Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 06.30.16

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

KanCare
Section 1115 Quarterly Report
Demonstration Year: 4 (1/1/2016-12/31/2016)
Federal Fiscal Quarter: 3/2016 (04/16-06/16)

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I. Introduction

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

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

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

This five year demonstration will:

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

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

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

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

This quarterly report is submitted pursuant to item #77 of the Centers for Medicare & Medicaid Services Special Terms and Conditions (STCs) issued with regard to the KanCare 1115(a) Medicaid demonstration program, and in the format outlined in Attachment A of the STCs.

II. Enrollment Information

The following table outlines enrollment activity related to populations included in the demonstration. It does not include enrollment activity for non-Title XIX programs, including the Children's Health Insurance Program (CHIP), nor does it include populations excluded from KanCare, such as Qualified Medicare Beneficiaries (QMB) not otherwise eligible for Medicaid. The table does include members retroactively assigned for the first quarter known as of June 30, 2016.

Demonstration Population	Enrollees at Close of Qtr. (06/30/2016)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	14,626	15,784	1,158
Population 2: ABD/SD Non Dual	27,889	28,339	450
Population 3: Adults	50,982	53,009	2,027
Population 4: Children	247,615	254,428	6,813
Population 5: DD Waiver	8,912	8,936	24
Population 6: LTC	20,941	21,257	316
Population 7: MN Dual	1,218	1,305	87
Population 8: MN Non Dual	1,180	1,263	83
Population 9: Waiver	4,372	4,446	74
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**377,735**	**388,767**	**11,032**

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.

During the 2nd quarter of 2016, Tribal Technical Advisory Group (TTAG) meetings with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations continued, on the following dates with attendees in person and by phone: April 5, 2016 (5 attendees), and May 3, 2016 (15 attendees)

Also the state's KanCare Advisory Council met on June 30, 2016. The 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 agenda for the Council's June meeting:

I. Welcome
II. Review and Approval of Minutes from Council meeting, March 31, 2016
III. KDHE Update – Mike Randol, Director, Division of Health Care Finance, Kansas Department of Health and Environment
IV. KDADS Update – Tim Keck, Interim Secretary, Kansas Department for Aging and Disability Services
V. Updates on KanCare with Q & A
    a. Amerigroup Kansas
    b. Sunflower State Health Plan
    c. UnitedHealthcare Community Plan
VI. Update from KanCare Ombudsman – Kerrie Bacon
VII. Miscellaneous Agenda Items
    a. Health Homes
    b. Current rate study results
    c. Upcoming CMS meetings in Kansas (Kansas City and Salina)
    d. Medicaid application backlog
VIII. Next Meeting of KanCare Advisory Council – September 12, 2016, Curtis State Office Building, Room 530, 2:00 to 3:30 p.m.
IX. Adjourn

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)
- PACE Program (quarterly)
- HCBS/MCO Provider Lunch and Learn teleconferences (1 hour, bi-weekly)
- 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 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)
- Multi-Functional Eligibility Instrument (FE, PD & TBI) Advisory Workgroup
- I/DD Functional Eligibility Instrument Advisory Workgroup
- Systems Collaboration with Aging & Disability, Behavioral Health and Foster Care Agencies
- Monthly meetings with the Association of Community Mental Health Centers, including Managed Care Organizations
- 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 9 subcommittees such as Suicide Prevention, Justice Involved Youth and Adult, and Rural and Frontier
- Mental Health Excellence and grant project meetings

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

Health Homes

Kansas implemented Health Homes (HH) for people with serious mental illness (SMI) July 1, 2014. As of June 1, 2016, there were 40,117 KanCare members identified as eligible for the SMI HH. The opt-out rate for June 2016 was 51.48%, leaving 19,464 enrolled in SMI HHs. This high opt out rate is reflective of the State's decision to end the SMI Health Homes program. The Health Homes program has been terminated effective July 1, 2016.

For those served in the SMI HH, total payments through June 2016 were $43,762,354. Health Home

members have been transitioned to targeted case management, provided by community providers, or to care coordination, disease management or case management programs operated, as applicable, by the three KanCare MCOs.

Waiver Integration Stakeholder Engagement (WISE) Workgroup

Work is resuming on the waiver integration project with the Waiver Integration Stakeholder Engagement (WISE) workgroup of stakeholders and smaller focus groups. The State continues to examine how best to combine services offered in our seven HCBS waivers into two integrated programs – one for children and one for adults. Stakeholders will help us develop the necessary detail to combine these services to meet the goals of waiver integration:

- Creating parity for all the HCBS populations
- Offering a broader array of services
- Supporting development and expansion of community-based services
- Improving transitions
- Making things simpler for KanCare members

The WISE group will be reconvened in September to review the work of the program manual and IT focus groups. It will also review and help create communication materials, and provide continued advice about services, policies and training. Details for this project will also be coordinated with other projects affecting HCBS programs, including:

- Complying with the federal HCBS settings rule, and
- Implementation of new HCBS functional eligibility instruments

KanCare Credentialing Uniformity Workgroup

The KanCare Credentialing Uniformity Workgroup membership consists of the State, the three MCOs, the Fiscal Agent, and healthcare providers from the Kansas Hospital Association and Kansas Medical Society. The agenda for this group is to analyze current credentialing practices in order to ease credentialing burdens for the providers, while still enabling the MCOs to meet their corporate credentialing needs. During 2016, standardization of the Disclosure of Ownership was discussed and finalized. The State will also enable this form to be available in electronic form. The workgroup is currently working with the Fiscal Agent to expand and upgrade the Provider Enrollment Portal. This will be a centralized portal where providers can submit required documents one time rather than having to complete the same forms up to four different times. The issuance of the new CMS Managed Care rule has caused a reassessment of priorities. Once the State has analyzed the finalized Managed Care rules, it will be important to work internally to develop best practices in the areas of provider enrollment, screening and data collection. Once this assessment is complete, the workgroup will be working with the Fiscal Agent to integrate the desired changes into the expanded Provider Enrollment Portal. The workgroup plans to reconvene summer 2016.

KanCare Consumer and Specialized Issues (CSI) Workgroup

The CSI Workgroup met on June 30, 2016 at the Sunflower Health Plan offices in Lenexa, Kansas. Topics discussed were KDADS' background checks for FMS providers and the backlog of Medicaid applications

at the KanCare Clearinghouse. State staff also received some feedback about the KanCare Renewal Stakeholder Feedback Forums. 14 people attended the meeting.

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 over 110 events for the second quarter of 2016. This included partner development, sponsorships, outreach and advocacy. The Community Relations Representatives' primary focus continues to be member education of services and how to get the most out of the KanCare program. They develop strong partnerships across the state by enhancing existing relationships and building new ones. Below is a sampling of Marketing activities Amerigroup supported in the second quarter:

- March of Dimes – executive sponsor for March for Babies (KC and Wichita)
- Swope Dental Clinic
- Latino Coalition Meeting
- Salina Senior Day Out
- Baldwin Community Wellness
- Governors Public Health Conference

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 continue with ongoing targeted outreach to improve member knowledge about the services available to them. The Community Relations Representatives participated in a variety of community events reaching almost 13,500 Kansans in the second quarter. 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, access to care, diabetes, well child visits, employment, high blood pressure, your PCP and you, and more. Below is a sampling of some of their outreach efforts this past quarter:

- March for Dimes, March for Babies walk (KC and Wichita)
- Employment First Summit
- USD 500 health fair exhibit
- NAMI walk Exhibit
- Butler County on Ageing – Spring Fling

Advocacy Activities: Amerigroup's advocacy efforts for second quarter 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 proactive 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 second 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 and grievance and appeal process with the assistance of the Grievance Specialists on site at the Health Plan. Here are a few examples of their Advocacy Activities this past quarter:

- Kearny County Rural Hospital Health Fair
- Stormont Vail Babies Jubilee
- SACK Convention
- Geary County Perinatal Coalition

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

Marketing Activities: During 2nd Quarter 2016, Sunflower Health Plan sponsored local and statewide member and provider events as well as fundraisers for charitable organizations such as the American Heart Association. Sunflower's marketing material for the second quarter included member postcards and customized letters addressing preventive health care gaps for diabetes screenings, childhood and adolescent immunizations and dental care. During this reporting period, there was enhanced promotion of Project SEARCH with media engagement at the Employment First Summit, and Sunflower collaborated with a community mental health center and other local partners to hold a grant kickoff event promoting enhanced behavioral health services in rural Kansas.

Notable Sponsorships of Stakeholder Events and Programs:

- LeadingAge Kansas Spring Convention & Expo
- Employment First Summit
- American Academy of Pediatrics Spring Meeting
- The Arc of Sedgwick County
- Kansas Healthcare Collaborative's 8th Annual Summit on Quality
- Kansas Special Olympics – Major sponsor of the Summer Games
- National Alliance on Mental Illness (NAMI) Walk
- Centene Foundation for Quality Healthcare (Sunflower parent company) Rural Health Grant Kickoff Event with Community Mental Health partners in Pawnee, Rice, Stafford and Barton counties

Outreach Activities: Sunflower Health Plan's MemberConnections representatives made approximately 425 successful home visits during 2nd Quarter 2016. In addition to Sunflower's reoccurring Adopt-a-School events and Baby Showers, the health plan launched a Farmers Market program with members to support healthful eating as well as community supported agriculture. Sunflower's MemberConnections representatives met with members in their homes and at the clinic to assist them with social services and questions about their coverage. Additionally, Sunflower developed a strategic partnership with a large hospital in Wichita to begin delivering in-person care coordination for members, especially for new moms and babies and for members receiving services for COPD and uncontrolled diabetes.

Example of member outreach activities this quarter:

• Held two Farmers Market member programs during June
• Held four Sunflower member baby showers and participated in other community baby showers to promote prenatal care
• Participated in 15 community health events serving all populations, including the Kickapoo Nation Health Center's 16th annual health fair and a dental clinic with Great Plains Dental
• Held Sunflower Health Plan's quarterly Member and Community Advisory Committee meeting on May 25, 2016, in Wichita. The two main topics on the agenda were Pharmacy Updates and 2016 Clinical Focus Areas. Input was also received on the state's closure of the health homes program.

Advocacy Activities: During 2nd quarter 2016, Sunflower staff contributed to community workgroups and coalitions advocating for health literacy, persons with disabilities and other topics addressing population health in Kansas. These workgroups include Health Literacy Kansas, the Fetal and Infant Mortality Review (FIMR) Community Action Teams and the Kansas Public Health Association. Sunflower participated in the planning of the Employment First Summit.

