 3 which is a significant increase of 10 from CY2018 Quarter 2.

Sunflower 3rd Qtr. Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	203		**Total # of Resolved Provider Appeals**	681	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Criteria Not Met - Pharmacy	68	33%	Trend 1: Hospital Outpatient (Non-Behavioral Health)	211	31%
Trend 2: Criteria Not Met – Durable Medical Equipment	31	15%	Trend 2: Hospital Inpatient (Non-Behavioral Health)	141	21%
Trend 3: Other – Noncovered Services	23	11%	Trend 3: Radiology	63	9%
Trend 4: Criteria Not Met – Radiology	20	10%	Trend 4: Denials of Authorization (Unauthorized by Members)	44	6%
Trend 5: Criteria Not Met – Medical Procedure (NOS)	14	7%	Trend 5: Durable Medical Equipment	42	6%

Sunflower Member Appeals:

- There are 11 member appeals categorized as Other – Medical Necessity in CY2018 Quarter 3 which is a significant increase of 10 from CY2018 Quarter 2.
- There are 23 member appeals categorized as Other – Noncovered Services in CY2018 Quarter 3 which is a significant increase of 12 from CY2018 Quarter 2.

Sunflower Provider Appeals:

- There are 141 provider appeals categorized as Hospital Inpatient (Non-Behavioral Health) in CY2018 Quarter 3 which is a significant increase of 52 from CY2018 Quarter 2.
- There are 211 provider appeals categorized as Hospital Outpatient (Non-Behavioral Health) in CY2018 Quarter 3 which is a significant increase of 28 from CY2018 Quarter 2.
- There are 31 provider appeals categorized as Medical Professional (Physical Health not Otherwise Specified) in CY2018 Quarter 3 which is a significant increase of 27 from CY2018 Quarter 2.
- There are 42 provider appeals categorized as Durable Medical Equipment in CY2018 Quarter 3 which is a significant increase of 19 from CY2018 Quarter 2.

United 3rd Qtr. Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	177		**Total # of Resolved Provider Appeals**	591	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Criteria Not Met – Pharmacy	73	41%	Trend 1: Hospital Inpatient (Non-Behavioral Health)	222	38%
Trend 2: Criteria Not Met – Inpatient Admissions (Non-Behavioral Health)	42	24%	Trend 2: Hospital Outpatient (Non-Behavioral Health)	139	24%

Trend 3: Criteria Not Met – Behavioral Health Outpatient Services and Testing	15	8%	Trend 3: Medical Professional (Physical Health not Otherwise Specified)	138	23%
Trend 4: Criteria Not Met – Durable Medical Equipment	14	8%	Trend 4: Behavioral Health Outpatient and Physician	17	3%
Trend 5: Criteria Not Met – Out of network provider, specialist or specific provider request	7	4%	Trend 5: Ambulance	16	3%

United Provider Appeals:

- There are 139 provider appeals categorized as Hospital Outpatient (Non-Behavioral Health) in CY2018 Quarter 3 which is a significant increase of 47 from CY2018 Quarter 2.

MCOs' State Fair Hearing Reversed Decisions
Member/Provider – CY18 3rd Quarter

- United Healthcare received 1 Default order this quarter.

Amerigroup 3rd Qtr.					
Total # of Member SFH	13		**Total # of Provider SFH**	38	
OAH reversed MCO decision	4	31%	OAH reversed MCO decision	24	63%

Sunflower 3rd Qtr.					
Total # of Member SFH	12		**Total # of Provider SFH**	18	
OAH reversed MCO decision	6	50%	OAH reversed MCO decision	2	11%

United 3rd Qtr.					
Total # of Member SFH	9		**Total # of Provider SFH**	29	
OAH reversed MCO decision	2	22%	OAH reversed MCO decision	6	21%

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

e. Summary of ombudsman activities for the third quarter of 2018 is attached.

f. *Summary of MCO critical incident report:* Shifting focus to opportunities for process and system improvement, the Cross-Agency Adverse Incident Management Team drafted a Critical Incident Form for MCOs to track MCO-specific critical incidents and document provider and MCO correspondence, collaboration and responses to each incident. The team made several suggestions to revise the types of critical incidents and current definitions of critical incidents collected in the Adverse Incident Reporting (AIR) database. An AIR timeline was developed and presented to the MCOs at the December Cross-Agency Adverse Incident Management Team meeting. Also, a review of the performance measures as they correspond to critical incidents was provided to the group to serve as a foundation for the work that needs to be completed. As a result, the Cross-Agency Adverse Incident Management Team agreed to devote more time to this project starting January 1, 2017 and meet bi-weekly until the appropriate processes and systems are in place.

Role and responsibility clarification for all parties will be prioritized and suggestions were made for reducing report duplication across the critical incident management system. The team began reassessing progress related to the applicable KanCare Special Terms and Conditions and documenting advancements by subject area and by agency.

KDADS has made significant progress on this project. Areas that are still being finalized include:

- Developing an automatic feed to pull APS and CPS reports into the AIR system
- Creating reports for each performance measure – specifically unexpected death, restraint, seclusion and restrictive interventions.
- Making final revisions to AIR, if needed, by KDADS IT
- Training MCO representatives once all system changes are in place
- Scheduling monthly meetings with each MCO to provide the appropriate amount of oversight of the AIR system, analyze trends and drill down in to any specific cases as necessary.

KDADS IT staff presented a demonstration of the AIR system for data element identification for future reporting requirements and preferences for canned reports and functionality. The system was revised to reflect the AIR policy revisions and assessed for performance measure reporting accuracy. Coordination meetings to leverage resources continue between KDADS' commissions and state agencies for full implementation. KDADS IT automation of the system to manage MCO-specific critical incidents in accordance with the AIR policy revisions is underway.

This team has met its goals, as stated in the STCs, to develop a statewide strategy for delineating and structuring multi-agency efforts by creating the Incident Reporting Guide. Also, the Adverse Incident Reporting system was built as a critical incident management reporting and monitoring system for the detection, prevention, reporting, investigation and remediation of critical incidents with design components to detect seclusion, restraint and medication management. The Adverse Incident Reporting system and accompanying AIR Memo and HCBS Adverse Incident Reporting and Management Policy have been finalized. This work is now with KDADS IT for operationalization of the system.

AIR is not intended to replace the State reporting system for abuse, neglect and exploitation (ANE) of individuals who are served on the behavioral health and HCBS programs. ANE substantiations are reported separately to KDADS from the Department of Children and Families (DCF) and monitored by the KDADS program integrity team. The program integrity team ensures individuals with reported ANE are receiving adequate supports and protections available through KDADS programs, KanCare, and other community resources. A summary of the 2018 AIRS reports through the quarter ending September 30, 2018 follows:

Critical Incidents		**1st Qtr.**	**2nd Qtr.**	**3rd Qtr.**	**4th Qtr.**	**YTD**
		AIR Totals	AIR Totals	AIR Totals	AIR Totals	**TOTALS**
Reviewed		2,096	1,905	1,703		5,704
Pending Resolution		0	0	115		115
Total Received		2,096	1,905	1,818		5,819
APS Substantiations*		104	121	112		337

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

XI. Safety Net Care Pool

The Safety Net Care Pool (SNCP) is divided into two pools: The Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool. The DY6 third quarter HCAIP UCC Pool payments were made July 19, 2018. The DY6 quarter three LPTH/BCCH UC Pool payments were made September 28, 2018.

SNCP and HCAIP reports for DY 6 Q3 are attached to this report.

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

XII. Demonstration Evaluation

The entity selected by KDHE to conduct KanCare Evaluation reviews and reports is the Kansas Foundation for Medical Care (KFMC). 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 addressed that feedback, and 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. KFMC developed and submitted quarterly evaluation reports, annual evaluation reports for 2013, 2014 and 2015, as well as a revised evaluation design in March 2015.

For the quarter ending 9.30.18, KFMC's quarterly report is attached. As with the previous evaluation design reports, the State will review the Quarterly Report, with specific attention to the related recommendations, and will continue to take responsive action designed to accomplish enhancements to the state's oversight and monitoring of the KanCare program, and to improve outcomes for members utilizing KanCare services.

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

a. *Post-award forums*
No post-award forum was held this quarter.

b. *Claims Adjudication Statistics*
KDHE's summary of the numerous claims adjudication reports for the KanCare MCOs, covering January-September 2018, is attached.

c. *Waiting List Management*
PD Waiting List Management
For the quarter ending September 30, 2018:

- Current number of individuals on the PD Waiting List: 1,600
- Number of individuals added to the waiting list: 384
- Number of individuals removed from the waiting list: 181
    - 107 started receiving HCBS-PD waiver services
    - 27 were deceased
    - 47 were removed for other reasons (refused services, voluntary removal, etc.)

I/DD Waiting List Management
For the quarter ending September 30, 2018:

- Current number of individuals on the I/DD Waiting List: 3,785

- Number of individuals added to the waiting list: 158
- Number of individuals removed from the waiting list: 110
    - 57 started receiving HCBS-I/DD waiver services
    - 2 were deceased
    - 51 were removed for other reasons (refused services, voluntary removal, etc.)

The current point-in-time limit for HCBS-IDD is 8,900. The IDD waiver renewal for 7/1/19 has updated that point-in-time number to 9,004. KDADS is currently serving 9,107 individuals.

d. *Money Follows the Person*

Kansas stopped taking new admissions to the MFP program 07/01/2017. The number of remaining MFP enrollees as of September 2018 is listed in the table below. The grand total is down from the 81 participants in June 2018 at the end of the previous quarter.

Level of Care	Count
MFP DD	1
MFP FE	10
MFP PD	22
Grand Total	33

XIV. Enclosures/Attachments

Section of Report Where Attachment Noted	Description of Attachment
VI	KanCare Budget Neutrality Monitoring Spreadsheet for QE 9.30.18
X(e)	Summary of KanCare Ombudsman Activities for QE 9.30.18
XI	Safety Net Care Pool Report DY 6 Q3 and HCAIP Report DY6 Q3
XII	KFMC KanCare Evaluation Report for QE 9.30.18
XIII(a)	KDHE Summary of Claims Adjudication Statistics for January-September 2018

XV. State Contacts

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XVI. Date Submitted to CMS

December 4, 2018

1115 WAIVER BUDGET NEUTRALITY
MEDICAID (EXCLUDES MCHIP)

DY1

MEG	MEMBER MONTHS	PMPM LIMIT	EXPENDITURE LIMIT	ACTUAL EXPENDITURES	(OVER)/UNDER LIMIT	% of Limit
ABD/SD DUAL	220,774	$ 192.83	42,571,850	$ 63,702,906	$ (21,131,056)	150%
ABD/SD NON DUAL	350,317	$ 1,072.16	375,595,875	$ 360,407,669	$ 15,188,206	96%
ADULTS	408,224	$ 631.05	257,609,755	$ 233,604,819	$ 24,004,936	91%
CHILDREN	2,553,631	$ 218.47	557,891,765	$ 510,884,155	$ 47,007,609	92%
DD WAIVER	103,493	$ 3,873.00	400,828,389	$ 383,508,707	$ 17,319,682	96%
LTC	263,398	$ 3,488.61	918,892,897	$ 812,869,815	$ 106,023,082	88%
MN DUAL	16,423	$ 1,380.10	22,665,382	$ 18,812,725	$ 3,852,657	83%
MN NON DUAL	15,432	$ 1,785.86	27,559,392	$ 21,926,311	$ 5,633,080	80%
WAIVER	52,877	$ 2,590.95	137,001,663	$ 150,672,912	$ (13,671,249)	110%
TOTAL	3,984,569		2,740,616,968	$ 2,556,390,020	$ 184,226,948	93%

DY2

MEG	MEMBER MONTHS	PMPM LIMIT	EXPENDITURE LIMIT	ACTUAL EXPENDITURES	(OVER)/UNDER LIMIT	% of Limit
ABD/SD DUAL	223,789	$ 192.83	43,153,233	$ 46,371,112	$ (3,217,879)	107%
ABD/SD NON DUAL	351,397	$ 1,092.75	383,989,072	$ 405,260,731	$ (21,271,659)	106%
ADULTS	492,318	$ 661.81	325,820,976	$ 288,602,462	$ 37,218,514	89%
CHILDREN	2,713,967	$ 224.30	608,742,798	$ 588,651,333	$ 20,091,465	97%
DD WAIVER	104,552	$ 3,915.99	409,424,586	$ 463,559,801	$ (54,135,215)	113%
LTC	257,610	$ 3,640.34	937,787,987	$ 903,390,688	$ 34,397,300	96%
MN DUAL	17,099	$ 1,440.12	24,624,612	$ 15,993,973	$ 8,630,639	65%
MN NON DUAL	13,675	$ 1,863.53	25,483,773	$ 24,957,923	$ 525,849	98%
WAIVER	48,206	$ 2,703.63	130,331,188	$ 134,408,366	$ (4,077,178)	103%
TOTAL	4,222,613		2,889,358,225	$ 2,871,196,388	$ 18,161,837	99%

DY3

MEG	MEMBER MONTHS	PMPM LIMIT	EXPENDITURE LIMIT	ACTUAL EXPENDITURES	(OVER)/UNDER LIMIT	% of Limit
ABD/SD DUAL	208,018	$ 192.83	40,112,111	$ 38,302,535	$ 1,809,576	95%
ABD/SD NON DUAL	343,678	$ 1,113.73	382,764,499	$ 402,573,114	$ (19,808,615)	105%
ADULTS	547,127	$ 694.07	379,744,437	$ 305,972,981	$ 73,771,456	81%
CHILDREN	2,717,057	$ 230.29	625,711,057	$ 625,482,082	$ 228,974	100%
DD WAIVER	105,107	$ 3,959.46	416,166,962	$ 483,273,951	$ (67,106,988)	116%
LTC	252,688	$ 3,798.66	959,875,798	$ 972,551,831	$ (12,676,033)	101%
MN DUAL	16,218	$ 1,502.75	24,371,600	$ 10,451,647	$ 13,919,953	43%
MN NON DUAL	13,504	$ 1,944.58	26,259,608	$ 19,272,511	$ 6,987,098	73%
WAIVER	46,519	$ 2,821.22	131,240,333	$ 146,139,082	$ (14,898,749)	111%
TOTAL	4,249,916		2,986,246,405	$ 3,004,019,734	$ (17,773,329)	101%

1115 WAIVER BUDGET NEUTRALITY
MEDICAID (EXCLUDES MCHIP)

DY4

MEG	MEMBER MONTHS	PMPM LIMIT	EXPENDITURE LIMIT	ACTUAL EXPENDITURES	(OVER)/UNDER LIMIT	% of Limit
ABD/SD DUAL	187,587	$ 192.83	36,172,401	$ 45,335,715	$ (9,163,313)	125%
ABD/SD NON DUAL	339,460	$ 1,135.11	385,324,441	$ 418,706,293	$ (33,381,853)	109%
ADULTS	633,174	$ 727.90	460,887,355	$ 320,014,039	$ 140,873,316	69%
CHILDREN	2,826,329	$ 236.44	668,257,229	$ 647,865,944	$ 20,391,285	97%
DD WAIVER	106,609	$ 4,003.41	426,799,537	$ 490,005,859	$ (63,206,323)	115%
LTC	247,124	$ 3,963.87	979,567,410	$ 962,427,493	$ 17,139,917	98%
MN DUAL	15,689	$ 1,568.11	24,602,078	$ 10,220,675	$ 14,381,403	42%
MN NON DUAL	14,651	$ 2,029.15	29,729,077	$ 25,461,522	$ 4,267,555	86%
WAIVER	52,179	$ 2,943.92	153,610,802	$ 147,808,982	$ 5,801,820	96%
TOTAL	4,422,802		3,164,950,328	$ 3,067,846,522	$ 97,103,806	97%

DY5

MEG	MEMBER MONTHS	PMPM LIMIT	EXPENDITURE LIMIT	ACTUAL EXPENDITURES	(OVER)/UNDER LIMIT	% of Limit
ABD/SD DUAL	182,103	$ 192.83	35,114,921	$ 44,457,240	$ (9,342,318)	127%
ABD/SD NON DUAL	344,212	$ 1,156.90	398,218,863	$ 409,351,020	$ (11,132,158)	103%
ADULTS	632,149	$ 763.38	482,569,904	$ 320,388,579	$ 162,181,325	66%
CHILDREN	2,609,965	$ 242.75	633,569,004	$ 601,233,030	$ 32,335,974	95%
DD WAIVER	107,520	$ 4,047.85	435,224,832	$ 514,399,415	$ (79,174,583)	118%
LTC	244,471	$ 4,136.26	1,011,195,618	$ 1,005,757,305	$ 5,438,313	99%
MN DUAL	15,537	$ 1,636.31	25,423,348	$ 9,874,332	$ 15,549,016	39%
MN NON DUAL	13,972	$ 2,117.40	29,584,313	$ 26,578,833	$ 3,005,479	90%
WAIVER	53,443	$ 3,071.96	164,174,758	$ 152,517,433	$ 11,657,325	93%
TOTAL	4,203,372		3,215,075,562	$ 3,084,557,188	$ 130,518,374	96%

DY6

MEG	MEMBER MONTHS	PMPM LIMIT	EXPENDITURE LIMIT	ACTUAL EXPENDITURES	(OVER)/UNDER LIMIT	% of Limit
ABD/SD DUAL	117,178	$ 192.83	22,595,434	$ 32,104,426	$ (9,508,992)	142%
ABD/SD NON DUAL	234,886	$ 1,179.11	276,956,030	$ 299,890,684	$ (22,934,654)	108%
ADULTS	406,474	$ 800.59	325,418,776	$ 246,556,219	$ 78,862,557	76%
CHILDREN	1,716,630	$ 249.23	427,832,945	$ 469,391,023	$ (41,558,078)	110%
DD WAIVER	72,725	$ 4,092.78	297,647,666	$ 361,302,981	$ (63,655,315)	121%
LTC	160,465	$ 4,316.15	692,590,576	$ 675,000,581	$ 17,589,995	97%
MN DUAL	9,940	$ 1,707.48	16,972,313	$ 9,607,112	$ 7,365,201	57%
MN NON DUAL	7,599	$ 2,209.49	16,789,900	$ 18,770,465	$ (1,980,565)	112%
WAIVER	36,277	$ 3,205.57	116,288,421	$ 114,779,962	$ 1,508,459	99%
TOTAL	2,762,174		2,193,092,061	$ 2,227,403,452	$ (34,311,391)	102%

GRAND TOTAL DY1-DY6	23,845,446		17,189,339,547	$ 16,811,413,303	$ 377,926,244	97.80%

1115 WAIVER BUDGET NEUTRALITY
MEDICAID (EXCLUDES MCHIP)

Note:
Member months are reported net of adjustments, sorted by capitation month (benefit month). The data is from the capitation files, including data through the capitation file paid in Sep 2018.
Expenditures are pulled from Schedule C, through QE 9 30 2018. See SCH C ADJUSTED tab for details and adjustments.
Above does not include MCHIP.

Kerrie J. Bacon
KanCare Ombudsman
Qtr. 3, 2018 (based on calendar year)

Quarterly Report
July 1-Sept. 30, 2018

Data downloaded on 10/12/18

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Highlights/Dashboard

Contact Information – page 3

Average Quarterly Initial Contacts for 2018 is trending 18% above last year's quarterly average (2017) and 29% above the 2016 quarterly average.

Initial Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Avg. qtr.
2016	**1,130**	846	687	523	797
2017	825	835	970	**1,040**	918
2018	**1,214**	**1,059**	1,085		1,119
2017 vs. 2018	47%	27%	11%		18%
2016 vs. 2018	7%	25%	37%		29%

Accessibility through the KanCare Ombudsman Volunteer Program – page 4

Both Satellite offices have answered KanCare questions and helped with issues as well as helping to fill out KanCare applications on the phone and in person at the offices. ***The Satellite office are each covering approximately 20 hours per week in serving KanCare beneficiaries.***

Data by Region (NEW) – pages 7 and 8

The KanCare Ombudsman's office has begun pulling data by region. The KanCare Ombudsman's office divided Kansas into four regions. The north and south dividing line uses the area codes by county to decide if the county is in the northern region or the southern region. The two regions with the most initial contacts are Northeast and Southeast.

Region	Q1/18	Q2/18	Q3/18
Northwest	14	16	10
Northeast	157	220	238
Southwest	14	18	14
Southeast	59	135	163
Out of State	14	17	21
Not Identified	955	653	639
Total	**1,213**	**1,059**	**1,085**

Accessibility by Ombudsman's Office

Initial Contacts

The KanCare Ombudsman was available to members and potential members of KanCare (Medicaid) by phone, email, written communication, and in person during third quarter of 2018. The number of initial contacts the Ombudsman's office received continues to increase. The initial contacts have been increasing for the last seven quarters. 2018 is averaging about 200 initial contacts per quarter higher than 2017.

Initial Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Avg. qtr.
2014	545	474	526	547	523
2015	510	462	579	524	519
2016	**1,130**	846	687	523	797
2017	825	835	970	**1,040**	918
2018	**1,214**	**1,059**	1,085		1,119
2017 vs. 2018	47%	27%	11%		18%
2016 vs. 2018	7%	25%	37%		29%

**2013 year does not include emails in the data*

Additional Contacts gives data on the many contacts that happen after the initial contact to the KanCare Ombudsman's office. These include requests for follow-up to another organization and their responses, and follow-up calls to and from the beneficiary.

Additional Contacts: Notes History (ongoing contacts with beneficiary to note calls and/or updates with issue/concern)	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
2017	1,388	1,651	1,954	2,122
2018	2,251	1,892	1,898	

Additional Contacts: Email History (emails with beneficiaries and follow up with agencies, MCOs and providers, to resolve cases)	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
2017	655	919	1,338	1,490
2018	1,389	1,252	1,315	

Responding to Issues

	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18
Avg. Days to Respond	1	1	2	2	1	1	1
% of contacts responded in 0-2 days	78%	80%	65%	69%	82%	90%	88%
% of contacts responded in 3-7 days	20%	19%	31%	22%	17%	10%	12%
% of contacts responded to in greater than 7 days	2%	1%	4%	9%	1%	0%	1%

Resolution of Issues

The change in average days to close/resolve an issue decreased dramatically from 2nd to 3rd quarter. This was due to clarification for staff and volunteers to close based on resolution date or if no response, on the date last contacted. Prior to this, cases were closed by many at the end of the quarter when I sent out the reminder to close cases; using the end of quarter date.

	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18
Avg. Days to close/resolve Issue	11	9	9	7	8	10	3
% files closed/resolved in 0-2 or less					60%	61%	73%
% of files closed/resolved in 3-7 days					17%	13%	17%
% of files closed/resolved in 7-30 days					12%	14%	8%
% of files closed/resolved in greater than 30 days					11%	13%	2%
% files closed	88%	92%	90%	83%	81%	93%	93%

Accessibility through the KanCare Ombudsman Volunteer Program

Both Satellite offices have answered KanCare questions and helped with issues as well as assisting with filling out KanCare applications on the phone and in person at the offices. The Satellite office are each covering approximately 20 hours per week in serving KanCare beneficiaries.

	Volunteer Hours	# of Volunteers	# of hours covered/wk	Area Codes covered
Olathe Satellite Office	M: 9:00-4, T:12:30-4:00, W:9-12, Th: 1-4, F: 10-1	6	19.5	913, 785, 816
Wichita Satellite Office	M: 12:30-4:30, T: 10-2, W: 12:30-4:30, Th: 10-2, F: 1-4	4	22	316, 620

Outreach by Ombudsman's office

Outreach through Collaboration and Education

- Presented at the Bel Aire Senior Center about the Ombudsman Office in Wichita, July 2
- Olathe Job Fair; Olathe, KS (July 12, 2018)
- 2018 Kansas Conference on Poverty; Topeka, KS (July 19th and 20th)
- Shared about the Ombudsman Office and the Medicare Savings Program at the Sedgwick County Extension Office's "Medicare Options" presentation; Wichita, 7/24.
- Aging Well; Kansas City, KS (July 30, 2018)
- Presentation to Long Term Care Ombudsman group in Kansa City Region; August 8
- Update on Ombudsman's office to Long Term Care State Agency Meeting, August 9, September 13
- Attended the Disability Caucus to help with Medicaid questions and outreach; Topeka, KS (August 9 and 10)
- Tabled at the Colvin Neighborhood Night Out (Wichita area) to provide outreach to families that attended, August 13
- Delivered 2 packages of Ombudsman Office fliers to Dental Services of Sedgwick County and educated them on our role and services; Wichita, KS (August 13)
- Presented Quarter 2, 2018 Report to Bob Bethel Joint HCBS and KanCare Oversight Committee, August 21-22
- Presented to 3 low-income senior housing complexes over Medicaid (Wichita area):
    - Pinecrest Place Senior Residences on 8/20
    - Wichita Place Senior Residences on 8/21
    - Mohr Place II Senior Residences on 8/22
- 2018 Midwest Ability Summit; Overland Park, (August 25, 2018)
- Attended KanCare Education Meetings on MCO Transition in Olathe (available as a resource to members), Wichita, 9/4
- Attended KanCare Education Meetings on MCO Transition in Olathe (available as a resource to members), September 5
- Attended HCBS 1915c Public Listening Session in Wichita (available as a resource to members), 9/11
- Attended HCBS 1915c Public Listening Session in Wichita (available as a resource to members), September 12
- Presented at the United Way Emergency Assistance Network Meeting over general Ombudsman's Office information, Wichita, 9/18
- Provided Ombudsman fliers to approximately 200 attendees at the Kansas Prevention Conference; Topeka (9/19-9/20)
- Tabled at the State Fair in the KDADS booth and discussed the KanCare Ombudsman Office and our services with approximately 250 people, 9/14-9/16

- Presented at the United Way Emergency Assistance Network Meeting over general Ombudsman's Office information to the approximately 25 community organization representatives, September 18.
- Presented Quarter 2, 2018 Report to KanCare Advisory Council Meeting, September 25
- Provided resources at the MCO provider training in Wichita, 9/25
- Provided resources at the MCO provider training in *Dodge City*, 9/26
- Manned a booth at the Central Plains Area Agency on Aging Senior Expo giving information to approximately 800 seniors about Ombudsman information, 9/27
- *Statewide mailing* of KanCare Ombudsman brochures to Community Based organizations in September (i.e. Centers for Independent Living, Community Developmental Disability Organizations, Community Mental Health Centers)

Outreach through Publications

- First Christian Church of Olathe – e-newsletter; Counties: Johnson (August 2018)
- Second Baptist Church of Olathe – Flyer posted; Counties: Johnson (August 2018)
- Statewide Community Health Workers monthly newsletter, September
- Shepherd's Voice; Kansas City, KS (July, August 2018)
- Livable Neighborhoods Task Force; Kansas City, KS (July, August 2018)
- Golden Years Newspaper; Counties: Franklin, Osage, Anderson, Linn, Coffey (July, Aug, Sept 2018)
- Olathe Public Library; Olathe, KS (July, August, September 2018)

Outreach through Collaboration and Training

- Conducted liaison training in Geary Co.; Junction City, KS (July 9, 2018)
- Conducted liaison training in *Ford County* at the Southwest Kansas Area Agency on Aging, 7/10.
- Conducted liaison training in *Rice County*, sponsored by the Rice County Council on Aging, 8/12
- Conducted liaison training in Sedgwick County at the Wichita downtown Senior Center, 8/24.
- Conducted liaison trainings in Cowley County, Arkansas City Senior Center. on 9/12, and
- Conducted liaison trainings in *Finney County* at the Finney County Health Department, 9/24.