Sunflower's employment initiatives have led to the health plan and its sister company, LifeShare, serving as the designated statewide coordinator for Project SEARCH, which is a one-year, school-to-work program for young adults with intellectual and developmental disabilities. Sunflower/LifeShare began providing technical assistance to community-based agencies implementing and sustaining their Project SEARCH program and have worked to increase the program's presence in the state.

Sunflower Health Plan supported a grant kickoff event in Pawnee County to enhance behavioral health services and increase accessibility in rural Kansas. The $110,000 Improving Health in Rural Counties grant was awarded to the Center for Counseling & Consultation and the Pawnee County Health Department for their program aimed at promoting public awareness for the treatment of mental illness and substance use disorder as well as access to local behavioral health services.

Information related to UnitedHealthcare Community Plan marketing, outreach and advocacy activities:
Marketing Activities: UnitedHealthcare Community Plan of Kansas' primary focus during this reporting period was continued emphasis on member, provider, and community education regarding benefits and health. UnitedHealthcare Community Plan participates in and supports a variety of community events, as well as engages in member events and outreach. UnitedHealthcare focused on completing new member welcome calls and Health Risk Assessments. UnitedHealthcare also engaged in other outreach calls to invite members to Community Baby Showers and Clinic Days. New members are sent ID Cards and new member welcome kits in a timely manner. UnitedHealthcare mails members the HealthTalk newsletter each quarter with tips on living a healthier life. UnitedHealthcare delivers the quarterly Practice Matters Newsletter to Providers with information that is important for their support of UnitedHealthcare Members. UnitedHealthcare also supported and managed two Provider Training sessions during the quarter. One was in Overland Park, the second was in Wichita. Over 1,000 providers signed up to attend one of the training sessions. Throughout the quarter, UnitedHealthcare hosted a number of meetings and presentation with key providers, hospitals and FQHC's throughout the state

that involved discussions around exploring innovative and collaborative opportunities. Additional UnitedHealthcare work continued to partner and work closely with providers to ensure accurate panel assignments and attribution, where appropriate. Additional work was done on the UnitedHealthcare online tools, like find a doctor, to better support both providers and members and improve overall satisfaction.

Outreach Activities: UnitedHealthcare leverages Bilingual Community Outreach Specialists that focus on activities targeted within assigned geographical areas across Kansas. These specialists are fluent in both English and Spanish languages and effectively communicate with members. The key responsibility of the Outreach Specialist is to conduct educational outreach to members, community based organizations and targeted provider offices about Medicaid benefits, KanCare and UnitedHealthcare. UnitedHealthcare educates Members and Providers on Value Added benefits and the features and benefits of KanCare. UnitedHealthcare also interacts with key provider offices and the provider community to assist with issue resolution. Several key outreach initiatives this quarter included lobby sits, "Food for Thought Programs" hosted on-site at provider offices, multiple health fairs and clinic days held throughout the state. UnitedHealthcare also participated in a number of community stakeholder committee meetings. The Outreach team supported numerous FQHC events.

In the second quarter of 2016, UnitedHealthcare hosted two Community Baby Showers, one in Wichita and one in Topeka. These Community Events have been well received and provide pregnant and new moms with information about healthy pregnancy and deliver, as well as child safe sleeping and car seat installation. In addition, UnitedHealthcare participated in two baby showers hosted by community based organizations. UnitedHealthcare also supported two dental clinic days and a medical clinic month at FQH's. The Member Advisory Meeting held in Q2 in Overland Park focused on the Community Rewards Program and the online tool. Members offered ideas and suggestions to improve the ease of navigating the tool.

Advocacy Activities: UnitedHealthcare leverages one outreach specialist that has the additional focus of supporting members with disabilities, and the individuals and agencies that support them. This person serves as a liaison between the community, members and the Health Plan. This outreach specialist divides her time between traditional outreach and supporting those with disabilities.

Throughout this quarter, many members and disability advocates learned more about how to access and navigate their benefits with United Healthcare, including how care coordination is provided to those on Home and Community Based Waiver programs and where to go when they have questions. UHC staff continued to stress to members with disabilities the Health Plan's desire to support the members' personal goals and to encourage them to make informed decisions about enrollment in a KanCare plan. At events, it is not uncommon to meet individuals with a newly acquired disability who are in need of good referrals and basic information about programs and services available to them. UnitedHealthcare remains committed to providing ongoing support and education to members and offering support to the consumers of Kansas.

This outreach specialist attended the Employment 1st Summit, hosted by the Kansas Council on Developmental Disabilities. This event enables the health plan to network with members and employment support providers to continue to build relationships. Attendees were also able to get information about UnitedHealthcare Community Plan at the resource table. In addition, one of the workshop sessions focused on the Empower Kansans System Change Grant funded by UnitedHealthcare. The grantee, the Employment Systems Change Coalition, is gathering feedback from stakeholders across Kansas and preparing recommendations based on that research. In addition, the SACK (Self Advocate Coalition of Kansas) conference took place during the quarter. This event had over 200 attendees, mostly individuals with intellectual and developmental disabilities, along with their support staff, who received information about UnitedHealthcare.

This same outreach specialist attended the National APSE Conference (Association of Persons Supporting Employment 1st) in Cincinnati, Ohio. This conference offered the opportunity to network with employment support providers and persons with disabilities from across the country and to learn more about best practices and efforts in other states related to improving employment outcomes for persons with disabilities.

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.

   CMS approved the KanCare MCO contract Amendment 21 on April 6, 2016. Amendment 21 instituted capitation rates for the time frame of January 1, 2016 through December 31, 2016 and the continuation of the Pay for Performance program. Amendment 22 was submitted to CMS on April 22, 2016. Amendment 22 is pending approval.

   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 service utilization, per each of the KanCare MCOs, by top three value added services and total for January-June, 2016, follows:

MCO	Value Added Service	Units YTD	Value YTD
Amerigroup	Adult Dental Care	1,904	$238,514

	Member Incentive Program	4,758	$104,980
	Mail Order OTC	5,292	$93,066
	Total of all Amerigroup VAS Jan-June 2016	***15,895***	***$512,731***
Sunflower	CentAccount Debit Card	38,204	$764,080
	Dental Visits for Adults	4,709	$154,278
	Smoking Cessation Program	233	$55,920
	Total of all Sunflower VAS Jan-June 2016	***62,519***	***$1,082,760***
United	Baby Blocks Program and Rewards	603	$72,360
	Adult Dental Services	1,049	$53,011
	Adult Briefs	485	$48,659
	Total of all United VAS Jan-June 2016	***11,673***	***$326,775***

c. Enrollment issues: For the second quarter of calendar year 2016 there were 10 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 first quarter of calendar year 2016. All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Newborn Assignment	7
KDHE - Administrative Change	49
WEB - Change Assignment	23
KanCare Default - Case Continuity	261
KanCare Default – Morbidity	317
KanCare Default - 90 Day Retro-reattach	161
KanCare Default - Previous Assignment	380
KanCare Default - Continuity of Plan	1049
AOE – Choice	468
Choice - Enrollment in KanCare MCO via Medicaid Application	1145
Change - Enrollment Form	311
Change - Choice	551
Change - Access to Care – Good Cause Reason	2
Change - Case Continuity – Good Cause Reason	0
Change - Quality of Care – Good Cause Reason	0
Assignment Adjustment Due to Eligibility	8
Total	**4,732**

d. Grievances, appeals and state hearing information

MCOs' Grievance Database
Members – CY16 2nd quarter report

MCO	QOC (non HCBS, non Trans)	Customer Svcs	Member Rights Dignity	Access to Svc or Care	Pharm	QOC (HCBS)	Trans (incl Riem.)	Trans (No Show)	Trans (Late)	Trans (Safety)	VAS	Billing/Fin Issues (non Trans)	Other
AMG	9	9	7	7	4	5	21	16	8	3	2	22	0
SUN	7	28	7	43	1	3	10	6	2	2	1	17	2
UHC	31	0	1	1	17	5	19	17	13	9	0	70	9
Total	47	37	15	51	22	13	50	39	23	14	3	109	11

MCOs' Appeals Database
Members – CY16 2nd quarter report

Member Appeal Reasons AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	SFH requested
MEDICAL NECESSITY DENIAL					
Criteria Not Met - DME	1 14 23	 7	 10 7	1 4 9	
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	1 31	 24	 3	 4	
Criteria Not Met - Medical Procedure (NOS)	3 7		1 3	2 4	
Criteria Not Met - Radiology	1 10		 3	1 7	
Criteria Not Met - Pharmacy	7 57 101	 25	6 40 30	1 17 46	
Criteria Not Met - PT/OT/ST	18		10	8	
Criteria Not Met - Dental	2 11	 8	 2	2 1	
Criteria Not Met or Level of Care - Home Health	4 1			4 1	
Criteria Not Met - Hospice					
Criteria Not Met - Out of network provider, specialist or specific provider request	 1		 1		

Criteria Not Met – Inpatient Behavioral Health	8 14		2	8 12	
Criteria Not Met – Behavioral Health Outpatient Services and Testing	2 8 6	1	1 3	1 5 5	
Level of Care - LTSS/HCBS	26 1	5	3	18 1	5
Level of Care - WORK					
Level of Care - LTC NF					
Level of Care - Mental Health					
Ambulance (include Air and Ground)	1		1		
Other- Medical Necessity	8	2	1	5	
NONCOVERED SERVICE DENIAL					
Service not covered - Dental	1			1	
Service not covered - Home Health	2	1	1		
Service not covered - Pharmacy	1		1		
Service not covered - Out of Network providers					
Service not covered - OT/PT/Speech					
Service not covered - DME	1 1		1	1	
Service not covered - Behavioral Health					
Other - Noncovered service	15	8	2	5	
LOCK IN					
BILLING AND FINANCIAL ISSUES					
PRIOR AUTHORIZATION DENIAL					
Late notification					
No authorization submitted	7		2	5	
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **57** **139** **199**	 **6** **0** **76**	 **13** **74** **47**	 **38** **65** **76**	 **5** **N/A** **N/A**

**N/A = Information pending*

MCOs' Appeals Database
Providers - CY16 2nd 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**	**SFH requested**
MEDICAL NECESSITY DENIAL					