Data by Ombudsman's Office

Data by Region *(NEW)*

The KanCare Ombudsman's office has begun pulling data by region. See regional map on next page. Most calls are coming from the east side of the state. The Ombudsman's office is reviewing ways to provide targeted outreach to the western half of Kansas.

Region	Q1/18	Q2/18	Q3/18
Northeast	157	220	238
Southeast	59	135	163
Northwest	14	16	10
Southwest	14	18	14
Out of State	14	17	21
Not Identified	955	653	639
Total	**1,213**	**1,059**	**1,085**

Population Density by KanCare Ombudsman Region

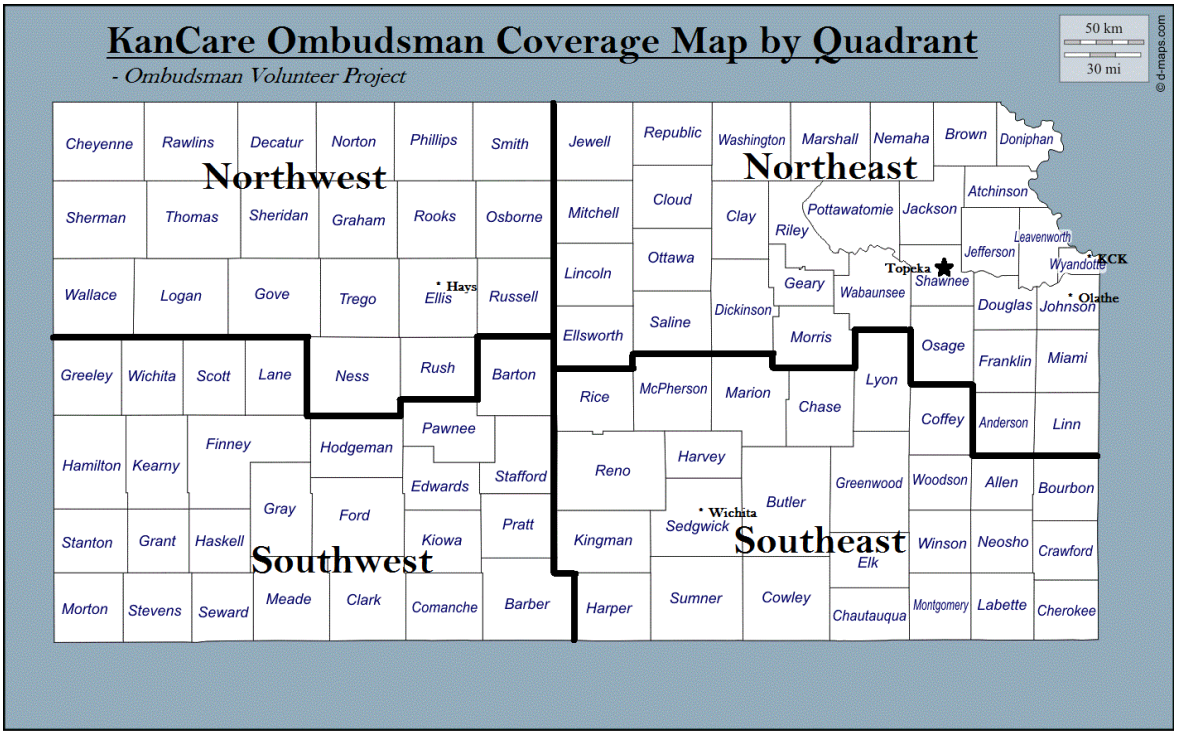
Population Density	Urban	Semi Urban	Densely Settled Rural	Rural	Frontier	Total Counties
NE	5	5	6	15	2	33
SE	1	5	9	7	4	26
NW			1	4	15	20
SW			4	7	15	26
Total	6	10	20	33	36	105

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

Frontier - less than 6 ppsm
Rural - 6 to 19.9 ppsm
Densely-Settled Rural - 20 to 39.9 ppsm
Semi-Urban - 40-149.9 ppsm
Urban - 150+ ppsm

The map shows the counties included in each region. The north/south dividing line is based on the 785 and 620 area codes (in general).

- 785, 913 and 816 area codes in the northern regions go to the Olathe Satellite office.
- 316 and 620 area codes in the southern regions go to the Wichita Satellite office.



NORTHWEST
CHEYENNE
RAWLINS
DECATUR
NORTON
PHILLIPS
SMITH
SHERMAN
THOMAS
SHERIDAN
GRAHAM
WALLACE
LOGAN
GOVE
TREGO
ELLIS
RUSSELL
NESS
RUSH

NORTHEAST
JEWELL
REPUBLIC
WASHINGTON
MARSHALL
NEMAHA
BROWN
DONIPHAN
MITCHELL
CLOUD
CLAY
RILEY
POTTAWATOMIE
JACKSON
ATCHISON
LINCOLN
OTTAWA
GEARY
WABAUNSEE
SHAWNEE
DOUGLAS
JEFFERSON
LEAVENWORTH
WYANDOTTE
JOHNSON
ELLSWORTH
SALINE
DICKENSON
MORRIS
OSAGE
FRANKLIN
MIAMI
ANDERSON
LINN

SOUTHWEST
GREELEY
WICHITA
SCOTT
LANE
BARTON
HIMILTON
KEARNEY
FINNEY
HODGEMAN
PAWNEE
STAFFORD
STANTON
GRANT
HASKELL
GRAY
FORD
EEDWARDS
PRATT
MORTON
STEVENS
SEWARD
MEADE
CLARK
KIOWA
COMANCHE
BARBER

SOUTHEAST
RICE
MCPHERSON
MARION
CHASE
LYON
COFFEE
RENO
HARVEY
BUTLER
GREENWOOD
WOODSON
ALLEN
BOURBON
KINGMAN
SEDGWICH
HARPER
SUMNER
COWLEY
ELK
CHAUTAUQUA
WILSON
MONTGOMERY
NEOSHO
CRAWFORD
LABETTE
CHEROKEE

Data by Issue Category

The "Other" issue category continues showing a reduction for the third quarter. Over the last several quarters the Ombudsman Office has expanded the Issue Categories to give more information on topics; this may be why the Other category is shrinking over time. The Medicaid Renewal issue has improved with third quarter reporting. There may be multiple selections for a member/contact.

Issue Category	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18	7 Qtr. Avg.
Access to Providers (usually Medical)	14	14	13	10	2	2	8	9
Abuse/Neglect Complaints	0	0	0	2	10	10	7	9
Affordable Care Act Calls	3	6	5	5	15	12	9	8
Appeals/Fair Hearing questions/issues	0	0	21	23	45	25	35	30
Background Checks	0	0	0	2	4	0	1	2
Billing	21	33	17	19	40	26	32	27
Care Coordinator Issues	5	11	6	12	10	11	7	9
Change MCO	3	1	2	6	12	7	5	5
Choice Info on MCO	0	0	0	0	3	3	3	3
Client Obligation	17	36	37	33	53	33	23	33
Coding Issues	3	0	8	18	32	8	10	11
Consumer said Notice not received	0	0	0	1	16	4	14	11
Cultural Competency	0	0	0	0	0	1	1	1
Data Requests	0	0	3	5	3	2	4	3
Dental	7	9	7	6	10	9	6	8
Division of Assets	2	2	5	5	10	3	5	5
Durable Medical Equipment	2	9	4	3	1	4	9	5
Estate Recovery	6	5	6	4	11	4	10	7
Grievances Questions/Issues	36	33	29	9	28	34	23	27
Guardianship	3	1	3	4	3	6	5	4
HCBS Eligibility issues	46	50	58	62	46	26	36	46
HCBS General Issues	33	34	21	49	36	33	60	38
HCBS Reduction in Hours of Service	7	2	4	6	7	2	3	4
HCBS Waiting List	6	9	8	4	4	4	4	6
Help understanding mail	0	0	0	0	4	15	21	18
Housing Issues	4	6	7	0	7	7	7	5
Medicaid Application Assistance	45	55	162	179	185	134	144	129

Issue Category	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18	7 Qtr. Avg.
Medicaid Eligibility Issues	237	177	237	300	208	212	182	222
Medicaid Fraud	0	0	0	0	3	2	2	2
Medicaid General Issues/Questions	0	0	0	0	62	181	198	190
Medicaid info (status) update	0	0	0	4	210	215	195	207
Medicaid Renewal	29	43	38	61	103	57	39	53
Medical Services	20	20	11	9	23	27	10	17
Medicare related Issues	0	0	15	22	17	22	27	21
Medicare Savings Plan Issues	0	0	9	21	19	17	20	17
Moving to/from Kansas	5	7	6	9	16	13	21	11
Nursing Facility Issues	40	26	23	21	21	18	23	25
Pharmacy	11	9	10	13	16	1	2	9
Prior authorization issues	0	0	0	0	1	2	0	1
Respite	0	0	0	0	0	1	0	1
Social Security Issues	0	0	1	4	9	13	11	9
Spend Down Issues	18	32	29	29	28	32	24	27
Transportation	8	9	12	5	16	10	9	10
Working Healthy	0	0	2	3	3	6	8	4
X-Other	275	315	241	187	214	132	132	214
Z Thank you.	238	319	416	433	556	490	476	418
Z Unspecified	44	36	61	75	79	72	73	63
TOTAL	**1,188**	**1,312**	**1,537**	**1,663**	**2,201**	**1,948**	**1,944**	

There may be multiple selections for a member/contact.

Data by Office Location

The increase for the Johnson County Satellite office is due to changing the toll-free number for the Ombudsman's office for numbers with 913, 785 and 816 area code. Phone calls from these area codes are now directed to the Johnson County Satellite office (Olathe) rather than the Topeka main Ombudsman's office.

Contacts by Office	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18
Main	648	639	759	718	772	619	491
Johnson County	28	81	51	62	68	81	223
Wichita	149	115	160	260	374	359	371
Total	**827**	**835**	**970**	**1,040**	**1,214**	**1,059**	**1,085**

Data by Contact Method

Although the bottom line number of contact remained stable from last quarter, the contacts by email and face-to-face increased over earlier quarters. There were several listening sessions during this quarter that the Ombudsman's office participated in which would account for the increase in face-to-face initial contacts.

Contact Method	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18
Email	125	127	143	122	112	119	150
Face-to-Face Meeting	11	5	6	8	7	9	22
Letter	2	0	0	0	2	1	2
ONLINE	0	0	0	0	0	0	0
Other	0	2	5	4	2	0	2
Telephone	689	701	816	906	1,091	930	909
TOTAL	**827**	**835**	**970**	**1,040**	**1,214**	**1,059**	**1,085**

Data by Caller Type

The Other type category has increased in the last two quarters. In researching the types of people that fall in that group tend to be schools, lawyers, students and/or researchers looking for data, and state workers. The staff and volunteers have received updates/reminders on this to improve data accuracy.

Caller Type	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18
Consumer	631	661	773	862	1066	799	896
MCO Employee	18	9	11	6	6	4	5
Other type	61	53	45	50	46	175	85
Provider	117	112	141	122	96	81	99
TOTAL	**827**	**835**	**970**	**1,040**	**1,214**	**1,059**	**1,085**

Data by Program Type

The top program types that we receive calls for are the three waivers (Physical Disability, Intellectual/Developmental disability, and Frail elderly) and nursing facility concerns.

PROGRAM TYPE	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18	7 Qtr. Avg.
PD	40	37	32	45	51	27	28	37
I/DD	43	28	52	77	29	27	36	42
FE	30	27	33	38	27	22	30	30
AUTISM	3	2	2	0	1	1	2	2
SED	4	4	5	5	9	2	8	5
TBI	6	8	7	6	7	10	9	8
TA	8	10	2	7	5	3	7	6
WH	0	0	1	3	5	4	6	5
MFP	2	1	0	0	1	0	0	1
PACE	0	0	1	1	0	0	0	0
MENTAL HEALTH	5	5	2	5	2	1	3	3
SUB USE DIS	0	0	0	0	0	0	0	0
NURSING FACILITY	66	45	79	61	47	39	28	52
PROGRAM TOTAL	**207**	**167**	**216**	**248**	**184**	**136**	**157**	

There may be multiple selections for a member/contact.

Action Taken to Resolve Issues by Ombudsman's Office

During 4th quarter we are tracking data to show the length of time it takes to resolve issues that need help from other organizations. That data will be available with the 4th quarter report.

Type of Resolution

ACTION TAKEN	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18	7 Qtr. Avg.
QUESTION/ISSUE RESOLVED (NO RESOURCES)	163	81	73	99	105	69	68	94
USED CONTACT OR RESOURCES/ISSUE RESOLVED	505	601	686	712	766	675	749	671
CLOSED (NO CONTACT)	91	75	112	89	100	133	108	101

There may be multiple selections for a member/contact.

Additional Help

ACTION TAKEN	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18	7 Qtr. Avg.
PROVIDED RESOURCES	239	307	347	447	772	758	787	522
MAILED/EMAIL RESOURCES	46	123	124	116	221	182	128	134

There may be multiple selections for a member/contact.

Referred Beneficiary to Organization for Follow-up

ACTION TAKEN	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18	7 Qtr. Avg.
KDHE CONTACT	135	76	77	60	71	51	41	73
DCF CONTACT	1	4	8	1	4	5	8	4
MCO CONTACT	34	29	18	18	21	29	20	24
CLEARINGHOUSE CONTACT	75	130	202	167	193	179	153	157
HCBS TEAM CONTACT	30	23	24	28	26	18	5	22
CSP MENTAL HEALTH CONTACT	2	0	1	0	0	2	1	1

There may be multiple selections for a member/contact.