Criteria Not Met - DME	1 4		1	4	
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	20 39 127		2 26 66	18 13 61	3
Criteria Not Met - Medical Procedure (NOS)	12 4	1	7 3	4 1	
Criteria Not Met - Radiology	1		1		
Criteria Not Met - Pharmacy	24 2		23 2	1	
Criteria Not Met - PT/OT/ST					
Criteria Not Met - Dental					
Criteria Not Met - Vision	43		16	27	
Criteria Not Met or Level of Care - Home Health	1 1		1		
Criteria Not Met - Hospice					
Criteria Not Met - Out of network provider, specialist or specific provider request				1	
Criteria Not Met – Inpatient Behavioral Health	4 1		2	2	
Criteria Not Met – Behavioral Health Outpatient Services and Testing				1	
Level of Care - LTSS/HCBS					
Level of Care - WORK					
Level of Care - LTC NF					
Level of Care - Mental Health					
Ambulance (include Air and Ground)	11		10	1	
Other-medical necessity	2 4		1 3	1 1	
NONCOVERED SERVICE DENIAL					
Service not covered - Dental	14		8	6	
Service not covered - Vision					
Service not covered - Home Health	2 1		2 1		
Service not covered - Pharmacy	1			1	
Service not covered - Out of Network providers					

Service not covered - OT/PT/Speech					
Service not covered - DME					
Service not covered - Behavioral Health					
Other- not covered service	2 100	11	1 19	1 70	
BILLING AND FINANCIAL ISSUES					
Claim Denied- contained errors	3351 2 8	1	1309 1 4	1888 1 3	22
Claim Denied- by MCO in Error	6531 1 2	2	3670 1	1956	32
PRIOR AUTHORIZATION DENIAL					
Late notification	22 9		5 5	17 4	
No authorization submitted	5 7 23	3	1 2 14	4 6 5	
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	**9970** **141** **271**	**1** **0** **17**	**5020** **79** **108**	**3890** **62** **146**	**57** **29** **N/A**

**N/A = Information pending*

***Amerigroup treats and counts every provider initiated claim action request from all sources (verbal, written, email, web-submission, submitted by provider representative or other individual in any form) as an appeal for reporting purposes. Even though there may be commonality of cause across a number of provider contacts, the action itself is counted as a singular event regardless of the number of claims impacted or reported (claim appeals are not aggregated for common cause). Amerigroup's appeal workflow system accounts for each appeal intake as a distinct action.*

MCO's Appeals Database

Provider Appeal Summary – CY16 2nd quarter report

AMG – Red **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**	**Proceeded to SFH**
Resolved at 1st Appeal Level	9551 0 271	1 0 17	4918 0 108	3607 0 146	- - 24
Resolved at 2nd Appeal Level	419 141 0	0 0 0	102 79 0	283 62 0	76 29 -

State of Kansas Office of Administrative Fair Hearings

Members – CY16 2nd quarter report

AMG-Red SUN-Green UHC-Purple	Dental Denied/ Not Covered	CT/ MRI/ X-ray Denied	Pharm Denied	DME Denied	Home Health Hours Denied	Comm Psych Support/ BH Svcs Denied	Inpt/ PT/OT Rehab Denied	LTSS/ HCBS/ WORK PCA Hrs Denied	Med Proc/ Genetic Testing Denied	Specialist Ofc Visit/ Ambulance Denied
Withdrawn				1			1	2		
Dismissed-Moot MCO reversed decision	1		1	1				3		
Dismissed-No Adverse Action	1							1		
Default Dismissal-Appellant did not appear	1		2		1					
Dismissed-Untimely				1	1			1		
OAH upheld MCO decision	1		1				1	1		
OAH reversed MCO decision					1		2	2 1		
TOTALS	3 1		2 2	3	3		4	6 3 2		

Providers – CY16 2nd quarter report

AMG-Red SUN-Green UHC-Purple	Claim Denied (Contained Errors)	Claim Denied By MCO In Error	Recoup-ment	DME Denied	Radio-logy Denied	Home Health/ Hospice/LTC Denied	Air Amb Charges	Inpt/Outpt / Observation Med Proc Denied	Mental Health HCBS/ TCM Hrs Denied	Pharm /Lab/ Genetic Testing Denied
Withdrawn	3			1 1	1	4		5 3 17	1 4	1
Dismissed-Moot MCO reversed decision	3	7		9	1	3 2	1	7 5 4	8 6	4 1 1
Dismissed-No internal appeal					1	1		5 1		10
Dismissed-No adverse action		1						2		
Default Dismissal-				2				1		

Appellant did not appear										
Dismissed-Untimely										
OAH upheld MCO decision								1	1	
OAH reversed MCO decision										
TOTALS	6	8		11 1 1	1 2	8 2	1	19 10 22	9 11	14 2 1

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 Q2 of 2016, there were a total of 174 requests, which is more than double the 68 requests in first quarter of 2016.

The majority of good cause requests during the Q2 of 2016 were due to members mistaken in their belief that they can file good cause requests because they prefer a provider outside of their assigned MCO's network. KDHE is continuing to explore educational materials or information to add to member enrollment packets to explain what would be considered 'good cause'. KDHE is also exploring provider educational materials regarding this matter. Unfortunately, GCRs still occur due to providers advising patients to file GCRs to switch plans. Most of the GCRs in the 1st and 2nd quarters of 2016 are due to two clinics advising their patients to file GCRs when their clinics were terminated from MCO networks. And as in previous quarters, GCRs (member "Good Cause Requests" for change in MCO assignment) 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 with that MCO 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 remaining requests show varied reasons and causes for changing plans. The GCR requests showed an overall downward trend from the requests at the beginning of 2015 through December 2015, but unfortunately the requests increased in the first and second quarters of 2016.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the second quarter of 2016, there were no state fair hearings filed for a denied GCR. A summary of GCR actions this quarter is as follows:

Status	April	May	June
Total GCRs filed	45	67	62
Approved	2	0	3
Denied	24	51	37
Withdrawn (resolved, no need to change)	15	11	14
Dismissed (due to inability to contact the member)	4	5	8
Pending	0	0	0

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. Numbers of contracting providers are as follows (for this table, providers were de-duplicated by NPI):

KanCare MCO	# of Unique Providers as of 9/30/15	# of Unique Providers as of 12/31/15	# of Unique Providers as of 3/31/16	# of Unique Providers as of 6/30/16
Amerigroup	15,954	13,652	15,802	16,410
Sunflower	20,226	19,914	20,389	20,647
UHC	20,840	20,190	21,290	22,133

h. MLTSS implementation and operation: In the second quarter, Kansas continued to offer services to individuals on the HCBS-PD Program waiting list, as well as individuals on the HCBS-I/DD Program waiting list. Additional details are included in section XIII below.

i. 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 DY4. A DSRIP Learning Collaborative was held on April 25, 2016, at the State of Kansas with The University of Kansas Hospital, Children's Mercy Hospital, and KFMC in attendance.

j. Information on any issues regarding the concurrent 1915(c) waivers and on any upcoming 1915(c) waiver changes (amendments, expirations, renewals):
    - The Serious Emotional Disturbance (SED) waiver is operating off an extension approved

through September 24, 2016. Previously the State had withdrawn the submitted renewal request, to address concerns CMS expressed regarding mitigation of conflict of interest. The State is working closely with CMS to mitigate the conflict of interest concerns. The State has had technical assistance calls with CMS and continues to work on the concerns. The state believes CMS is close to granting approval of our conflict of interest mitigation strategy.

- The Autism waiver is currently operating off an extension through September 28, 2016. CMS has required the state to remove three autism wavier services and provide them under the state plan as EPSDT services. At the direction of CMS, the state has been unable to submit the autism waiver until the SPAs for the autism services are submitted.

k. *Legislative activity:* The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight, a statutory joint legislative committee, met on April 18, 2016, to review the current state of KanCare and HCBS services.
    - The committee received information from KDHE about MCO financial status, health homes status report, KanCare opportunities and waiver integration project, pending provider-specific claim issues as well as general claims information, Medicaid application backlog status, MCO contractual requirements, potential impact of step therapy implementation and financial managed services program update.
    - The committee received information from KDADS about state hospital issues, HCBS waiver and waiting list updates, waiver renewal/amendment status, and responses to specific stakeholder concerns.
    - The committee also received presentations from each of the KanCare MCOs about innovations, received information from the KanCare Ombudsman, and took comments from stakeholders (with related responses from agency and MCO staff).

V. Policy Developments/Issues

General Policy Issues: Kansas addressed policy concerns related to managed care organizations and state requirements through weekly KanCare Policy Committee, biweekly 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: KDHE issues retroactive monthly capitated payments; therefore, the budget neutrality document cannot be reconciled on a quarterly basis to the CMS 64 expenditure report

because the CMS 64 reflects only those payments made during the quarter. Based on this, the State is not using the CMS-64 as the source document, but rather is using a monthly financial summary report provided by HP, the State's fiscal agent. The budget neutrality monitoring spreadsheet for QE 06.30.16 is attached. Utilizing the HP-provided monthly financial summary, the data is filtered by MEG excluding CHIP and Refugee, and retro payments in the demonstration year are included.

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

VII. Member Month Reporting

Sum of Member Unduplicated Count	Member Month			Totals
MEG	*2016-04*	*2016-05*	*2016-06*	*Grand Total*
Population 1: ABD/SD Dual	15,291	14,863	14,626	44,780
Population 2: ABD/SD Non Dual	28,049	27,932	27,892	83,873
Population 3: Adults	49,600	50,461	50,982	151,043
Population 4: Children	244,978	246,703	247,617	739,298
Population 5: DD Waiver	8,859	8,884	8,912	26,655
Population 6: LTC	20,514	20,784	20,966	62,264
Population 7: MN Dual	1,257	1,266	1,219	3,742
Population 8: MN Non Dual	1,220	1,246	1,180	3,646
Population 9: Waiver	4,291	4,354	4,372	13,017
Grand Total	**374,059**	**376,493**	**377,766**	**1,128,318**

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

VIII. Consumer Issues

Summary of consumer issues during the second quarter of 2016:

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.

Member authorization denials for variety of reasons. This caused some consumers to have a delay in service.	Most of the denials were due to confusing communication between the providers and the MCO, leading to incorrect or incomplete authorization requests, which were subsequently denied.	A few requirements were relaxed, but there are lingering issues due to the process being largely a manual review process.
Client obligation assessed on incorrect claims/patients.	MCOs occasionally assess (or fail to assess) client obligation on the correct member and/or claims.	This happens sporadically, and there are multiple causes.
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.	The State is working with the MCOs by reviewing the network reports and making suggestions for improvement. This discussion is part of our State on site reviews.
Retroactively eligible members are denied authorizations or claims denied for timely filing.	Members are denied authorization, services and care coordination due to retroactive eligibility.	The new eligibility system KEES is available but has some lingering system issues. Also there was a departmental shift in the processing of eligibility requests which has caused some delays in establishing eligibility. Some of the processes require manual intervention, which still may lead to errors.

Continued consumer support was conducted by KDHE's out-stationed eligibility workers (OEW). OEW staff assisted in determining eligibility for nearly 5,000 consumers. OEW also assisted in resolving over 2,100 issues involving such matters as urgent medical needs, providing information on applications and addressing gaps or errors in pending applications/reviews with the KanCare Clearinghouse.

During this quarter, OEW staff also participated in 15 community events providing KanCare program outreach, education and information.

IX. Quality Assurance/Monitoring Activity

Kansas has created a broad-based structure to ensure comprehensive, collaborative and integrated oversight and monitoring of the KanCare Medicaid managed care program. KDHE and KDADS have established the Medicaid Enterprise Leadership (MEL) team for comprehensive oversight and monitoring. The MEL team is a review, feedback and policy direction body partly focusing on the monitoring and implementation of the State's KanCare Quality Improvement Strategy (QIS). The MEL 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. The MEL team 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 the MEL team's review of and feedback regarding the overall KanCare quality plan. This combined information assists the MEL team and the MCOs to identify and recommend quality initiatives and metrics of importance to the Kansas Medicaid population.

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

The State values a collaborative approach that will allow all KanCare MCOs, providers, policy makers and monitors to maximize the strength of the KanCare program and services. Kansas recognizes that some of the performance measures for this program represent performance that is above the norm in existing programs, or first-of-their-kind measures designed to drive to stronger ultimate outcomes for members, and will require additional effort by the KanCare MCOs and network providers. Therefore, Kansas continues to work collaboratively with the MCOs and provide ongoing policy guidance and program direction in a good faith effort to ensure that all of the measures are clearly understood; that all measures are consistently and clearly defined for operationalizing; that the necessary data to evaluate the measures are identified and accessible; and that every concern or consideration from the MCOs is heard. When that process is complete (and as it recurs over time), as determined by the State, final details are communicated and binding upon each MCO.

During the first quarter of 2016, some of the key quality assurance/monitoring activities have included:

- Quarterly 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 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 for 2016, with the associated deliverables detail. The ongoing quarterly business meetings mentioned in first bullet also are used to discuss and plan EQRO activities, the MCO requirements related to those activities, and the associated EQRO timeline/action items.
- Work continued during the second quarter on the planning for the comprehensive annual compliance reviews of the MCOs – which are done in partnership between Kansas' EQRO and

the two state agencies (KDHE and KDADS) managing the KanCare program, to maximize leverage and efficiency. The 2016 review is the full Balanced Budget Act review, and planning started in the 4th quarter 2015 for this audit. It will assess identified compliance issues as well as findings from previous audits. The State will also monitor for compliance with the state contract. As of June 30, 2016, the first BBA on site audit at one MCO has occurred, with two more to follow this year.

- MFCU monthly meetings to address fraud, waste, and abuse cases, referrals to MCOs and State, and collaborate on solutions to identify and prevent fraud, waste and abuse.
- 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.
- Complex Case staffing of HCBS and Behavioral Health issues. Each MCO brings complex cases for State consideration, and the State provides technical assistance about program policies and alternatives to address identified needs. These are held biweekly and integrated the State's behavioral health and long-term supports and services teams.
- 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 Special Terms and Conditions.
- 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 procedure manual is in the draft stages, and once finalized it will be utilized to document this process. In the manual, protocols and interpretive guidelines have been established with the goal of ensuring consistency in the reviews.
- During this quarter, the Quality Assurance team within KDADS reviewed the 2014 quality outcomes and remediation process with each MCO. MCOs were provided with draft protocols from the draft quality assurance procedure manual. 2015 data was uploaded by each MCO in July. The QA team began their reviews with an expected completion date of 11/30/2016.

- MCOs were given their sample for Q1 and Q2 on 6/30/16 with upload to be completed by 8/31/16. Quality Review will be completed for Q1 and Q2 by 12/1/16.
- Timelines for the quarterly reviews were established and sent to begin for the third quarter of 2016.

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. Each MCO also submits a separate report on HCBS service provider participation. Based on these network reports, two reports are published to the KanCare website monthly for public viewing:
   1. Summary and Comparison of Physical and Behavioral Health Network is posted at http://www.kancare.ks.gov/download/KanCare_MCO_Network_Access.pdf. This report pulls together a summary table from each MCO and provides a side-by-side comparison of the access maps for each plan by specialty.
   2. HCBS Service Providers by County: http://www.kancare.ks.gov/download/HCBS_Report_Update.pdf, includes a network status table of waiver services for each MCO.

b. Customer service reporting, including total calls, average speed of answer and call abandonment rates, for MCO-based and fiscal agent call centers, January-June 2016:

KanCare Customer Service Report - Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:23	2.52%	93,396
Sunflower	0:17	1.79%	85,666
United	0:09	.55%	80,426
HP – Fiscal Agent	0.00	0.10%	14,203

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:23	1.73%	41,166
Sunflower	0:10	0.71%	49,426
United	0:05	0.32%	35,496
HP – Fiscal Agent	0.00	0.10%	3,406

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

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

e. Summary of ombudsman activities for the second quarter of 2016 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. 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 re-assessing progress related to the applicable KanCare Special Terms and Conditions and documenting advancements by subject area and by agency.

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 2016 AIRS reports through the quarter ending June 30, 2016, follows:

Critical Incidents	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	**TOTALS**
Reviewed	**263**	**394**			**657**
Pending Resolution	**1**	**3**			**4**
Total Received	**264**	**397**			**661**
APS Substantiations*	**69**	**65**			**134**

**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 State has requested a sixty day extension to submit Attachment J to determine

the impact on the Rural Healthcare Initiative. The HCAIP first and second quarter payments will be made in August. The LPTH/BCCH Pool second quarter payments were processed on April 14, 2016. The attached Safety Net Care Pool Report identifies pool payments to participating hospitals, including funding sources, applicable to the first quarter.

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. Since then, KFMC has developed and submitted quarterly evaluation reports, annual evaluation reports for 2013 and 2014, and a revised evaluation design in March 2015.

For the second quarter of 2016, 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. Claims Adjudication Statistics

KDHE's summary of the numerous claims adjudication reports for the KanCare MCOs, covering January-June, 2016, is attached.

b. Waiting List Management

PD Waiting List Management

For the quarter ending June 30, 2016:

- Current number of individuals on the PD Waiting List: 438
- Number of individuals added to the waiting list: 445
- Number of individuals removed from the waiting list: 980
    - 370 placed on HCBS PD waiver services
    - 37 were deceased
    - 573 were removed for other reasons (refused services, voluntary removal, etc.)

I/DD Waiting List Management

For the quarter ending June 30, 2016:

- Current number of individuals on the I/DD Waiting List: 3387
- Number of individuals added to the waiting list: 134

- Number of individuals removed from the waiting list: 249
    - 158 placed on HCBS services
    - 1 was deceased
    - 90 were removed for other reasons (refused services, voluntary removal, etc.)

The current point-in-time limit for HCBS-I/DD is 8,900. KDADS is currently serving 8,896 individuals. Based upon appropriations, KDADS will continue to offer services until waiver membership has reached 8,900 participants.

XIV. Enclosures/Attachments

Section of Report Where Attachment Noted	Description of Attachment
VI	KanCare Budget Neutrality Monitoring Spreadsheet for QE 06.30.16
X(e)	Summary of KanCare Ombudsman Activities for QE 06.30.16
XI	KanCare Safety Net Care Pool Report for QE 06.30.16
XII	KFMC KanCare Evaluation Report for QE 06.30.16
XIII(a)	KDHE Summary of Claims Adjudication Statistics for QE 06.30.16

XV. State Contacts

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XVI. Date Submitted to CMS

August 31, 2016

DY 4
Start Date: 1/1/2016
End Date: 12/31/2016

Quarter 2
Start Date: 4/1/2016
End Date: 6/30/2016

	Total Expenditures	Total Member-Months
Apr-16	$249,006,898	369,777
May-16	$248,730,528	368,161
Jun-16	$247,487,173	373,470
PCP	$0	
Q2 Total	$745,224,600	1,111,408

ADMIN SUMMARY	
	Expenditures
DY4Q2	50,186,294

	Population 1: ABD/SD Dual	Population 2: ABD/SD Non Dual	Population 3: Adults	Population 4: Children	Population 5: DD Waiver	Population 6: LTC	Population 7: MN Dual	Population 8: MN Non Dual	Population 9: Waiver
Apr-16									
Expenditures	$1,773,917	$36,938,287	$28,819,588	$56,510,109	$41,157,037	$68,186,093	$906,798	$2,292,691	$12,422,378
Member-Months	7,649	36,221	52,495	236,450	8,942	20,804	1,493	1,328	4,395
May-16					0				
Expenditures	$1,462,938	$36,906,489	$28,315,795	$56,409,224	$40,884,962	$69,196,438	$758,719	$2,116,112	$12,679,851
Member-Months	6,898	35,921	52,262	236,432	8,919	20,690	1,387	1,205	4,447
Jun-16									
Expenditures	$1,496,383	$36,504,294	$26,741,492	$55,881,710	$41,079,460	$70,403,893	$742,859	$2,052,118	$12,584,965
Member-Months	6,900	36,451	53,158	239,461	8,995	21,405	1,374	1,274	4,452
Q2 Total									
Expenditures	$4,733,238	$110,349,070	$83,876,874	$168,801,043	$123,121,459	$207,786,424	$2,408,376	$6,460,922	$37,687,193
Member-Months	21,447	108,593	157,915	712,343	26,856	62,899	4,254	3,807	13,294
DY 4 - Q2 PMPM	$221	$1,016	$531	$237	$4,585	$3,303	$566	$1,697	$2,835

Notes:

1. For DY4 Member-Months are CAP + RETRO combined.
2. PCP expired at the end of DY2.
3. Unique Enrollees: this table is populated at the end of DY4.
4. DY4Q1: Decrease in Expenditures and Member-Months for Dual populations decreased due to shift of Dual population to NonDuals. This resulted in an increase of expenditures and member months in the NonDual populations.
5. DY4Q2: Continue to see decrease in Expenditures and Member-Months for Duals due to Dual population shifting to NonDuals.

KanCare Ombudsman KDHE Quarterly Report

Kerrie J. Bacon, KanCare Ombudsman
2nd Quarter, 2016 Report

Accessibility by Ombudsman's Office

The KanCare Ombudsman was available to members and potential members of KanCare (Medicaid) through the phone, email, letters and in person during the second quarter of 2016. There were 846 contacts through these various means, 150 of which had an MCO or an issue with an MCO (18 percent).

Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Comments
2013	615	456	436	341	this year does not include emails
2014	545	474	526	547	
2015	510	462	579	524	Avg. for 2014/2015 is 521
2016	1130	846			
% incr./dec.	117%	63%			Increase over average of 2014/2015

MCO related	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16
Amerigroup	53	69	63	45	92	46
Sunflower	96	92	72	62	92	57
United Health	75	47	52	32	66	47
Total	**224**	**208**	**187**	**139**	**250**	**150**

The KanCare Ombudsman webpage (http://www.kancare.ks.gov/ombudsman.htm) continues to provide information and resources to members of KanCare and consumers. It is updated on a regular basis.

Outreach by Ombudsman's office

- Provided a report and testimony for the Robert Bethel Joint Committee on HCBS and KanCare Oversight, April 18, 2016.
- Attended the Employment First Summit and provided a vendor booth for outreach for the Ombudsman's office, April 21-22, 2016.
- Attended the May KanCare Listening Sessions in Hays, Wichita; May 24, 26, 2016.
- Attended the Final Rule Listening Session in Topeka and Overland Park; June 15, 16, 2016.
- Provided vendor outreach for the SACK Conference, June 25. 2016.
- The Ombudsman's office sponsors the KanCare (I/DD) Friends and Family Advisory Council which met two times during the second quarter.
- Hosted the KanCare Member Lunch-and-Learn bi-weekly conference calls for all KanCare members, parents, guardians, consumers and other interested parties. Calls address topics of interest, resources in the community, emerging issues and includes a question and answer time. Managed care organizations continue to participate on the calls and answer questions as needed...

Outreach through the

KanCare Ombudsman Volunteer Program Update

- Lisa Churchill was hired as the KanCare Ombudsman Volunteer Coordinator. She is originally from Kansas. Most recently she was working as the Volunteer Coordinator for a hospital in Corpus Christi, Texas with over 400 volunteers. We are very pleased she has returned to Kansas and is working with our program.
- The ***KanCare Ombudsman Johnson County Satellite Office*** opened in July. We have two volunteers fully trained and new training starting in August with potentially three Johnson County volunteer trainees, one Wyandotte County volunteer trainee and one Wichita volunteer trainee.
- The ***KanCare Ombudsman Southern Kansas Satellite Office (Wichita)*** is in its third quarter of providing assistance to KanCare members.
  - It has assisted approximately 224 consumers.
  - There are five active volunteers.
  - The Project Coordinator has attended two functions for outreach with a vendor booth: Health Fair in April and Butler County Aging Fair in June.
- Volunteer Applications are available on the KanCare Ombudsman webpage. www.KanCare.ks.gov/ombudsman.htm.

Data by Ombudsman's Office

Contact Method	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16
phone	415	378	462	438	862	644
email	94	82	112	83	265	191
letter	1	1	0	2	2	3
in person	0	1	5	1	0	8
online	0	0	0	0	1	0
Total	**510**	**462**	**579**	**524**	**1130**	**846**

Caller Type	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16
Provider	111	94	102	93	179	110
Consumer	366	343	426	385	866	601
MCO employee	3	3	5	3	7	4
Other	30	22	46	43	78	131
Total	**510**	**462**	**579**	**524**	**1130**	**846**

Contact Information. The average number of days it took to resolve an issue during second quarter was five.

	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16
Avg. Days to Resolve Issue	7	7	11	6	7	5
% files resolved in one day or less	54%	38%	36%	45%	50%	56%
% files closed	87%	88%	93%	83%	77%	88%

The most frequent calls regarding home- and community-based services (HCBS) waivers during the second quarter of 2016 and for all of 2015 were in regard to the physical disability waiver and the intellectual/developmental disability waiver. Occasionally more than one option can be chosen; for example when mental health or substance abuse might be included in addition to a waiver or a nursing facility.

Waiver	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16
PD	57	48	33	28	48	22
I/DD	35	25	29	28	48	27
FE	15	12	16	18	23	19
AUTISM	4	3	4	5	1	2
SED	1	7	5	4	4	0
TBI	10	9	7	9	10	3
TA	11	13	11	13	10	9
MFP	2	2	3	1	8	5
PACE	0	0	1	1	0	0
MENTAL HEALTH	5	9	7	11	8	6
SUB USE DIS	0	0	0	2	0	0
NURSING FACILITY	12	28	33	29	47	27
Other	512	320	443	391	941	739
Total	**664**	**476**	**592**	**540**	**1148**	**859**

The Issue Categories listed below reflect the last six quarters in alphabetical order. The top five issues for each quarter are highlighted. The issues that carry across many quarters are Medicaid Eligibility Issues and Other. There may be multiple issues for a member/contact.

Issues	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16
Access to Providers	3	11	1	12	7	6
Appeals, Grievances	42	33	47	26	49	42
Billing	36	40	41	30	43	39
Care Coordinators	10	8	9	8	7	3
Change MCO	8	4	10	9	15	3
Dental	7	5	1	4	4	5
Durable Medical Equipment	25	12	7	8	7	7
Guardianship Issues	5	1	2	1	0	1
HCBS Eligibility issues	11	15	24	30	45	33
HCBS General Issues	60	36	54	34	69	32
HCBS Reduction in hours of service	10	8	13	16	12	4
HCBS Waiting List issues	11	8	9	11	18	2
Housing issues	1	6	4	3	8	2
Medicaid Eligibility Issues	139	108	206	182	512	244
Medicaid Service Issues	20	24	27	21	29	20
Nursing Facility Issues	15	34	34	29	40	25
Other	130	150	141	149	332	377
Pharmacy	25	33	14	20	24	13
Questions for Conf Calls/sessions	5	2	0	1	0	0
Thank you	14	15	11	12	72	85
Transportation	12	17	8	7	6	8
Unspecified	31	12	36	21	79	38
Total	**620**	**582**	**699**	**634**	**1378**	**989**

The Resource Category below shows what resources were used to resolve an issue. If a Question/Issue is resolved, then it is answered without having to call, refer to another resource, or provide another resource for assistance. If an issue is resolved using a resource, then one of the other categories below is also usually noted to indicate which resource was accessed to find the help needed, or to which resource the member was referred, or possibly what document was provided. Often multiple resources are provided to a member/contact.

Resource Category	**Q1/15**	**Q2/15**	**Q3/15**	**Q4/15**	**Q1/16**	**Q2/16**
QUESTION/ISSUE RESOLVED	84	61	65	58	122	239
USED RESOURCES/ISSUE RESOLVED	262	234	321	296	463	394
KDHE RESOURCES	95	77	124	87	214	97
DCF RESOURCES	20	13	25	37	6	2
MCO RESOURCES	79	73	48	62	48	43
HCBS TEAM	32	43	36	29	28	21
CSP MH TEAM	0	1	0	2	1	1
OTHER KDADS RESOURCES	31	31	38	58	53	16
PROVIDED RESOURCES TO MEMBER	85	108	177	184	361	239
REFERRED TO STATE/COMMUNITY AGENCY	22	54	75	72	111	40
REFERRED TO DRC AND/OR KLS	26	16	19	5	13	7
CLOSED	14	29	60	72	198	313
Total	**750**	**740**	**988**	**962**	**1618**	**1412**

Managed Care Organization Issues: by Category, by Quarter

Highlighted are the top four- five issues for each quarter over the last six quarters for each managed care organization. The issues are sorted in alphabetical order. If there are more than four issues highlighted for a quarter, it is because there was a tie for the fourth place, so the additional issue(s) was included. There may be multiple issues for a member/contact.

Amerigroup

Issue Category - Amerigroup	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16
Access to Providers (usually Medical)	0	1	0	1	1	1
Appeals / Grievances	3	9	5	1	9	5
Billing	10	12	7	10	11	6
Care Coordinator Issues	1	3	3	3	4	1
Change MCO	2	1	4	2	1	1
Dental	2	0	0	11	0	0
Durable Medical Equipment	2	2	0	0	2	2
Guardianship	1	0	0	0	0	0
HCBS Eligibility issues	0	2	9	4	8	5
HCBS General Issues	14	12	12	3	13	3
HCBS Reduction in hours of service	0	0	5	6	6	1
HCBS Waiting List	2	2	3	2	0	0
Housing Issues	0	1	1	1	1	1
Medicaid Eligibility Issues	9	4	10	2	28	8
Medical Services	1	4	2	2	7	2
Nursing Facility Issues	2	1	5	5	2	1
Other	10	20	11	3	19	16
Pharmacy	1	4	2	1	3	1
Questions for Conference Calls/Sessions	0	0	0	4	0	0
Thank you.	0	0	1	1	6	4
Transportation	1	7	4	0	2	1
Unspecified	2	0	5	1	2	0
Total	63	85	89	63	125	59

Sunflower

Issue Category - Sunflower	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16
Access to Providers (usually Medical)	0	3	0	8	1	1
Appeals / Grievances	22	15	18	4	14	11
Billing	13	11	9	6	6	7
Care Coordinator Issues	2	3	3	2	2	1
Change MCO	3	1	3	6	3	1
Dental	1	3	0	1	1	2
Durable Medical Equipment	10	7	1	9	5	2
Guardianship	0	0	1	3	0	0
HCBS Eligibility issues	2	6	1	0	3	7
HCBS General Issues	22	9	10	0	15	9
HCBS Reduction in hours of service	4	4	4	7	0	3
HCBS Waiting List	0	0	2	1	1	0
Housing Issues	0	2	0	0	0	0
Medicaid Eligibility Issues	17	16	13	12	26	7
Medical Services	5	7	7	4	4	8
Nursing Facility Issues	3	3	3	0	3	3
Other	14	19	14	2	23	12
Pharmacy	7	16	5	2	4	1
Questions for Conference Calls/Sessions	1	0	0	0	0	0
Thank you.	4	3	5	1	7	6
Transportation	3	4	1	6	1	2
Unspecified	3	0	1	7	1	0
Total	136	132	101	81	120	83

United

Issue Category - United	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16
Access to Providers (usually Medical)	2	4	1	2	2	1
Appeals / Grievances	11	3	6	0	6	4
Billing	5	5	7	2	3	5
Care Coordinator Issues	5	2	2	9	0	0
Change MCO	2	1	1	0	3	0
Dental	2	1	0	1	1	3
Durable Medical Equipment	6	1	2	1	0	1
Guardianship	1	0	0	4	0	0
HCBS Eligibility issues	3	1	4	1	6	3
HCBS General Issues	11	6	7	3	11	5
HCBS Reduction in hours of service	4	2	2	1	2	0
HCBS Waiting List	3	0	1	0	2	1
Housing Issues	0	2	1	3	0	0
Medicaid Eligibility Issues	11	8	10	4	18	4
Medical Services	6	4	6	1	4	1
Nursing Facility Issues	4	4	4	0	2	1
Other	16	11	10	1	14	20
Pharmacy	8	6	2	0	7	2
Questions for Conference Calls/Sessions	1	0	0	1	0	0
Thank you.	2	1	0	1	5	8
Transportation	5	3	2	3	1	0
Unspecified	0	0	2	4	2	0
Total	108	65	70	42	89	59

Next Steps for Ombudsman's Office

KanCare Ombudsman Volunteer Program

- A long-term project includes creating training programs for volunteers so they can assist members one-on-one with the grievance, appeal, and/or state fair hearing process, to be started in the 4th quarter of 2016.