Referred Beneficiary to Call Organization for Assistance

ACTION TAKEN	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18	7 Qtr. Avg.
MCO REFERRAL	19	34	33	29	39	29	29	30
CLEARINGHOUSE REFERRAL	26	104	142	143	246	218	207	155
HCBS TEAM REFERRAL	7	12	18	19	14	10	11	13
OTHER KDADS CONTACT/REFERRAL	49	41	46	88	87	54	30	56
STATE OR COMMUNITY AGENCY REFERRAL	46	78	72	83	101	91	104	82
DISABILITY RIGHTS AND/OR KLS REFERRAL	8	2	1	6	6	4	1	4
(NOT IDENTIFIED)	15	12	11	44	58	5	49	28

KanCare Ombudsman

Appendix A – Information by Managed Care Organization

Amerigroup-Issue Category

There may be multiple selections for a member/contact.

ISSUE CATEGORY	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18
Access to Providers (usually Medical)	3	7	2	2	1	0	2
Abuse / neglect complaints	0	0	0	0	1	2	0
Affordable Care Act Calls	0	0	0	0	1	0	0
Appeals/Fair Hearing questions/issues	0	0	2	3	2	1	2
Background Checks	0	0	0	1	1	0	0
Billing	1	5	3	2	7	7	4
Care Coordinator Issues	1	4	0	3	3	4	1
Change MCO	1	0	0	1	4	2	4
Choice Info on MCO	0	0	0	0	0	1	2
Client Obligation	1	7	4	3	8	10	3
Coding Issues	0	0	3	2	5	2	2
Consumer said Notice not received	0	0	0	1	2	0	2
Cultural Competency	0	0	0	0	0	0	0
Data Requests	0	0	0	0	0	0	1
Dental	0	0	1	0	3	0	0
Division of Assets	0	0	0	0	0	0	0
Durable Medical Equipment	0	1	1	0	0	1	3
Estate Recovery	0	1	0	1	0	0	0
Grievances Questions/Issues	9	4	4	0	3	5	2
Guardianship	1	0	0	0	0	0	0
HCBS Eligibility issues	6	7	7	10	6	3	2
HCBS General Issues	11	10	3	8	4	5	5
HCBS Reduction in hours of service	2	0	0	2	6	1	0
HCBS Waiting List	1	2	0	1	0	0	0
Help understanding mail	0	0	0	0	1	1	1
Housing Issues	0	1	1	0	0	1	1
Medicaid Application Assistance	0	0	0	1	3	4	2
Medicaid Coding	0	0	0	0	0	0	0
Medicaid Eligibility Issues	8	5	10	17	10	13	8
Medicaid Fraud	0	0	0	0	0	1	0
Medicaid General Issues/questions	0	0	0	0	6	11	9

Medicaid info (status) update	0	0	0	0	10	8	6
Medicaid Renewal	4	7	3	8	8	6	6
Medical Services	5	7	1	0	4	4	1
Medicare related Issues	0	0	2	3	1	1	2
Medicare Savings Plan Issues	0	0	0	1	0	2	0
Moving to / from Kansas	1	0	0	1	0	0	0
Nursing Facility Issues	1	4	0	0	1	1	1
Pain management issues	0	0	0	0	0	0	0
Pharmacy	1	2	2	1	1	0	1
Prior authorization issues	0	0	0	0	0	0	0
Questions for Conference Calls/Sessions	0	0	0	0	0	0	0
Respite	0	0	0	0	0	0	0
Social Security Issues	0	0	0	0	1	0	1
Spend Down Issues	2	5	2	4	4	4	0
Transportation	1	1	3	0	3	2	2
Working Healthy	0	0	0	0	0	0	0
X-Other	14	19	11	6	18	9	7
Z Thank you.	23	31	13	26	38	42	33
Z Unspecified	1	1	1	0	2	0	3
ISSUE CATEGORY TOTAL	**98**	**133**	**79**	**108**	**168**	**154**	**119**

Amerigroup–Waiver Information

There may be multiple selections for a member/contact.

Program Type	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18
PD	12	9	3	12	5	6	4
I/DD	8	2	6	8	3	3	5
FE	3	6	3	7	4	5	2
AUTISM	1	1	0	0	0	0	0
SED	1	3	2	1	4	1	2
TBI	2	2	3	1	1	5	0
TA	2	4	2	1	0	1	1
WH	0	0	1	0	0	1	0
MFP	0	0	0	0	0	0	0
PACE	0	0	0	0	0	0	0
MENTAL HEALTH	1	1	2	0	0	1	0
SUB USE DIS	0	0	0	0	0	0	0
NURSING FACILITY	2	3	2	0	3	6	0
(NOT IDENTIFIED)	28	40	22	25	68	53	38
WAIVER TOTAL	**32**	**31**	**24**	**30**	**20**	**29**	**14**

Sunflower–Issue Category

There may be multiple selections for a member/contact.

ISSUE CATEGORY	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18
Access to Providers (usually Medical)	4	3	2	3	3	1	4
Abuse / neglect complaints	0	0	0	0	2	0	0
Affordable Care Act Calls	0	1	0	0	0	0	1
Appeals/Fair Hearing questions/issues	0	0	1	1	0	4	4
Background Checks	0	0	0	0	1	0	0
Billing	3	6	5	9	8	6	6
Care Coordinator Issues	1	2	1	6	2	2	0
Change MCO	0	0	0	3	3	2	1
Choice Info on MCO	0	0	0	0	0	0	0
Client Obligation	3	5	4	5	5	3	3
Coding Issues	2	0	1	3	7	2	1
Consumer said Notice not received	0	0	0	0	1	2	2
Cultural Competency	0	0	0	0	0	0	0
Data Requests	0	0	0	0	0	0	0
Dental	0	1	1	1	3	1	0
Division of Assets	0	0	0	0	1	0	0
Durable Medical Equipment	0	2	1	2	1	1	0
Estate Recovery	0	0	1	0	0	0	0
Grievances Questions/Issues	5	8	1	3	2	5	5
Guardianship	0	0	1	0	0	1	1
HCBS Eligibility issues	3	10	10	6	8	5	7
HCBS General Issues	5	6	3	9	12	3	9
HCBS Reduction in hours of service	1	1	1	0	1	0	0
HCBS Waiting List	1	1	0	1	0	0	0
Help understanding mail	0	0	0	0	0	2	1
Housing Issues	1	1	1	0	1	0	0
Medicaid Application Assistance	1	0	3	2	2	2	0
Medicaid Coding	0	0	0	0	0	0	0
Medicaid Eligibility Issues	14	8	13	14	8	13	10
Medicaid Fraud	0	0	0	0	0	0	0
Medicaid General Issues/questions	0	0	0	0	7	9	13
Medicaid info (status) update	0	0	0	0	7	5	8
Medicaid Renewal	6	5	8	6	3	6	4
Medical Services	5	3	5	1	4	4	0
Medicare related Issues	0	0	1	1	0	3	3
Medicare Savings Plan Issues	0	0	0	1	2	2	3
Moving to / from Kansas	0	1	0	0	1	0	0
Nursing Facility Issues	2	1	0	1	1	0	3

Pain management issues	0	0	0	0	0	0	0
Pharmacy	4	3	1	0	2	0	0
Prior authorization issues	0	0	0	0	0	1	0
Questions for Conference Calls/Sessions	0	0	0	0	0	0	0
Respite	0	0	0	0	0	0	0
Social Security Issues	0	0	0	1	1	0	0
Spend Down Issues	2	4	4	3	0	3	1
Transportation	4	3	1	1	2	1	1
Working Healthy	0	0	0	0	0	1	1
X-Other	18	19	11	15	8	9	8
Z Thank you.	20	25	31	32	49	27	47
Z Unspecified	1	0	1	2	0	2	0
ISSUE CATEGORY TOTAL	**106**	**119**	**113**	**132**	**158**	**128**	**147**

Sunflower-Waiver Information

There may be multiple selections for a member/contact.

Program Type	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18
PD	7	8	8	8	13	5	7
I/DD	8	4	10	12	5	3	4
FE	4	5	3	6	5	2	0
AUTISM	1	0	1	0	0	0	1
SED	0	1	0	0	0	0	1
TBI	1	2	0	1	1	0	3
TA	2	2	0	1	2	0	0
WH	0	0	0	1	1	1	1
MFP	0	1	0	0	1	0	0
PACE	0	0	0	0	0	0	0
MENTAL HEALTH	1	1	0	0	0	0	0
SUB USE DIS	0	0	0	0	0	0	0
NURSING FACILITY	4	6	3	3	4	1	3
WAIVER TOTAL	**28**	**30**	**25**	**32**	**32**	**12**	**20**

UnitedHealthcare-Issue Category

There may be multiple selections for a member/contact.

ISSUE CATEGORY	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18
Access to Providers (usually Medical)	4	2	0	2	0	0	0
Abuse / neglect complaints	0	0	0	1	0	3	0
Affordable Care Act Calls	0	0	0	0	0	0	0
Appeals/Fair Hearing questions/issues	0	0	3	2	4	2	4
Background Checks	0	0	0	0	0	0	0
Billing	3	7	3	0	6	3	9
Care Coordinator Issues	3	1	4	1	4	4	3
Change MCO	2	1	1	2	2	1	0
Choice Info on MCO	0	0	0	0	0	1	0
Client Obligation	2	2	3	5	8	2	6
Coding Issues	0	0	0	3	2	0	1
Consumer said Notice not received	0	0	0	0	0	0	1
Cultural Competency	0	0	0	0	0	0	0
Data Requests	0	0	0	0	0	0	1
Dental	1	3	2	0	0	1	0
Division of Assets	0	0	1	0	1	0	0
Durable Medical Equipment	2	2	1	0	0	0	0
Estate Recovery	0	1	0	0	0	0	0
Grievances Questions/Issues	3	3	4	0	3	3	4
Guardianship	0	0	1	0	0	0	1
HCBS Eligibility issues	9	6	3	7	5	3	6
HCBS General Issues	2	4	5	5	4	5	15
HCBS Reduction in hours of service	2	0	2	0	0	0	1
HCBS Waiting List	0	0	0	0	0	1	1
Help understanding mail	0	0	0	0	0	3	6
Housing Issues	0	0	1	0	1	0	0
Medicaid Application Assistance	0	1	1	2	4	4	1
Medicaid Coding	0	0	0	0	0	0	0
Medicaid Eligibility Issues	7	7	9	19	11	14	10
Medicaid Fraud	0	0	0	0	0	0	0
Medicaid General Issues/questions	0	0	0	0	4	7	10
Medicaid info (status) update	0	0	0	0	4	9	4
Medicaid Renewal	1	1	6	6	7	6	3

Medical Services	3	3	0	2	2	7	5
Medicare related Issues	0	0	2	1	0	0	1
Medicare Savings Plan Issues	0	0	0	1	4	1	1
Moving to / from Kansas	0	0	0	0	1	0	0
Nursing Facility Issues	2	2	1	2	0	3	3
Pain management issues	0	0	0	0	0	0	0
Pharmacy	0	1	0	3	4	1	0
Prior authorization issues	0	0	0	0	1	0	0
Questions for Conference Calls/Sessions	0	0	0	0	0	0	0
Respite	0	0	0	0	0	1	0
Social Security Issues	0	0	0	0	0	1	0
Spend Down Issues	0	1	6	2	3	7	6
Transportation	2	2	2	1	6	2	2
Working Healthy	0	0	0	0	0	0	1
X-Other	15	17	13	12	9	3	4
Z Thank you.	11	22	30	33	46	40	42
Z Unspecified	2	0	4	4	1	0	1
ISSUE CATEGORY TOTAL	**76**	**89**	**108**	**116**	**147**	**138**	**153**

UnitedHealthcare-Waiver Information

There may be multiple selections for a member/contact.

Program Type	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18
PD	8	3	5	4	7	5	3
I/DD	5	2	6	9	2	3	7
FE	7	3	5	6	4	2	4
AUTISM	0	1	0	0	0	0	0
SED	1	0	0	0	1	0	3
TBI	2	1	2	0	1	1	3
TA	0	1	0	2	0	1	0
WH	0	0	0	0	2	1	1
MFP	0	0	0	0	0	0	0
PACE	0	0	0	0	0	0	0
MENTAL HEALTH	0	1	0	2	0	0	0
SUB USE DIS	0	0	0	0	0	0	0
NURSING FACILITY	5	2	6	3	3	3	2
WAIVER TOTAL	**28**	**14**	**24**	**26**	**20**	**16**	**23**

1115 Waiver - Safety Net Care Pool Report
Demonstration Year 6 - Quarter 3

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

Paid date 9/28/2018

Provider Name	DY/QTR: 2018/3	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	616,034	278,817	337,217
University of Kansas Hospital	1,848,103	836,451*	1,011,652
Total	2,464,137	1,115,268	1,348,869

*IGT funds are received from the University of Kansas Hospital

1115 Waiver - Safety Net Care Pool Report
Demonstration Year 6 - Quarter 3
Health Care Access Improvement Pool
Paid dates 7/19/2018, 7/26/2018, 8/9/2018

Provider Name	HCAIP DY/QTR: 2018/3	Provider Access Fund 2443	Federal Medicaid Fund 3414
Bob Wilson Memorial Grant County Hospital	36,435.80	16,491	19,945
Childrens Mercy South	241,447.07	109,279	132,168
Coffeyville Regional Medical Center Inc	77,400.22	35,031	42,369
Geary County Hospital	77,273.39	34,974	42,299
Great Bend Regional Hospital	95,175.39	43,076	52,099
Hays Medical Center Inc	172,279.75	77,974	94,306
Hutchinson Regional Medical Center Inc	354,206.32	160,314	193,893
Kansas Heart Hospital Llc	5,132.14	2,323	2,809
Labette Co Med	52,140.68	23,599	28,542
Lawrence Memorial Hospital	252,470.39	114,268	138,202
Mcpherson Hospital Inc	48,080.19	21,761	26,319
Menorah Medical Center	163,717.24	74,098	89,619
Mercy Hospital Fort Scott	63,197.71	28,603	34,594
Mercy Hospital Inc	5,683.60	2,572	3,111
Miami County Medical Center Inc	49,444.74	22,379	27,066
Midwest Division Oprmc Llc	849,032.05	384,272	464,760
Newton Medical Center	149,867.36	67,830	82,037
Olathe Medical Center Inc	254,272.64	115,084	139,189
Prairie View Hospital	2,866.07	1,297	1,569
Pratt Regional Medical Center Corportation	36,950.91	16,724	20,227
Providence Medical Center	344,961.01	156,129	188,832
Ransom Memorial Hospital	64,186.19	29,051	35,136
Saint Lukes Cushing Hospital	50,784.31	22,985	27,799
Saint Lukes South Hospital Inc	59,506.45	26,933	32,574
Salina Regional Health Center	233,575.69	105,716	127,859
Salina Surgical Hospital	2,868.14	1,298	1,570
Shawnee Mission Medical Center Inc	670,563.95	303,497	367,067
South Central Kansas Regional Medical Center	48,117.66	21,778	26,340
Southwest Medical Center	94,516.32	42,778	51,738
St Catherine Hospital	215,248.72	97,422	117,827
Topeka Hospital LLC	480,562.67	217,503	263,060
St John Hospital	80,740.23	36,543	44,197
Stormont Vail Health Care Inc	1,178,866.96	533,555	645,312
Susan B Allen Memorial Hospital	113,210.64	51,239	61,972
Via Christi Hospital Manhattan	267,463.41	121,054	146,409
Via Christi Hospital Pittsburg	208,785.45	94,496	114,289
Via Christi Hospital Wichita St Teresa Inc	90,128.63	40,792	49,336
Via Christi Hospitals Wichita Inc	1,875,550.42	848,874	1,026,676
Via Christi Rehabilitation Hospital Inc	22,648.49	10,251	12,398
Wesley Medical Center	1,154,814.24	522,669	632,145
Western Plains Medical Complex	120,573.97	54,572	66,002
Total	10,364,747	4,691,085	5,673,663

KanCare Evaluation Quarterly Report
Year 6, Quarter 3, July – September 2018
November 20, 2018

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) in August 2013; it was approved by CMS in September 2013 and updated in March 2015. The Kansas Foundation for Medical Care (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 of the KanCare demonstration managed care Medicaid program. A subset of the annual performance measures was selected to be assessed and reported quarterly. The quarterly measures for the third quarter (Q3) Calendar Year (CY) 2018 report include the following:

- Timely resolution of member and provider 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.

KanCare healthcare 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 (UnitedHealthcare). 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.

Quarterly and annual KanCare Evaluation topics and recommendations are discussed with MCO staff at quarterly KanCare interagency meetings that include participants from the State, the MCOs, and the EQRO, and at project-specific site visits at the MCO offices in Lenexa and Overland Park, Kansas.

Timely Resolution of Customer Service Inquiries

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

Data Sources

The data sources for the KanCare Quarterly Evaluation Reports are monthly call center customer service reports MCOs submit to KDHE. In these reports, MCOs report the monthly number and category of member and provider inquiries resolved within 2, 5, 8, 15, and greater than 15 days, as well as the percentage of inquiries pending at month's end.

The MCO monthly customer service call center reports do not specifically report whether the number of reported inquiries represents all inquiries from all monthly contacts. Reporting both the number of contacts and number of inquiries is necessary for accurate trend analysis by MCO and for aggregating results. An MCO reporting half as many inquiries as another MCO may have had the same number of contacts but may be reporting only one inquiry for each contact even if the contact addressed multiple topics. UnitedHealthcare, for example, confirmed in February 2018 that each contact equals one inquiry, with only the "primary inquiry" categorized; according to KDHE staff, Amerigroup and Sunflower reported categorizing multiple inquiries per contact if the contact includes more than one inquiry. The quarterly aggregated comparisons over time, including this quarterly report, have, to date, likely been based on consistent processes but may have been based on underreported inquiry counts.

Current Quarter and Trend Over Time

A new monthly Customer Service Report template became effective in August 2018 for July MCO reporting. KDHE staff provided the MCOs training focused on the revisions in April 2018. The new template included changes to both the member and provider inquiry types. The changes included combining some provider service inquiry categories, removing a customer service member inquiry category, and adding some new categories for both provider inquiries and member inquiries. Also, the description was modified for some categories. Due to these changes, categories that cannot be compared in Q3 with prior quarters have been shaded in Tables 2 and 3.

In the new template, the *Time to Resolve* inquiry category was moved from inquiry types to monthly performance data in separate tabs. During review of this data, KFMC identified some differences for each of the MCOs and among the three MCOs. For example, the member and provider inquiry counts were different from the data included with the monthly performance data, and the number of some inquiries were much higher than before. These differences were discussed with KDHE. With the new template, inquiry data is being captured from the MCO's vendors. KDHE reported that the MCO vendor data compliance is in process and it should improve in the future.

Another new Customer Service Report template will be effective in February 2019 for January MCO reporting. The template does not include changes to the member or provider inquiry types. However, the Contact Center measures included in the same template have been modified and expanded. Measures were also added for "Documentation & Quality" and "Inquiry Timeliness."

The timeliness to resolution for member and provider customer service inquiries reported in Q3 CY2018 are detailed in Table 1. The number of member and provider inquiries resolved within 2, 5, and 15

business days may be greater than the number of inquiries received in the quarter due to the carryover of open inquiries from the previous quarter.

Table 1. Timeliness of Resolution of Member and Provider Customer Service Inquiries, by MCO and Combined CY2018 Quarter 3

	Member Inquiries				Provider Inquiries			
	AGP	SSHP	UHC	Total	AGP	SSHP	UHC	Total
Number of Inquiries Received	43,040	55,956	52,861	151,857	29,048	17,910	20,420	67,378
Number Resolved within 2 Business Days	43,809	55,862	51,528	151,199	26,306	17,910	20,263	64,479
Number Not Resolved within 2 Business Days	48	67	1,314	1,429	189	0	156	345
% Resolved Within 2 Business Days	99.89%	99.88%	97.51%	99.06%	99.29%	100.00%	99.24%	99.47%
Number Resolved within 5 Business Days	43,817	55,899	52,331	152,047	26,330	17,910	20,281	64,521
Number Not Resolved within 5 Business Days	40	30	511	581	165	0	138	303
% Resolved within 5 Business Days	99.91%	99.95%	99.03%	99.62%	99.38%	100.00%	99.32%	99.53%
Number Resolved within 15 Business Days	43,828	55,927	52,821	152,576	26,359	17,910	20,325	64,594
Number Not Resolved within 15 Business Days	29	2	21	52	136	0	94	230
% Resolved within 15 Business Days	99.93%	99.996%	99.96%	99.97%	99.49%	100.00%	99.54%	99.65%

Resolved within 2 business days:

- In Q3 CY2018, all three MCOs met contractual requirements to resolve 95% of customer service inquiries within 2 business days.
- Of the 151,857 customer service member inquiries during Q3 CY2018, 99.06% were resolved within 2 business days; 99.47% of the 67,378 provider inquiries were resolved within 2 business days.
- Of the 1,429 customer service inquiries from members in Q3 CY2018 not resolved within 2 business days, 48 were reported by Amerigroup, 67 were reported by Sunflower, and 1,314 were reported by UnitedHealthcare. Of the 345 provider inquiries not resolved within 2 business days, 189 were reported by Amerigroup and 156 were reported by UnitedHealthcare.

Resolved within 5 business days:

- In Q3 CY2018, all three MCOs met contractual requirements to resolve 98% of customer service inquiries within 5 business days.
- Of the 151,857 customer service member inquiries, 99.62% were resolved within 5 business days and 99.53% of the 67,378 provider inquiries met this timeliness of resolution standard.
- Of the 581 customer service inquiries from members in Q3 CY2018 not resolved within 5 business days, 40 were reported by Amerigroup, 30 were reported by Sunflower, and 511 were reported by UnitedHealthcare. Of the 303 provider inquiries not resolved within 5 business days, 165 were reported by Amerigroup and 138 were reported by UnitedHealthcare.

Resolved within 15 business days:

- Sunflower met the contractual requirement to resolve 100% of provider inquiries within 15 business days; 100% of their provider inquiries were resolved within 2 business days. Amerigroup and UnitedHealthcare did not meet the contractual requirement to resolve 100% of provider inquiries within 15 business days.
- Amerigroup reported 99.93%, Sunflower reported 99.996%, and UnitedHealthcare reported 99.96% of member inquiries were resolved within 15 business days. Of the 52 customer service inquiries

from members in Q3 CY2018 not resolved within 15 business days, 29 were reported by Amerigroup, 2 were reported by Sunflower, and 21 were reported by UnitedHealthcare. Amerigroup reported 99.49% and UnitedHealthcare reported 99.54% of provider inquiries were resolved within 15 business days. Of the 230 provider inquiries not resolved within 15 business days, 136 were reported by Amerigroup and 94 were reported by UnitedHealthcare.

Member Customer Service Inquiries

In Q3 CY2018, four new categories were added, *Expression of dissatisfaction*, *Client obligation*, *HCBS – Waiver questions*, and *Spend down.* The description of *Eligibility inquiry was changed to Eligibility questions.* One category was removed, *Concern with access to service or care*; *or concern with service or care disruption.* As noted in the Q2 CY2018 report, this category potentially described contacts tracked as grievances or appeals in the State's quarterly Grievance and Appeal (GAR) reports. To address this, KDHE removed this category beginning in July 2018, and added the category *Expression of dissatisfaction.* They are also working with MCO staff to ensure inquiries meeting grievance criteria receive appropriate follow-up. The MCOs categorize member customer service inquiries in their monthly call center reports by 21 service inquiry categories (see Table 2).

- Of the 152,056 customer service inquiries from members in Q3 CY2018, 28% were reported by Amerigroup, 37% by Sunflower, and 35% by UnitedHealthcare.
- The highest number and percent of member inquiries was *Need transportation,* at 68,778 (45.2%) and the second highest was *Benefit questions (previously Benefit inquiries)* at 21,794 (14.3%) in Q3 CY2018. In previous quarters, *Benefit questions* had been the highest.
- As in previous quarters, there are categories where two-thirds or more of the inquiries in the quarter were reported by one MCO. This seems likely to be due to differing interpretations of the criteria for several of the categories in the reporting template. The categories where two-thirds or more of the inquiries were reported by one MCO included:

  Amerigroup
  - *Assistance with scheduling an appointment:* 70.6% of 17 inquiries
  - *Client obligation:* 100% of 20 inquiries
  - *HCBS – waiver questions:* 100% of 20 inquiries
  - *Spenddown:* 100% of 75 inquiries

  Sunflower – *Member emergent or crisis call*: 73.2% of 395 inquiries

  UnitedHealthcare – *Expression of dissatisfaction*: 75.7% of 645 inquiries

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Table 2. Customer Service Inquiries from Members, Q2 & Q3, CY2017 and CY2018				
Member Inquiries	CY2017		CY2018	
	Q2	Q3	Q2	Q3
1. Assistance with scheduling an appointment	88	119	44	17
2. Benefit questions	17,216	16,143	17,372	21,794
3. Expression of dissatisfaction				645
4. Care management or health plan program	1,001	1,140	901	1,398
5. Claim or billing question	5,398	4,830	5,550	6,060
6. Client obligation				20
7. Coordination of benefits	3,280	3,098	2,324	2,484
8. Disenrollment request	524	424	431	522
9. Eligibility questions	14,420	13,077	13,184	14,741
10. Enrollment information	3,234	3,086	2,314	1,993
11. Find/change PCP	9,554	9,413	8,834	8,505
12. Find a specialist	3,043	3,043	3,061	3,423
13. HCBS – Waiver questions				20
14. Member emergent or crisis call	371	321	323	395
15. Need transportation	1,594	1,821	1,534	68,778
16. Order ID card	6,190	4,521	5,408	5,692
17. Question about letter or outbound call	2,253	1,045	2,211	2,015
18. Request member materials	751	661	930	883
19. Spend down				75
20. Update demographic information	12,568	10,572	6,821	6,516
21. Other	5,085	4,332	4,311	6,080
Shaded categories with member inquiry data only in Q3 CY2018 were new for this quarter.				

Provider Customer Service Inquiries

The MCOs categorize provider customer service inquiries in their monthly call center reports by 17 provider service inquiry categories (see Table 3).

- Of the provider inquiries in Q3 CY2018, Amerigroup reported 39% (Q1 CY2018: 44%; Q2 CY2018: 40%), Sunflower 24% (Q1 CY2018: 46%; Q2 CY2018: 51%), and UnitedHealthcare 37% (Q1 CY2018: 11%; Q2 CY2018: 9%).
- *Claim status questions* in Q3 was the highest percentage (33.4%) of provider inquiries and the second highest was *Benefit questions* (15.8%).

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Table 3. Customer Service Inquiries from Providers, Q2 & Q3, CY2017 and CY2018				
Provider Inquiries	CY2017		CY2018	
	Q2	Q3	Q2	Q3
1. Authorization – New	1,561	1,332	2,715	4,219
2. Authorization – Status	2,351	2,360	2,394	6,954
3. Expression of dissatisfaction				33
4. Benefit questions	2,730	1,980	2,049	14,726
5. Billing questions	337	330	334	1,808
6. Claim status questions	20,320	20,718	20,350	31,038
7. Claim payment denial/ dispute questions				3,519
8. Coordination of benefits	283	202	141	2,201
9. Credentialing/contracting issues	147	153	368	284
10. Member eligibility inquiry	1,634	1,490	1,999	8,377
11. Recoupment	40	53	52	402
12. Pharmacy/prescription inquiry	499	496	582	4,842
13. Prior authorization				2,770
14. Update demographic information or request provider materials				1,299
15. Change participation status	243	186	313	137
16. Web support	101	99	42	213
17. Other	940	757	971	10,130
Shaded categories with provider inquiry data only in Q3 CY2018 were either new or modified for this quarter.				