Safety Net Care Pool Report

Demonstration Year 4 - QE June 2016

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

Paid 04/14/2016

Medicare #	Medicaid #	Provider Name	1st Qtr Amt Paid	State General Fund 1000 *	Federal Medicaid Fund 3414
263302	100080290A	Children's Mercy Hospital	1,241,034.00	546,551.37	694,482.63
170040	100099470A	University of Kansas Hospital	3,723,103.00	1,639,654.56	2,083,448.44
		Total	**4,964,137.00**	**4,293,546.63**	**2,777,931.07**

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

Kansas Foundation for Medical Care, Inc

2947 SW Wanamaker Drive
Topeka, Kansas 66614-4193
Phone 785-273-2552
kfmc.org

August 22, 2016

Elizabeth Phelps, MPA, JD
Public Service Executive III
Kansas Department of Health & Environment
Division of Health Care Finance
900 SW Jackson St.
Topeka, KS 66612

RE: 2016 KanCare Evaluation Quarterly Report
Year 4, Quarter 2, April - June

Dear Ms. Phelps:

Enclosed is the 2016 KanCare Evaluation Quarter 2 report. If you have questions regarding this information, please contact me, jpanichello@kfmc.org.

Sincerely,

Janice D. Panichello, Ph.D., MPA
Director of Quality Review & Epidemiologist

Enclosure

Kansas Foundation for Medical Care, Inc.

2016 KanCare Evaluation

Quarterly Report

Year 4, Quarter 2, April - June

Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**August 22, 2016**
Review Team:	**Janice Panichello, PhD, MPA, Director of Quality Review & Epidemiologist**

Prepared for:

KanCare

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2016 KanCare Evaluation Quarterly Report
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August 22, 2016

Background/Objectives

The Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF), submitted the KanCare Evaluation Design to the Centers for Medicare & Medicaid Services (CMS) on 8/24/2013; it was approved by CMS on 9/11/2013 and updated in March 2015. The Kansas Foundation for Medical Care, Inc. (KFMC) is conducting the evaluation. KFMC also serves as the External Quality Review Organization (EQRO) for Kansas Medicaid managed care.

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

A subset of the annual performance measures was selected to be assessed and reported quarterly. The quarterly measures for the second quarter (Q2) CY2016 report include the following:

- Timely resolution of customer service inquiries.
- Timeliness of claims processing.
- Grievances
  - Track timely resolution of grievances.
  - Compare/track the number of access-related grievances over time, by population categories.
  - Compare/track the number of grievances related to quality over time, by population.
- Ombudsman's Office
  - Track the number and type of assistance provided by the Ombudsman's office.
  - Evaluate for trends regarding types of questions and grievances submitted to the Ombudsman's office.

KanCare healthcare services are coordinated by three managed care organizations (MCOs): Amerigroup of Kansas, Inc. (Amerigroup or AGP), Sunflower State Health Plan (Sunflower or SSHP), and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare or UHC). 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.

In CY2015, the KanCare Reporting System Automation Project was launched. This system provides central access for MCOs to upload KanCare reports. Reports are categorized as being approved or under review. State staff, MCOs, and the EQRO are able to provide comments and receive email confirmation when new reports or revised versions of reports are uploaded. For the KanCare Evaluation process, this has allowed timely access to reports and has greatly streamlined the reporting and review process.

Recommendations from the quarterly and annual KanCare Evaluation reports are also discussion items at quarterly KanCare interagency meetings that include participants from the State, the MCOs, and the EQRO.

Timely Resolution of Customer Service Inquiries

Quarterly tracking and reporting 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% of all inquiries 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 counts, cumulative counts, and percentages of member and provider inquiries resolved within two, five, eight, 15, and greater than 15 days, as well as the percentage of inquiries pending at month's end. The call center reports also provide counts of customer service inquiries by inquiry type from members and providers each month.

Current Quarter and Trend over Time

In Q2 CY2016, 99.8% of the 96,632 member customer service inquiries received by the MCOs and 99.99% of the 43,315 provider customer service inquiries were resolved within two business days (see Table 1). All three MCOs in Q2 CY2016 met contractual requirements for resolving at least 98% of customer service inquiries within five business days. Two of the three MCOs (AGP and SSHP) met the contractual requirements to resolve 100% of inquiries within 15 business days; UHC reported 39 member customer inquiries not resolved within 15 business days. In nine of the 10 previous quarters, the MCOs' reported results met or exceeded contractual requirements for timeliness of resolution of customer service inquiries. (Q4 CY2014 was the one exception due to seven inquiries not resolved within 15 business days.)

Table 1. Timeliness of Resolution of Member and Provider Customer Service Inquiries, Q2 CY2016 compared to Q2 CY2015

	Member Inquiries		Provider Inquiries	
	Q2 CY2015	Q2 CY2016	Q2 CY2015	Q2 CY2016
Number of Inquiries Received	97,594	**96,632**	46,742	**43,315**
Number of Inquiries Resolved Within 2 Business Days	97,587	**96,441**	46,742	**43,312**
Number of Inquiries Not Resolved Within 2 Business Days	7	**191**	0	**3**
Percent of Inquiries Resolved Within 2 Business Days	99.99%	**99.80%**	100%	**99.99%**
Number of Inquiries Resolved Within 5 Business Days	97,594	**96,502**	46,742	**43,315**
Number of Inquiries Not Resolved Within 5 Business Days	0	**130**	0	**0**
Percent of Inquiries Resolved Within 5 Business Days	100%	**99.87%**	100%	**100%**
Number of Inquiries Resolved Within 15 Business Days	97,594	**96,593**	46,742	**43,315**
Number of Inquiries Not Resolved Within 15 Business Days	0	**39**	0	**0**
Percent of Inquiries Resolved Within 15 Business Days	100%	**99.96%**	100%	**100%**

In Q2 CY2016, 64 of the 194 inquiries not resolved within two business days were resolved within five business days, and an additional 91 were resolved within 15 business days. Three of the inquiries not resolved within two business days were from providers; all provider inquiries were identified as resolved within five business days. During each quarter to date the two-day resolution rate exceeded 99.7%.

In comparison to Q1 CY2016, the number of member customer service inquiries decreased by about 5.9% in Q2 CY2016, primarily due to a decrease of 4,524 in the number of calls related to eligibility (see Table 2). The number of provider customer service inquiries decreased by 11.5% in Q2 CY2016 compared to Q1 CY2016, primarily due to fewer inquiries related to claim status and claim denial (see Table 3). In comparison to Q2 CY2015, the number of member customer service inquiries decreased by about 1%, and the number of provider customer service inquiries decreased by 7.3% in Q2 CY2016.

Member Customer Service Inquiries

The MCOs categorize member customer service inquiries in their monthly call center reports by 18 service inquiry categories (see Table 2). Sunflower added a category for Health Homes; the 77 grievances reported in Q2 CY2016 as related to "Health Homes" were added to the "Other" category for consistency in reporting aggregated counts and percentages for the three MCOs.

Table 2. Customer Service Inquiries from Members, Q1 CY2015 to Q2 CY2016

	CY2015				CY2016	
Member Inquiries	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
1. Benefit Inquiry – regular or VAS	20,775	19,702	18,611	18,031	21,924	**22,319**
2. Concern with access to service or care; or concern with service or care disruption	2,059	1,754	1,691	1,597	1,934	**1,716**
3. Care management or health plan program	2,309	2,976	3,008	2,882	1,597	**1,584**
4. Claim or billing question	7,107	6,983	7,383	6,396	6,416	**6,381**
5. Coordination of benefits	3,437	3,079	3,030	2,898	3,280	**2,964**
6. Disenrollment request	632	561	634	544	606	**600**
7. Eligibility inquiry	13,330	12,750	15,214	14,423	18,002	**13,478**
8. Enrollment information	2,141	2,210	2,838	2,371	3,203	**2,396**
9. Find/change PCP	15,586	13,407	12,823	11,765	12,893	**12,488**
10. Find a specialist	4,070	3,875	3,835	3,469	3,512	**3,375**
11. Assistance with scheduling an appointment	46	36	26	40	30	**47**
12. Need transportation	1,812	1,789	1,402	1,220	1,326	**1,200**
13. Order ID card	7,653	6,348	6,240	5,797	6,958	**6,453**
14. Question about letter or outbound call	1,013	898	1,175	1,319	1,322	**1,961**
15. Request member materials	1,080	1,112	1,511	1,056	1,083	**1,119**
16. Update demographic information	13,404	12,639	13,481	11,967	12,944	**13,343**
17. Member emergent or crisis call	938	834	717	661	699	**687**
18. Other	5,768	6,641	5,388	4,801	5,018	**4,491**
Total	**103,160**	**97,594**	**99,007**	**91,237**	**102,742**	**96,632**

- Of the 96,632 member customer service inquiries in Q2 CY2016, 42.2% were received by Sunflower, 39.6% by UnitedHealthcare, and 18.2% by Amerigroup.

- The number of member customer service inquiries was lower in Q2 CY2016 than in four of the previous five quarters; compared to Q1 CY2016, there were 6,110 fewer inquiries in Q2 CY2016.
- Benefit inquiries continue in Q2 to be the highest percentage (23.1%) of member inquiries.
- As in previous quarters, there are categories where two thirds or more of the inquiries in the quarter were reported by one MCO; three of the five with over 70% of the inquiries reported by one MCO for the past seven quarters. This seems likely to be due to differing interpretations of the criteria for several of the categories in the reporting template. The categories where over two thirds of the reported inquiries were from one MCO include:
  - "Member emergent or crisis call" – 99.6% of 687 inquiries in Q2 CY2016 were reported by Sunflower. (CY2016: Q1 99.7%; CY2015: Q4 – 99.4%; Q3 – 99.4%; Q2 - 99.8%; Q1 – 99.7%; CY2014: Q4 – 99.7%)
  - "Update demographic information" – 78.9% of 13,343 inquiries in Q2 CY2016 were reported by Sunflower. (CY2016: Q1 – 78.1%; CY2015: Q4 – 81.4%; Q3 – 82.1%; Q2 - 82.3%; Q1 – 82.1%; CY2014: Q4 – 71.0%)
  - "Enrollment information" – 75.8% of 2,396 inquiries were reported in Q2 CY2016 by Amerigroup. (CY2016: Q1 – 85.4%; CY2015: Q4 – 80.5%; Q3 – 76.8%; Q2 - 76.4%; Q1 CY2015 - 76.6%; CY2014: Q4 – 80.5%)
  - "Concern with access to service or care; or concern with service or care disruption" – 69.7% of 1,716 inquiries were reported in Q2 CY2016 by Sunflower.
  - "Care management or health plan program" – 82.1% of 1,584 inquiries in Q2 CY2016 were reported by Amerigroup.