Categories where two-thirds or more of the provider inquiries were reported by one MCO included:

Amerigroup

- *Authorization—New*: 66.8% of 4,219 inquiries
- *Expression of dissatisfaction*: 90.9% of 33 inquiries
- *Billing questions*: 72.7% of 1,808 inquiries
- *Claim payment question/dispute*: 91.8% of 3,519 inquiries
- *Recoupment*: 76.6% of 402 inquiries
- *Prior authorization*: 71.3% of 2,770 inquiries

Sunflower

- *Credentialing contracting issues*: 85.6% of 284 inquiries
- *Pharmacy/prescription inquiry*: 73.0% of 4,842 inquiries
- *Update demographic information or request provider materials*: 70.1% of 1,299 inquiries

United Healthcare

- *Coordination of benefits*: 88.0% of 2,201 inquiries

Of the 17 provider inquiry categories, six are claims-related: *Authorization—New*, *Authorization—Status*, *Benefit questions* (changed in Q3 CY2018 from *Benefits inquiry*), *Claim Status questions* (changed in Q3 CY2018 from *Claims status inquiry*), *Claim payment denial/dispute payment*, and *Billing questions* (changed in Q3 CY2018 from *Billing inquiry*). As shown in Table 4, the range of inquiries for these six

claims-related categories varied greatly, but consistently, by MCO. For the last 6 quarters, for example, Amerigroup has reported over 67% of the provider inquiries categorized as *Authorization—New* and prior to Q3 CY2018, Sunflower had reported 0% of the *Claim Denial* provider inquiries. In Q3 CY2018, the categories *Claim denial and Claim payment questions/dispute were* combined; therefore, data for these separate categories are no longer available and there are only six claims-related inquiries.

Table 4. Maximum and Minimum Numbers of Claim-Related Provider Inquiries by MCO - Q1 CY2017 to Q3 CY2018

	CY2017								CY2018					
	Q1		Q2		Q3		Q4		Q1		Q2		Q3	
	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min
Authorization – New	1,695	0	1,546	1	1,323	1	1,324	0	1,369	0	2,706	0	2,818	0
Authorization – Status	1,816	134	1,741	172	1,615	267	1,367	266	1,492	97	1,857	47	3,531	1,567
Benefit questions	1,550	431	1,762	441	1,441	181	1,376	107	1,847	96	1,611	95	6,286	2,898
Claim status questions	10,011	1	12,903	670	12,779	466	11,267	569	12,085	313	14,497	258	14,055	8,149
Claim payment denial/ dispute payment													3,229	10
Billing questions	241	1	217	0	182	0	146	0	155	0	218	0	1,314	58

Amerigroup UnitedHealthcare
Sunflower

Combining the six claims-related inquiries may allow a better comparison over time overall and by MCO (see Table 5). In Q3 2018, UnitedHealthcare's percentage of the total MCO quarterly reported claims-related provider inquiries was 38.4%, Amerigroup's was 37.9%, and Sunflower's was 23.7%.

Table 5. Combined Totals of the Claims-Related Provider Inquiry Categories by MCO, Q2 CY2017 to Q3 CY2018

	CY2017			CY2018		
	Q2	Q3	Q4	Q1	Q2	Q3
Amerigroup	14,663	14,813	13,715	14,445	14,069	23,593
Sunflower	16,787	16,604	14,187	14,206	16,218	14,731
UnitedHealthcare	5,004	5,024	3,781	3,721	3,519	23,940
Total	36,454	36,441	31,683	32,372	33,806	62,264

Follow-up on Previous Recommendations (Timely Resolution of Customer Service Inquiries)

- *After implementation of the revised customer service inquiry template, the State should monitor to ensure comparable categorization of inquiries by each of the MCOs. Of particular focus should be ensuring inquiries that meet grievance or appeal criteria are being appropriately forwarded for follow-up and tracking as grievances or appeals.*
  Follow-up response: This will continue to be evaluated in future quarterly reports by the State. The new template was implemented in Quarter 3 2018.

Timeliness of Claims Processing

MCOs, including their vendors, are contractually required to process 100% of "clean" claims within 30 days; 99% of "non-clean" claims within 60 calendar days; and 100% of all claims within 90 calendar days, except those meeting specific exclusion criteria. Claims 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*."

A "clean claim" is a claim that can be paid or denied with no additional intervention required and does not include the following: adjusted or corrected claims; claims that require documentation (i.e., consent forms, medical records) for processing; claims from out-of-network providers that require research and setup of that provider in the system; claims from providers where the updated rates, benefits, or policy changes were not provided by the State 30 days or more before the effective date; claims from providers under investigation for fraud or abuse; and/or claims under review for medical necessity. Claims received in the middle or end of a month may be processed in that month or the following month(s). Since a non-clean claim may take up to 60 days to process, a claim received in mid-March, for example, may be processed in March or may not be processed until early May and still meet contractual requirements.

Data Sources

In monthly Claims Overview reports, MCOs report the monthly number of claims received and processed, including whether these claims were processed in a timely manner as defined by the type of claim and State-specified timelines. Due to claims lag, claims processed in one month may be from that month or from a month or two prior to that month.

Timeliness of Claims Processing by Claim Type and Date Received

To allow for claims lag, the KanCare Evaluation Report for Q3 CY2018 assesses timeliness of processing clean, non-clean, and all claims reports received through Q2 CY2018. See Table 6 for quarterly aggregated claims processing counts by claim type.

Clean claims:

- None of the MCOs met the contractual requirement to process 100% of clean claims within 30 days.
- Of the 4,182,056 included clean claims received in Q2 CY2018, 99.96% were reported by the MCOs as processed within 30 days.
- Of the 1,727 included clean claims not processed within 30 days – 97 (6%) were claims received by Amerigroup; 1,339 (78%) were claims received by Sunflower; and 291 (17%) were claims received by UnitedHealthcare.

Table 6. Timeliness of Claims Processing - Q2 CY2017 to Q2 CY2018					
	CY2017			CY2018	
	Q2	Q3	Q4	Q1	Q2
Clean Claims					
Clean claims received in quarter	4,289,623	4,216,700	4,141,115	4,372,076	4,182,217
Number of claims excluded	343	362	183	125	161
Number of clean claims not excluded	4,289,280	4,216,338	4,140,932	4,371,951	4,182,056
Clean claims received within quarter processed within 30 days	4,285,879	4,214,069	4,125,063	4,363,258	4,180,329
Clean claims received within quarter not processed within 30 days	3,401	2,269	15,869	8,693	1,727
Percent of clean claims processed within 30 days	99.92%	99.95%	99.62%	99.80%	99.96%
Non-Clean Claims					
Non-clean claims received in quarter	166,333	181,989	198,106	285,427	259,307
Number of claims excluded	1,193	2,005	491	104	84
Number of non-clean claims not excluded	165,140	179,984	197,615	285,323	259,223
Non-clean claims received within quarter processed within 60 days	163,503	178,459	197,359	285,064	258,469
Non-clean claims received within quarter not processed within 60 days	1,637	1,545	256	259	754
Percent of non-clean claims processed within 60 days	99.01%	99.15%	99.87%	99.91%	99.71%
All Claims					
All claims received in quarter	4,455,956	4,398,689	4,339,221	4,657,503	4,441,524
Number of claims excluded	1,536	2,367	674	229	245
Number of claims not excluded	4,454,420	4,396,322	4,338,547	4,657,274	4,441,279
Number of all claims received within quarter processed within 90 days	4,453,939	4,396,198	4,338,003	4,656,967	4,441,059
Number of all claims received within quarter not processed within 90 days	481	124	544	307	220
Percent of all claims processed within 90 days	99.989%	99.997%	99.987%	99.993%	99.995%

Non-clean claims:

- Of the 259,223 included non-clean claims received in Q2 CY2018, 99.71% were reported by the MCOs as processed within 60 days. Of the 259,223 non-clean claims – 24.5% were claims received by Amerigroup; 47.1% were claims received by Sunflower; and 28.4% claims received by UnitedHealthcare.
- Of the 754 non-clean claims not processed within 60 days – 4 (0.5%) were claims received by Amerigroup; 675 (89.5%) were claims received by Sunflower; and 75 (9.9%) were claims received by UnitedHealthcare.

All claims:

- 99.995% of 4,441,279 "all claims" (included) received in Q2 CY2018 were reported by the MCOs as processed within 90 days.
- Of the 220 claims not processed within 90 days – 2 (0.90%) were claims received by Amerigroup, 176 (80%) were claims received by Sunflower, and 42 (19.1%) were claims received by UnitedHealthcare.

Due to the high volume and same-day processing of pharmacy claims, questions were previously raised at KanCare legislative public meetings about the impact of pharmacy claims on the reported high percentage of clean claims processed within 30 days. To assess the impact of pharmacy claims on the clean claims processing rate, KFMC also calculates the processing rates excluding pharmacy claims (see Table 7). From Q2 2017 through Q2 2018 the rate of clean claims processing within 30 days decreased by 0.02 to 0.21 percentage points when excluding pharmacy claims. Over the past five quarters, the clean claims processing rate excluding pharmacy claims has ranged from 99.41% to 99.94%.

Table 7. Timeliness of Clean Claims Processing - Q2 CY2017 to Q2 CY2018, Excluding Prescriptions

	CY2017			CY2018	
	Q2	Q3	Q4	Q1	Q2
Clean claims received in quarter	4,289,623	4,216,700	4,141,115	4,372,076	4,182,217
Number of pharmacy claims (excluded)	1,722,540	1,445,711	1,456,248	1,586,923	1,470,634
Number of other claims excluded	343	362	183	125	161
Number of clean claims not excluded	2,566,740	2,770,627	2,684,684	2,785,028	2,711,422
Clean claims (not excluded) processed within 30 days	2,563,339	2,768,358	2,668,815	2,776,335	2,709,695
Clean claims not processed within 30 days	3,401	2,269	15,869	8,693	1,727
Percent of clean claims processed within 30 days (excluding pharmacy)	99.87%	99.92%	99.41%	99.69%	99.94%
Percent of clean claims processed within 30 days (including pharmacy)	*99.92%*	*99.95%*	*99.62%*	*99.80%*	*99.96%*

Previous Recommendations (Timeliness of Claims Processing by Claim Type and Date Received)

- *All MCOs should evaluate the claims that were not processed within the timeliness requirements to determine possible actions to take for improvement. Continue to provide notes regarding rationale for changes in rates and plans for improvement.*
- *The three MCOs should update their annual totals for 2016, to reflect the criteria used by all three MCOs (and their vendors) as revised during the validation of P4P claims metrics, adapted to meet contractual timeliness standards for clean claims (30 days), non-clean claims (60 days), and all claims (90 days).*

Recommendations (Timeliness of Claims Processing by Claim Type and Date Received)

Given that 2018 is the last year of Amerigroup's contract with the State of Kansas, no recommendations are included in this report for Amerigroup.

Sunflower and UnitedHealthcare should evaluate the claims that were not processed within the timeliness requirements to determine possible actions to take for improvement. Continue to provide notes regarding rationale for changes in rates and plans for improvement.

Average Turnaround Time (TAT) for Processing Clean Claims

As indicated in Table 8, the MCOs reported 4,065,634 clean claims were processed in Q3 CY2018 (includes claims received prior to Q3). Excluding 1,417,812 pharmacy claims (processed same-day), there were 2,647,822 clean claims processed in Q3 CY2018.

Table 8. Average Monthly Turnaround Time Ranges for Processing Clean Claims, by Service Category - Comparison of Current and Previous Quarter and Annual Monthly Ranges*

Service Category	Current and Previous Quarter		Annual Monthly Ranges			
	Q2 CY2018	Q3 CY2018	CY2014	CY2015	CY2016	CY2017
Hospital Inpatient	12.0 to 16.0	10.3 to 15.2	5.0 to 19.2	6.4 to 15.9	7.1 to 18.4	6.0 to 15.6
Hospital Outpatient	5.8 to 11.4	5.1 to 10.2	3.6 to 12.8	3.5 to 10.8	4.0 to 12.9	4.5 to 10.1
Pharmacy	same day	same day	same day	same day	same day	same day
Dental	6.0 to 14.0	6.0 to 13.0	2.0 to 21.0	4.0 to 13.1	6.0 to 13.0	6.0 to 13.0
Vision	4.0 to 15.0	5.0 to 14.4	7.0 to 12.5	9.0 to 12.5	7.0 to 12.7	5.0 to 15.1
Non-Emergency Transportation	10.9 to 13.0	10.7 to 15.0	10.9 to 18.0	10.4 to 16.0	9.0 to 14.4	10.9 to 14.0
Medical (Physical health not otherwise specified)	5.6 to 10.2	5.5 to 9.8	3.3 to 10.6	3.4 to 10.5	4.2 to 10.7	4.7 to 9.8
Nursing Facilities	5.8 to 10.1	5.9 to 9.3	4.3 to 11.5	4.1 to 9.7	4.6 to 9.0	4.3 to 10.5
HCBS	7.5 to 15.2	6.9 to 9.7	3.2 to 15.6	4.1 to 10.2	5.7 to 10.8	5.7 to 12.2
Behavioral Health	4.8 to 10.7	4.5 to 10.9	3.4 to 8.6	2.7 to 10.5	4.1 to 11.7	3.8 to 9.9
Total Claims (Including Pharmacy)	4,237,786	4,065,634	16,763,501	17,820,402	17,820,402	17,302,422
Total Claims (Excluding Pharmacy)	2,767,150	2,647,822	10,370,998	10,999,807	10,999,807	10,887,328
Average TAT (Excluding Pharmacy)^	**6.4 to 10.3**	**6.2 to 9.7**	**4.3 to 11.5**	**4.3 to 10.3**	**5.0 to 10.6**	**5.3 to 9.9**

*The average TAT monthly ranges reported in Table 8 only include clean claims processed by the MCOs and do not include clean claims received but not yet processed.
^Average TATs are weighted averages calculated after excluding pharmacy claims.

Of the 2,647,822 clean claims processed in Q3 CY2018 (excluding 1,417,812 pharmacy claims), the average TAT was 6.2– 9.7 days. The average TAT for processing clean claims for individual service types varies by service type and by MCO.

- Average monthly ranges were widest in Q3 CY2018 for Hospital Outpatient (5.1 – 10.2 days), Dental (6.0 – 13.0 days), Vision claims (5.0 – 14.4 days); Hospital Inpatient (10.3 – 15.2 days); and Behavioral Health (4.5–10.9).
- The average monthly ranges were longest in Q3 CY2018 for Vision claims (5.0 – 14.4 days).

The widest average service type monthly ranges in Q3 CY2018 by MCO were:

- **Vision** – Average monthly TATs for Vision had the widest range for Q3 CY2018 among the service categories. The TATs ranged from 5.0 days for Amerigroup, 12.0–13.0 days for Sunflower, and for UnitedHealthcare, 13.3–14.4 for March–Vision and 8.1–10.5 for Envolve Vision.
- **Dental** – Average monthly TATs for Dental claims had the second widest range for Q3 CY2018 among the service categories. Amerigroup and UnitedHealthcare had an average TAT of 13.0 days, compared to Sunflower's TAT at 6.0 that was the shortest average among the three MCOs, consistent with Q1 and Q2 CY2018, and ranged from 6.0–7.0 in both Q1 and Q2 CY2018.

Grievances

Data Sources

Grievances are reported and tracked on a quarterly basis by MCOs in the Grievance and Appeal (GAR) report. The report tracks the number of grievances received in the quarter, the number of grievances closed in the quarter, the number of grievances resolved within 30 calendar days, and the number of grievances resolved within 60 calendar days. The GAR report also provides detailed descriptions of each

grievance resolved, including narratives of grievance descriptions and resolution, category type, date received, Medicaid ID, waiver type, and number of calendar days to resolve.

Timeliness of Grievance Resolution

Quarterly tracking and reporting of timely resolution of grievances in the KanCare Evaluation are based on the MCOs' contractual requirements to resolve 98% of all grievances within 30 calendar days and 100% of all grievances within 60 calendar days (via an extension request). 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 (and is not expected to) equal the number of grievances "resolved" during the quarter (see Table 9). Of the 530 grievances resolved in Q3 CY2018, 158 (30%) were reported by Amerigroup, 152 (29%) by Sunflower, and 220 (42%) by UnitedHealthcare.

Table 9. Timeliness of Resolution of Grievances - Q1 CY2017 to Q3 CY2018

	CY2017				CY2018		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Grievances received in quarter	412	458	541	506	516	599	530
Grievances resolved in quarter*	412	447	546	507	498	566	530
Grievances resolved within 30 business days*	410	441	543	498	486	564	527
Percent resolved within 30 business days	99.5%	98.7%	99.5%	98.2%	97.6%	99.6%	99.0%
Grievances not resolved within 30 business days	2	6	3	9	12	2	3
Grievances resolved within 60 business days*	412	446	546	505	488	565	530
Percent resolved within 60 business days*	100%	99.8%	100%	99.6%	98.0%	99.8%	100%
Grievances closed in quarter not resolved in 60 business days*	0	1	0	2	10	1	0

*Grievances resolved in the quarter include grievances received in the previous quarter.

Amerigroup – In Q3 CY2018, 99.0% (527) of the 530 grievances reported by the MCOs were reported as resolved within 30 calendar days. The number of grievances not resolved within 60 days for Q1 CY2018 was the highest in five years (10); however, in Q2 CY2018 only 1 grievance was reported not resolved within 60 days, and in Q3 CY2018, there were no grievances reported as not resolved within 60 days.

- Amerigroup – Resolved 155 of 158 (98.1%) grievances within 30 days
- Sunflower – Resolved 100% of grievances (152) within 30 days
- UnitedHealthcare – Resolved 100% of grievances (220) within 30 days

Compare/Track the Number of Grievances, Including Access-Related and Quality-Related Grievances, Over Time, by Population Categories

All Grievances

In August 2018, KDHE staff updated the grievance report template which included a new grievance category for *Quality of Care – Opioids*. The new category was added to the GARs in Q3 CY2018. Additional definition and examples clarifications were added for *Quality of Care non-HCBS provider, Quality of Care HCBS provider, and Pharmacy issues.*

In Q3, 10% (52) of the grievances appeared to be categorized incorrectly (based on grievance descriptions and resolution details). See Table 10 for the number of reclassifications within each grievance reason category. In the comparison of grievances between "as categorized by MCOs" and "based on grievance descriptions," the three categories with the most changes were "Quality of Care (non-HCBS provider) (9), "Transportation – Other" (6), and "Other" (6).

Transportation-related grievances continued to be the most frequently reported grievances – 216 (40%) in Q3 CY2018. Of the 216 transportation-related grievances, 57 (26%) were reported by Amerigroup, 71 (33%) were reported by Sunflower, and 88 (41%) were reported by UnitedHealthcare. The number of *Transportation – Other* and *Transportation – Late* grievances continued to be high, with 82 "*Transportation – Other*" grievances, and 58 "*Late*" grievances in Q3. Also, of concern is the number of *Transportation – No Show* (37), and *Transportation – Safety* grievances, 24 in Q1 CY2018, 39 in Q2 CY2018, and 23 in Q3 CY2018. The State requires the MCOs to send monthly Non-Emergency Medical Transportation (NEMT) reports, in addition to quarterly reports, to promote quicker follow-up and resolution of transportation-related issues.

Table 10. Comparison of Grievances as Categorized by MCOs and Based on Grievance Descriptions Q3 CY2018*

	As Categorized by MCOs	Based on Grievance Descriptions
Billing and Financial Issues	91	96
Access to Service or Care	39	34
Quality of Care (non-HCBS provider)	67	76
Quality of Care HCBS provider	16	20
Quality of Care - Opioids	7	8
Customer Service	42	39
Pharmacy Issues	16	14
Member's Rights/Dignity	4	6
Value-Added Benefit	6	6
Transportation - Other	76	82
Transportation Reimbursement	11	11
Transportation Safety	24	23
Transportation No Show	34	37
Transportation Late	56	58
Transportation No Driver Available	5	5
Other	29	23
Non-Covered Services	7	8
Not Applicable	0	1
Appeals^	***0***	***1***
Total	**530**	**547**

*Includes grievances received in Quarter 2 CY2018 resolved in Quarter 3 CY2018

^Appeals are not included in total counts.

Of 547 grievances in Q3 CY2018 (based on grievance descriptions), 188 (34%) were from members receiving waiver services; 359 grievances (66%) were from members not receiving waiver services (see Table 11). One grievance was removed from the non-waiver grievances, as it was an appeal. The majority (54%) of grievances from waiver members were from members receiving PD Waiver services; 16% were from members receiving FE services; and 12% were from members receiving I/DD waiver services. There were a total of 96 (18%) QOC grievances (non-HCBS and HCBS); 39 (41%) of these were reported by Waiver members. Of the 34 *Access to Service or Care grievances*, 32% were waiver members.

Table 11. Grievances Reported by Waiver/non-Waiver Members Resolved in Q3 CY2018*								
	Waiver Members							Non-Waiver
	FE	I/DD	PD	SED	TA	TBI	Grievances	Grievances
Access to Service or Care	1	1	4	3	1	1	11	23
Billing and Financial Issues	1	9	7	2	4	0	23	73
Customer Service	1	1	11	0	0	3	16	23
Member's Rights/Dignity	1	0	2	0	0	1	4	2
Non-Covered Service	0	1	0	0	0	1	2	6
Other	1	1	0	1	0	1	4	19
Pharmacy Issues	0	0	4	0	0	0	4	10
Quality of Care - HCBS	2	3	7	1	0	2	15	5
Quality of Care (non-HCBS)	1	3	18	0	0	2	24	52
Quality of Care - Opioids	0	0	2	0	0	0	2	6
Transportation - Reimbursement	0	1	0	0	1	0	2	9
Transportation No Show	5	0	13	0	0	0	18	19
Transportation Late	8	1	13	1	0	1	24	34
Transportation Safety	2	0	2	1	0	1	6	17
Transportation No Driver Available	1	0	2	0	0	0	3	2
Transportation - Other	7	1	16	1	1	2	28	54
Value-Added Benefit	0	0	1	0	0	0	1	5
Not Applicable	0	0	0	0	1	0	1	0
Total	**31**	**22**	**102**	**10**	**8**	**15**	**188**	**359**

*Counts are based on MCO grievance descriptions.
In Quarter 3 2018, there were no members in the Autism Waiver, and there were no grievances reported

As shown in Table 12, the percentage of transportation-related grievances was higher among waiver members in the last four quarters (43%–58%) compared to members not receiving waiver services (35%–38%).

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Table 12. Percentage of Transportation-Related Grievances Resolved in Q4 CY2017 to Q3 CY2018, by Waiver/Non-Waiver	# Total Grievances				% Transportation Related			
	2017	2018			2017	2018		
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Waiver Member Grievances	191	189	218 *	188	47%	44%	58%	43%
Non-Waiver Member Grievances	336	333	367	359	38%	37%	35%	38%
All Member Grievances	527	522	585	547	41%	40%	44%	39%
Physical Disability (PD)	103	96	133	102	57%	60%	71%	45%
Frail Elderly (FE)	29	34	30	31	50%	38%	50%	74%
Intellectual/Developmental Disability (I/DD)	26	26	25	22	23%	12%	20%	14%
Traumatic Brain Injury (TBI)	10	10	8	15	30%	20%	38%	27%
Serious Emotional Disturbance (SED)	18	10	17	10	39%	40%	47%	30%
Technology Assisted (TA)	5	13	4	8	20%	23%	25%	25%
*1 Autism Waiver grievance is not transportation related, and therefore is not included in the grievances by waiver; it is counted in the number of waiver member grievances.								

In Q3, of the 188 grievances reported by waiver members, 81 (43%) were transportation-related.

- Physical Disability (PD) Waiver members – of the 102 grievances, 46 were transportation-related; 102 (19%) of the 547 total grievances reported in Q3 were from PD Waiver members.
- Frail Elderly (FE) Waiver members – of the 31 grievances, 23 were transportation-related.
- Intellectual/Developmental Disability (I/DD) Waiver members – of the 22 grievances, 3 were transportation-related.
- Serious Emotional Disturbance (SED) Waiver members – of the 10 grievances, 3 were transportation-related.
- Traumatic Brain Injury (TBI) Waiver members – of the 15 grievances, 4 were transportation-related.
- Technology Assistance (TA) Waiver members – of the 8 grievances, 2 were transportation-related.

Previous Recommendations (Grievances)

- MCOs should continue to report QOC grievances separately for HCBS-related services and for QOC grievances not related to HCBS services. Provide additional staff training as needed.

Recommendations (Grievances)

Given that 2018 is the last year of Amerigroup's contract with the State of Kansas, no recommendations are included in this report for Amerigroup.

1. MCOs should continue to report QOC grievances separately for HCBS-related *services* and for QOC grievances not related to HCBS *services*. Provide additional staff training as needed.
2. The MCOs and the State should continue to compare Customer Service Reports and Grievance Reports each quarter to assess whether customer service inquiry counts for Expression of Dissatisfaction relatively correlate to the number of grievances reported.

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

The primary data source in Q3 CY2018 is the quarterly KanCare Ombudsman Quarterly Report.

Current Quarter and Trend over Time

Ombudsman Office assistance is provided by the Ombudsman (Kerrie Bacon), a Volunteer Coordinator, a Project Coordinator, and trained volunteers at satellite offices. The Ombudsman's Office has three full-time staff positions and has increased the number of volunteers to a total of ten (an increase from eight) in the two satellite offices. The Ombudsman's Office is located in Topeka, with satellite offices in Wichita (Sedgwick County) and Olathe (Johnson County). Assistance is provided by phone and in person (by appointment), including assistance completing Medicaid applications.

Volunteer assistance has been a critical factor in helping meet the high demand for assistance. Since the last quarterly report, the Olathe satellite office increased the number of weekly covered hours from 16 to 20, and increased office hour availability to five days a week, Monday through Friday. The Wichita office added one hour to their weekly coverage, for a total of 19 hours over five weekdays.

Information (as well as volunteer applications) is available on the Ombudsman's Office website, www.KanCare.ks.gov/kancare-ombudsman-office and is provided to members by mail and email as-needed. A wide variety of resources are available on the KanCare Ombudsman website, including forms, fact sheets, application and documentation checklists, information on where to find additional assistance, information on applying for eligibility and renewal, and grievance and appeal process. During Q3 2018, the Ombudsman's Office conducted outreach through collaboration and education during 26 opportunities/events. Seven instances of outreach through publications occurred and six liaison trainings were conducted in Q3 2018.

As delineated in the CMS Kansas Special Terms and Conditions (STC), revised in January 2014, the Ombudsman's Office data to be tracked include date of incoming requests (and date of any change in status); contact method; the volume and types 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.

The Ombudsman reported they are completing tracking system updates to allow them to track timeliness of issue resolution by entity (Managed Care Organizations/MCO, Clearinghouse, Kansas Department on Aging and Disability Services/KDADS, Kansas Department for Health and Environment/KDHE, etc.).

The Ombudsman's Office also reports contact issues by waiver-related type. As shown in Table 13, there were 120 waiver-related contacts in Q3 2018, and 50 waiver-related inquiries from members belonging to an MCO. The three most frequent waiver-related issues in Q3 were related to the I/DD Waiver (36), FE Waiver (30), and PD Waiver (28). The number and percentage of waiver-related inquiries from members belonging to an MCO was higher in Q3 2018 (50) compared to Q3 2016, and lower in Q3 CY2018 (50) compared to Q3 CY2017 (60).