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). Sunflower added a category for provider inquiries related to Health Homes; the three grievances reported in Q2 CY2016 as related "Health Homes" were added to the "Other" category for consistency in reporting aggregated counts and percentages for the three MCOs.

Similar to member inquiries, the number of provider inquiries decreased in Q2 CY2016 compared to the previous quarter and in comparison to Q2 of the previous year.

- Of the 43,315 provider inquiries received by MCOs in Q2 CY2016, Amerigroup received 38.1%, Sunflower 44.7%, and UnitedHealthcare 17.3%.
- For providers, claim status inquiries were again the highest percentage (50.1%) of the 43,315 provider inquiries.

As noted in previous quarterly reports, there are a number of categories where aggregated data primarily reflect one MCO rather than all three over time. Categories where two thirds or more of the provider inquiries in six or more quarters were reported by one MCO included:

- "Authorization – New" – 99.0% of 1,812 inquiries in Q2 CY2016 were reported by Amerigroup. (CY2016: Q1 – 99.0%; CY2015: Q4 – 98.6%, Q3– 98.0%; Q2– 99.1%; Q1– 99.1%; CY2014: Q4 – 98.1%)
- "Authorization – Status" – 67.6% of 2,373 inquiries in Q2 CY2016 were reported by Amerigroup. (CY2016: Q1 – 69.7%; CY2015: Q4 – 69.9%, Q3– 67.4%; Q2 - 71.0%; Q1 - 70.8%; CY2014: Q4 - 72.0%)
- "Update demographic information" – 95.4% of 710 inquiries were reported in Q2 CY2016 by Sunflower. (CY2016: Q1 – 95.3%; CY2015: Q4 – 93.7%, Q3 – 96.2%; Q2 - 91.4%; Q1 - 95.5%; CY2014: Q4 - 99.5%)

- "Coordination of benefits" – 77.5% of 396 inquiries were reported in Q2 CY2016 by UnitedHealthcare. (CY2016: Q1 – 73.7%; CY2015: Q4 – 87.9%, Q3– 85.5%; Q2 - 76.8%; Q1 - 90.7%; CY2014: Q4 - 91.0%)
- "Verify/Change participation status" – 77.7% of 103 inquiries in Q2 CY2016 were reported by Sunflower. (CY2016: Q1 – 71.9%; CY2015: Q4 – 72.2%, Q3 – 77.8%; Q2 - 68.1%; Q1 - 67.6%; CY2014: Q4 - 66.4%)

Table 3. Customer Service Inquiries from Providers, Q1 CY2015 to Q2 CY2016

	CY2015				CY2016	
Provider Inquiries	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
1. Authorization – New	2,351	2,369	1,880	1,759	1,942	**1,812**
2. Authorization – Status	2,456	2,417	2,323	2,594	2,773	**2,373**
3. Benefits inquiry	4,594	4,144	4,043	3,806	3,259	**3,121**
4. Claim denial inquiry	5,182	3,990	5,498	4,411	5,605	**4,423**
5. Claim status inquiry	19,457	21,314	19,898	22,399	23,613	**21,685**
6. Claim payment question/dispute	6,822	6,005	5,315	4,833	4,575	**4,142**
7. Billing inquiry	851	436	363	308	596	**389**
8. Coordination of benefits	1,167	939	792	777	373	**396**
9. Member eligibility inquiry	1,866	1,804	1,935	1,564	2,030	**1,646**
10. Recoupment or negative balance	353	243	165	91	66	**85**
11. Pharmacy/prescription inquiry	599	599	438	477	598	**529**
12. Request provider materials	31	62	62	34	71	**40**
13. Update demographic information	538	418	764	495	744	**710**
14. Verify/change participation status	272	282	441	273	345	**258**
15. Web support	197	209	252	194	182	**103**
16. Credentialing issues	163	239	208	195	231	**162**
17. Other	2,353	1,270	988	1,068	1,918	**1,441**
Total	**49,252**	**46,742**	45,365	45,278	**48,921**	**43,315**

Of the 17 categories, seven are focused on claims: "Authorization – New," "Authorization – Status," "Benefit Inquiry," "Claim Denial Inquiry," "Claim Status Inquiry," "Claim Payment Question/Dispute," and "Billing Inquiry." As shown in Table 4, the range of inquiries for these seven claims-related categories varied greatly by MCO over the last six quarters. Combining the seven claims-related inquiries, as shown in Table 5, may allow a better comparison over time overall and by MCO. Based on the combined totals for the seven claims-related categories, MCOs more clearly differed over time in the number of claims-related inquiries. Comparing Q2 CY2016 with Q2 CY2015:

- UnitedHealthcare had 4,826 fewer claims-related inquiries reported in Q2 CY2016 (6,796) than in Q2 CY2015 (11,622) and 488 fewer than the previous quarter (Q1 CY2016).
- Sunflower had an increase of 3,568 claims-related inquiries in Q2 CY2016 (16,182) compared to Q2 CY2015 (12,614), but 2,524 fewer claims-related inquiries than in Q1 CY2016.
- Amerigroup's claims-related inquiries had 1,474 fewer claims-related inquiries in Q2 CY2016 (14,967) than in Q2 CY2015 (16,441) and 1,406 fewer than in Q1 CY2016.

Table 4. Maximum and Minimum Numbers of Claims-Related Provider Inquiries by MCO, Q1 CY2015 to Q2 CY2016

	CY2015								CY2016			
	Q1		Q2		Q3		Q4		Q1		Q2	
	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min
Authorization - New	2,330	0	2,347	1	1,842	3	1,735	3	1,923	3	1,793	3
Authorization - Status	1,739	335	1,718	298	1,565	176	1,814	141	1,932	66	1,604	91
Benefits Inquiry	2,621	318	2,163	265	2,017	489	1,865	477	1,648	755	1,542	514
Claim Denial Inquiry	3,169	0	2,098	0	1,905	0	2,644	0	3,593	0	2,574	0
Claim Status Inquiry	7.09	5,941	8,399	6,273	8,209	5,174	10,466	5,720	14,458	2,473	12,825	2,751
Claim Payment Question/Dispu	4,142	990	3,303	785	2,772	669	2,404	570	2,276	293	1,955	311
Billing Inquiry	650	19	223	4	195	6	184	2	426	0	194	1

Amerigroup
Sunflower
UnitedHealthcare
Amerigroup & Sunflower

Table 5. Combined Totals of the Seven Claims-Related Provider Inquiry Categories by MCO, Q1 CY2015 to Q2 CY2016

	CY2015				CY2016	
	Q1	Q2	Q3	Q4	Q1	Q2
Amerigroup	16,035	16,441	15,433	14,974	16,373	14,967
Sunflower	11,454	12,614	12,249	14,191	18,706	16,182
UnitedHealthcare	14,224	11,622	11,638	10,945	7,284	6,796
Total	**41,713**	**40,677**	**39,320**	**40,110**	**42,363**	**37,945**

One MCO customer service manager told KFMC staff the MCO had no clear criteria to categorize member and provider customer service inquiries – they "just select what seems best" for the call. Drop-down menu options used by the MCOs do not always clearly correlate with those in the State tracking template and likely differ by MCO.

Recommendations

The State should work with the MCOs to develop consistent criteria for classifying the member and provider customer service inquiries.

Timeliness of Claims Processing

Clean claims are to be processed within 30 days, non-clean claims within 60 days, and all claims within 90 days. Clean claims received in the middle or end of a month may be processed in that month or the following month. 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.

A "clean claim" is a claim that can be paid or denied with no additional intervention required and does not include: adjusted or corrected claims; claims that require documentation (i.e., consent forms,

medical records) for processing; claims from out-of-network providers that require research and setup of that provider in the system; and 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. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Claims that are excluded from the measures include "claims submitted by providers placed on prepayment review or any other type of payment suspension or delay for potential enforcement issues" and "any claim which cannot be processed due to outstanding questions submitted to KDHE." In Table 6, the numbers of excluded claims in CY2015 are listed by quarter for each of the claim categories – clean claims, non-clean claims, and all claims.

To allow for claims lag, the KanCare Evaluation Report for Q2 CY2016 assesses timeliness of processing clean, non-clean, and all claims reports received through Q1 CY2016.

Data Sources

In monthly Claims Overview reports, MCOs report the monthly number of claims received and processed, including whether or not these claims were processed in a timely manner as defined by the type of claim and State-specified timelines.

The report also includes average turnaround time (TAT) for processing clean claims. Due to claims lag, claims processed in one month may be from that month or from a month or two prior to that month. The average TATs are compared to those from the previous quarter and during the same time period year-to-date.

Timeliness of Claims Processing by Claim Type and Date Received

The MCOs are contractually required to process 100% of clean claims within 30 days; 99% of non-clean claims within 60 days; and 100% of all claims within 90 days. In Table 6, the number and percentages of clean, non-clean, and all claims processed within these contractual time periods are summarized.

For claims received in Q1 CY2016:

- Clean claims: 99.955% of 4,380,378 clean claims received in Q1 CY2016 were reported by the MCOs as processed within 30 days.
  - In Q1 CY2016, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days.
  - In Q1 CY2016, the number of clean claims not processed within 30 days (1,956) increased slightly compared to Q4 CY2015 (1,836), but was lower than Q2 CY2015 (2,932) and Q3 CY2015 (3,507).
  - Of the 1,956 clean claims not processed within 30 days – 1,671 (85.4%) were claims received by Sunflower; 203 (10.4%) were claims received by UnitedHealthcare and 82 (4.2%) were claims received by Amerigroup.
- Non-clean claims: 99.873% of 195,584 non-clean claims received in Q1 CY2016 were reported by the MCOs as processed within 60 days.
  - In Q1 CY2016, all of the MCOs met the contractual requirement of processing at least 99% of the non-clean claims within 60 days.
  - In Q1 CY2016, the numbers and percentages of non-clean claims not processed within 60 days (249) was lower than the previous quarter (881) but higher than in Q1 to Q3 CY2015 (ranging from 29 to 203).