Table 13. Waiver-Related Inquiries to Ombudsman - Q3 CY2016 to CY2018

Waiver	Q3					
	2016		2017		2018	
	All	MCO-related	All	MCO-related	All	MCO-related
Intellectual/Developmental Disability	21	11	28	8	36	16
Physical Disability	13	4	37	20	28	14
Technology Assisted	4	3	10	7	7	1
Frail Elderly	10	3	27	14	30	6
Traumatic Brain Injury	7	6	8	5	9	6
Serious Emotional Disturbance	1	1	4	4	8	6
Autism	2	2	2	2	2	1
Total	**58**	**30**	**116**	**60**	**120**	**50**

The number of initial contacts has increased annually over time, with an average of 523 in CY2014 and an average of 1,119 in the first three quarters of CY2018. Since some contacts include more than one issue, the Ombudsman's Office tracks the number of certain issues addressed during contacts, including the number of issues that are MCO-related (see Table 14). The most frequently reported MCO-related issues quarterly to date have been Medicaid Eligibility Issues, HCBS-related issues, and Client Obligation & Spenddown Issues.

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Table 14. MCO-Related Issues Tracked by Ombudsman's Office - Q2 & Q3, CY2017 and CY2018

	CY2017				CY2018			
	Q2		Q3		Q2		Q3	
	All	MCO Related	All	MCO Related	All	MCO Related	All	MCO Related
Medicaid Eligibility Issues	177	**20**	237	**32**	212	**38**	182	**28**
Medicaid Info (status) update	^	^	^	^	215	**22**	195	**18**
Medicaid Renewal	43	**13**	38	**17**	57	**18**	39	**13**
Medicaid General Issues/Questions	^	^	^	^	181	**26**	198	**32**
Medicaid Application Assistance	55	**1**	162	**4**	134	**10**	144	**3**
HCBS - Total	95	**47**	91	**34**	65	**26**	103	**46**
HCBS General Issues	*34*	*20*	*21*	*11*	*33*	*13*	*60*	*29*
HCBS Eligibility Issues	*50*	*23*	*58*	*20*	*26*	*11*	*36*	*15*
HCBS Reduction in Hours of Service	*2*	*1*	*4*	*3*	*2*	*1*	*3*	*1*
HCBS Waiting List	*9*	*3*	*8*	*0*	*4*	*1*	*4*	*1*
Appeal/Fair Hearing questions/issues	^	^	21	**6**	25	**7**	35	**10**
Grievances Questions/Issues	33	**15**	29	**9**	34	**13**	23	**11**
Billing	33	**18**	17	**11**	26	**16**	32	**19**
Client Obligation & Spenddown Issues	68	**24**	66	**23**	65	**27**	47	**19**
Coding Issues	0	**0**	8	**4**	8	**4**	10	**4**
Transportation	9	**6**	12	**6**	10	**5**	9	**5**
Medical Services	20	**13**	11	**6**	27	**15**	10	**6**
Care Coordinator Issues	11	**7**	6	**5**	11	**10**	7	**4**
Change MCO & Choice Info on MCO	1	**1**	2	**1**	10	**7**	8	**7**
Medicare-related issues	^	^	24	**5**	39	**9**	47	**10**
Pharmacy	9	**6**	10	**3**	1	**1**	2	**1**
Dental	9	**4**	7	**4**	9	**2**	6	**0**
Consumer said Notice not received	^	^	^	^	4	**1**	14	**5**
Abuse/neglect complaints	^	^	^	^	10	**5**	7	**0**
Social Security Issues	^	^	1	**0**	13	**1**	11	**1**
Nursing Facility Issues	26	**7**	23	**1**	18	**4**	23	**7**
Housing Issues	6	**2**	7	**3**	7	**1**	7	**1**
Access to Providers	14	**12**	13	**4**	2	**1**	8	**6**
Moving to/from Kansas	7	**1**	6	**0**	13	**0**	21	**0**
Background Checks	^	^	^	^	0	**0**	1	**0**
Durable Medical Equipment	9	**5**	4	**3**	4	**2**	9	**3**
Help Understanding Mail	^	^	^	^	15	**6**	21	**8**
Prior Authorization Issues	^	^	^	^	2	**1**	0	**0**
Other	323	**56**	251	**36**	161	**26**	161	**28**
Total Issues - All & MCO-Related*	**948**	**258**	**1,046**	**217**	**1,378**	**304**	**1,380**	**295**
% MCO-Related*		**27%**		**21%**		**22%**		**21%**

^Category added at a later date
*Excludes in Q3: Unspecified (73; 4 MCO-related), Thank You (476; 122 MCO-related), and categories with no MCO-related issues (Cultural Competency - 1, Division of Assests - 5, Estate Recovery - 10 and Respite - 0)

Conclusions Summary (Quarter 3, 2018)

Timely Resolution of Customer Service Inquiries

- The MCOs met the contractual requirements of two and five business day inquiry resolution:
  - 95% within 2 business days - member inquiries: 99.06%; provider inquiries: 99.47%
  - 98% within 5 business days - member inquiries: 99.62%; provider inquiries: 99.53%.
- The requirement for 100% inquiry resolution within 15 business days was overall not met, at 99.97% member and 99.65% provider inquiry resolution. Sunflower fully met the requirement for provider inquiries. Amerigroup reported 99.93%, Sunflower reported 99.996%, and UnitedHealthcare reported 99.97% of member inquiries were resolved within 15 business days. Amerigroup reported 99.49% and UnitedHealthcare reported 99.54% of provider inquiries were resolved within 15 business days. There were 52 (AGP – 29; SSHP – 2; and UHC – 21) inquiries from members and 230 (AGP – 136 and UHC – 94) provider inquiries in Q3 CY2018 reported as not resolved within 15 business days.
- Member customer service inquiries:
  - Of the 152,056 customer service inquiries from members in Q3 CY2018, 28% were reported by Amerigroup, 37% by Sunflower, and 35% by UnitedHealthcare.
  - Need transportation inquiries were the highest percentage (45.2%) of member inquiries in Q3.
- Provider customer service inquiries:
  - The provider inquiries received by MCOs in Q3 CY2018 were, Amerigroup 39%, Sunflower 24%, and UnitedHealthcare 37%.
  - Claim status inquiries were again the highest percentage (33.4%) of provider inquiries.
  - Since the previous Q2 CY2018 report, the categories *claim denial* and *claim payment question/dispute* inquiries were combined; therefore, data for these separate categories are no longer available and there are only six related inquires.
  - Of the 17 provider inquiry categories, six are focused on claims; the range of inquiries for each of the six varied greatly by MCO. The combined total number of claims-related inquiries for these six categories may allow a better comparison over time overall and by MCO.

Timeliness of Claims Processing

Timeliness of meeting contractual requirements for processing clean claims within 30 days, non-clean claims within 60 days, and all claims within 90 days

- For claims received in Q2 CY2018, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days. Of 4,182,056 included clean claims, 99.96% were processed within 30 days.
- Of the 1,727 included clean claims not processed within 30 days – 97 (6%) were Amerigroup claims; 1,339 (78%) were Sunflower claims; and 291 (17%) were UnitedHealthcare claims.
- In Q2 CY2018, all three MCOs did not meet the contractual requirement of processing at least 99% of the included non-clean claims within 60 days.
- 99.995% of 4,441,279 “all claims” (included) received in Q2 CY2018 were reported by the MCOs as processed within 90 days. Of the 220 claims not processed within 90 days – 2 (0.90%) were Amerigroup claims; 176 (80.0%) were Sunflower claims; and 42 (19.1%) were UnitedHealthcare claims.
- To assess the impact of pharmacy claims on the clean claims processing rate, KFMC calculated processing rates excluding pharmacy claims. Over the past five quarters, the rate of clean claims processing within 30 days, excluding pharmacy claims, has ranged from 99.41% to 99.94%.

Turnaround time (TAT) ranges for processing clean claims

- Of the 2,647,822 clean claims processed in Q3 CY2018 (excluding 1,417,812 pharmacy claims), the average TAT was 6.2– 9.7 days.
- The average TAT for processing clean claims for individual service types varies by service type and by MCO:
  - Average monthly ranges were widest in Q3 CY2018 for Hospital Outpatient (5.1 – 10.2 days), Dental (6.0 – 13.0 days), Vision claims (5.0 – 14.4 days); Hospital Inpatient (10.3 – 15.2 days); and Behavioral Health (4.5–10.9).
  - The average monthly ranges were longest in Q3 CY2018 for Vision claims (5.0 – 14.4 days).

Grievances

- Of the 530 grievances resolved in Q3 CY2018, 158 (30%) were reported by Amerigroup, 152 (29%) by Sunflower, and 220 (42%) by UnitedHealthcare.
- In Q3 CY2018, 99.0% (527) of the 530 grievances reported by the MCOs were reported as resolved within 30 calendar days. The number of grievances not resolved within 60 days for Q1 CY2018 was the highest in five years (10); however, in Q2 CY2018 only 1 grievance was reported not resolved within 60 days, and in Q3 CY2018, there were no grievances reported as not resolved within 60 days.
- UnitedHealthcare and Sunflower resolved 100% of grievances (220 and 152, respectively) within 30 days. Amerigroup resolved 155 of 158 (98.1%) grievances within 30 days.
- In Q3, 10% (52) of the grievances appeared to be categorized incorrectly (based on grievance descriptions and resolution details). The three categories with the most changes were "Quality of Care (non-HCBS provider) (9), "Transportation – Other" (6), and "Other" (6). KDHE continues to provide clarification and guidance to the MCOs regarding grievance reason categorization.
- Transportation-related grievances continued to be the most frequently reported grievances – 216 (40%) in Q3 CY2018. Of the 188 grievances reported by waiver members, 81 (43%) were transportation-related. The State requires the MCOs to send monthly NEMT reports, in addition to quarterly reports, to promote quicker follow-up and resolution of transportation-related issues.
- Of 547 grievances in Q3 (based on grievance descriptions), 188 (34%) were from members receiving waiver services. The majority (54%) of grievances from waiver Members were from members receiving PD Waiver services; 16% were from members receiving FE services; and 12% were from members receiving I/DD waiver services.

Ombudsman's Office

- Ombudsman's Office assistance is available at the main office in Topeka, two satellite offices (Wichita and Olathe), and on the Ombudsman's Office website.
- The Olathe satellite office increased the number of weekly covered hours from 16 to 20, and increased office hour availability to five days a week, Monday through Friday. The Wichita office added one hour to their weekly coverage, for a total of 19 hours over five weekdays.
- The number of initial contacts has increased annually over time, with an average of 523 in CY2014 and an average of 1,119 in the first three quarters of CY2018.
- The most frequently reported MCO-related issues quarterly to date have been Medicaid Eligibility Issues, HCBS-related issues, and Client Obligation & Spenddown Issues.
- The three most frequent waiver-related issues in Q3 were related to the I/DD Waiver (36), FE Waiver (30), and PD Waiver (28).

KDHE Summary of Claims Adjudication Statistics –

January through September 2018 – KanCare MCOs

AMERIGROUP Service Type	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
Hospital Inpatient	26,661	$1,247,453,792.24	4,268	$259,274,564.99	16.01%
Hospital Outpatient	242,724	$693,423,905.89	28,970	$78,003,952.61	11.94%
Pharmacy	1,450,992	$116,709,201.63	431,129	Not Applicable	29.71%
Dental	104,531	$31,852,412.44	10,617	$3,798,710.20	10.16%
Vision	59,241	$16,838,174.40	8,109	$2,667,934.02	13.69%
NEMT	105,436	$4,203,416.53	487	$28,394.52	0.46%
Medical (physical health not otherwise specified)	1,420,996	$816,063,170.95	178,802	$120,170,216.94	12.58%
Nursing Facilities-Total	65,471	$181,603,333.81	7,539	$24,876,645.63	11.52%
HCBS	224,841	$144,597,438.27	13,594	$13,035,152.81	6.05%
Behavioral Health	434,421	$62,467,218.79	32,579	$4,904,199.75	7.50%
Total All Services	4,135,314	$3,315,212,064.95	716,094	$506,759,771.47	17.32%

SUNFLOWER Service Type	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
Hospital Inpatient	26,502	$1,172,623,531	6,152	$318,382,048	23.21%
Hospital Outpatient	243,476	$663,050,007	30,193	$109,883,129	12.40%
Pharmacy	1,665,172	$212,246,405	609,396	$115,118,277	36.60%
Dental	116,494	$33,784,187	11,775	$2,383,876	10.11%
Vision	74,984	$19,092,881	11,939	$3,128,017	15.92%
NEMT	120,842	$3,446,928	1,878	$47,821	1.55%
Medical (physical health not otherwise specified)	1,237,589	$687,491,302	176,598	$132,556,942	14.27%
Nursing Facilities-Total	92,539	$217,005,122	7,635	$30,210,279	8.25%
HCBS	424,272	$234,213,062	23,885	$13,855,259	5.63%
Behavioral Health	574,979	$95,302,218	51,425	$9,737,354	8.94%
Total All Services	4,576,849	$3,338,255,645	930,876	$735,303,003	20.34%

UNITED Service Type	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
Hospital Inpatient	20,886	$892,998,800	4,608	$224,190,012	22.06%
Hospital Outpatient	237,520	$682,678,828	44,473	$138,732,632	18.72%
Pharmacy	1,359,207	$206,400,413	347,473	$111,751,359	25.56%
Dental	114,313	$34,989,034	14,843	$5,319,457	12.98%
Vision	63,396	$14,749,969	12,213	$2,776,243	19.26%
NEMT	126,992	$3,499,197	1,204	$38,374	0.95%
Medical (physical health not otherwise specified)	1,216,437	$650,169,532	204,436	$159,198,562	16.81%
Nursing Facilities-Total	71,076	$199,101,463	9,631	$28,154,559	13.55%
HCBS	287,931	$129,726,766	11,898	$6,019,719	4.13%
Behavioral Health	493,330	$122,449,480	31,978	$14,276,063	6.48%
Total All Services	3,991,088	$2,936,763,485	682,757	$690,456,983	17.11%