- Of the 249 "non-clean claims" not processed within 60 days - 131 (52.6%) were claims received by Sunflower, 116 (46.6%) were claims received by Amerigroup; and 2 (0.8%) were claims received by UnitedHealthcare.
- As indicated in Table 6, the number of "non-clean claims" excluded from the measure has increased each quarter since Q1 CY2015, ranging from 29 (0.2% of non-clean claims) in Q1 CY2015 to 2,974 (1.5% of non-clean claims) in Q1 CY2016.

- All claims: 99.997% of 4,575,699 "all claims" received in Q1 CY2016 were reported by the MCOs as processed within 90 days.
  - In Q1 CY2016, none of the MCOs met the requirement of processing 100% of claims within 90 days. Of the 147 claims not processed within 90 days – 76 (51.7%) were claims received by Sunflower; 63 (42.9%) were claims received by Amerigroup; and 8 (0.5%) were claims received by UnitedHealthcare.
  - In Q1 CY2016, the number of "all claims" not processed within 90 days (147) was lower than Q4 CY2015 (307) and Q2 CY2015 (254), but higher than in Q1 CY2015 (79) and Q3 CY2015 (60).

Table 6. Timeliness of Claims Processing Q1 CY2015 to Q1 CY2016

	CY2015				CY2016
	Q1	Q2	Q3	Q4	Q1
Clean Claims					
Number of clean claims received in quarter	4,286,318	4,289,698	4,293,070	4,265,406	**4,380,378**
Number of claims excluded	0	149	332	2,269	**263**
Number of clean claims not excluded	4,286,318	4,289,549	4,292,738	4,263,137	**4,380,115**
Number of clean claims received within quarter processed within 30 days	4,285,468	4,286,617	4,289,231	4,261,301	**4,378,159**
Number of clean claims received within quarter **not** processed within 30 days	850	2,932	3,507	1,836	**1,956**
Percent of clean claims processed within 30 days	**99.980%**	**99.932%**	**99.918%**	**99.957%**	**99.955%**
Non-Clean Claims					
Number of non-clean claims received in quarter	180,925	164,617	150,266	176,809	**198,558**
Number of claims excluded	352	306	1,310	1,849	**2,974**
Number of non-claims not excluded	180,573	164,311	148,956	174,960	**195,584**
Number of non-clean claims received within quarter processed within 60 days	180,544	164,251	148,753	174,079	**195,335**
Number of non-clean claims received within quarter **not** processed within 60 days	29	60	203	881	**249**
Percent of non-clean claims processed within 60 days	**99.984%**	**99.963%**	**99.864%**	**99.496%**	**99.873%**
All Claims					
Number of claims received in quarter	4,467,243	4,454,315	4,443,336	4,442,215	**4,578,936**
Number of claims excluded	352	455	1,642	4,118	**3,237**
Number of claims not excluded	4,466,891	4,453,860	4,441,694	4,438,097	**4,575,699**
Number of claims received within quarter processed within 90 days	4,466,812	4,453,606	4,441,634	4,437,802	**4,575,552**
Number of claims received within quarter **not** processed within 90 days	79	254	60	307	**147**
Percent of claims processed within 90 days	**99.998%**	**99.994%**	**99.999%**	**99.993%**	**99.997%**

Average Turnaround Time for Processing Clean Claims

As indicated in Table 7, the MCOs reported 4,315,854 clean claims processed in Q2 CY2016 (includes claims received prior to Q2). Excluding pharmacy claims (which are processed same day) there were 2,622,624 claims, 24,079 fewer claims processed in Q2 CY2016 compared to Q1 CY2016, and 123,852 fewer clean claims (excluding pharmacy claims) processed in Q2 CY2016 compared to Q2 CY2015.

The average TAT for Total Services (excluding pharmacy claims processed same day) was 5.2 to 9.1 days in Q2 CY2016, compared with 5.3 to 10.0 days in Q1 CY2016 and 5.3 to 10.2 days in Q2 CY2015.

Table 7. Average Monthly Turnaround Time (TAT) Ranges for Processing Clean Claims, by Service Category

	CY2016		Average TAT Monthly Ranges by Year (CY2014 & CY2015)	
Service Category	**Q1**	**Q2**	**CY2014**	**CY2015**
Hospital Inpatient	8.1 to 15.1	**7.1 to 12.4**	5 to 19.2	6.4 to 15.9
Hospital Outpatient	4.8 to 10.5	**4.3 to 9.5**	3.6 to 12.8	3.5 to 10.8
Pharmacy	same day	**same day**	same day	same day
Dental	7.0 to 13.0	**7.0 to 13.0**	2 to 21	4 to 13.1
Vision	9.0 to 12.7	**7.0 to 12.0**	7 to 12.5	9 to 12.5
Non-Emergency Transportation	9.0 to 14.0	**9.5 to 14.4**	10.9 to 18	10.4 to 16
Medical (Physical health not otherwise specified)	4.4 to 9.9	**4.4 to 8.9**	3.3 to 10.6	3.4 to 10.5
Nursing Facilities	5.6 to 9.0	**4.7 to 9.0**	4.3 to 11.5	4.1 to 9.7
HCBS	5.8 to 9.7	**6.0 to 8.7**	3.2 to 15.6	4.1 to 10.2
Behavioral Health	4.2 to 10.3	**4.2 to 9.3**	3.4 to 8.6	2.7 to 10.5
Total Claims (Including Pharmacy)	4,409,846	**4,315,854**	16,763,501	17,820,402
Total Claims (Excluding Pharmacy)	2,646,703	**2,622,624**	10,370,998	10,999,807
Average TAT (Excluding Pharmacy)	5.3 to 10.0	**5.2 to 9.1**	4.3 to 11.5	4.3 to 10.3

It should be noted that the average TAT monthly ranges reported in Table 7 only include clean claims processed by the MCOs and do not include clean claims received but not yet processed. Also, the average TATs reported for "Total Claims" are weighted averages calculated after excluding pharmacy claims, as pharmacy claims for each of the MCOs are processed "same day."

The average TAT for processing clean claims for individual service types again varied by service type and by MCO.

- Pharmacy - Clean pharmacy claims had the shortest turnaround times and were consistently processed on a same day basis by each of the three MCOs.
- Hospital Inpatient – Hospital Inpatient claims had TATs in Q2 CY2016 ranging from 7.1 to 12.4 days, a decrease compared to Q1 CY2016 (8.1 to 15.1 days). Amerigroup had the shortest TATs in Q2 (7.1 to 8.3 days; compared to 8.1 to 8.9 days in Q1); Sunflower had the highest TATs (11.6 to 12.4 days), which represented, however, an improvement compared to Q1 CY2016 (13.4 to 15.1).
- Dental - Dental claims TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 7.0 to 13.0 days in Q2 CY2016 and Q1 CY2016. Sunflower had the

shortest TATs each month (7.0 days); Amerigroup and UnitedHealthcare had TATs of 13.0 days for each month in Q2 CY2016, Q1 CY2016, and Q4 CY2015.

- Non-emergency transportation (NEMT) - Clean claims for NEMT had longer TATs for all MCOs, with monthly average TATs ranging from 9.5 to 14.4 days, compared to 9.0 to 16.9 days in Q1 CY2016. Amerigroup had the longest TATs in Q2, ranging from 13.4 to 14.4 days, compared to 9.6 to 9.9 for Sunflower and 9.5 to 10.0 for UnitedHealthcare.
- Vision – The average TATs were consistently a week or longer in Q2 and previous quarters for all of the MCOs. In Q2 CY2016, the average monthly TATs ranged from 7.0 to 12.0 days, compared to 7.0 to 12.7 in Q1.
- Nursing Facilities – Nursing Facility claims had TATs ranging from 4.7 to 9.0 days, comparable to 4.9 to 9.0 days in Q1 CY2016.
- HCBS – HCBS claims had TATs ranging from 6.0 to8.7 days in Q2, which is a decrease compared to Q1 (6.5 to 9.7 days).
- Behavioral Health (BH) – BH claims TATs ranged from 4.2 to 9.3 days in Q2 CY2016, compared to 4.2 to 10.3 days in Q1. Amerigroup had the shortest TATs (4.2 to 4.9 days), compared to Sunflower (8.4 to 9.3 days) and UnitedHealthcare (8.7 to 9.1 days).

Recommendation

MCOs should continue to work to reduce the turnaround times for clean claims, particularly for processing claims where other MCOs have much lower average monthly turnaround times.

Grievances

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

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

- The Special Terms and Conditions (STC) Quarterly Report tracks the number of grievances received in the quarter, the total number of the grievances received in the quarter that were resolved, and counts of grievances by category type. The report includes space for MCOs to provide a brief summary for each of these types of grievances of trends and any actions taken to prevent recurrence.
- The Grievance and Appeal (GAR) report tracks the number of grievances received in the quarter, the number of grievances closed in the quarter, the number of grievances resolved within 30 business days, and the number of grievances resolved within 60 business days. The GAR report also provides detailed descriptions of each of grievance resolved, including narratives of grievance description and resolution, category type, date received, Medicaid ID, waiver type, and number of business days to resolve.

Data Sources

Timeliness of resolution of grievances is reported by each MCO in the quarterly GAR report described above. The number of grievances received and resolved each quarter is also reported in the STC quarterly report.

Beginning in Q2 CY2016, grievances and appeals are to be reported using updated categories. KDHE staff provided training to MCO staff to clarify criteria for each category and provided more detailed grievance

and appeal criteria definitions and examples in the reporting template to promote more accurate and consistent reporting. A number of categories (including "Criteria Not Met – DME," "Criteria Not Met – Medical Procedure," and "Level of Care Dispute") are now to be tracked as "appeals" instead of "grievances."

Track Timely Resolution of Grievances

Quarterly tracking and reporting of timely resolution of grievances in the KanCare Evaluation is based on the MCOs' contractual requirements to resolve 98% of all grievances within 30 business days and 100% of all grievances within 60 business days (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 equal the number of grievances "resolved" during the quarter.

Current Quarter Compared to Previous Quarters

As shown in Table 8, 99.5% (421) of the 423 grievances reported by the MCOs as closed in Q2 CY2016 were reported as resolved within 30 business days.

- Amerigroup reported 113 (100%) of 113 grievances closed in Q2 were resolved within 30 business days.
- Sunflower reported 127 (98.4%) of 129 grievances closed in Q2 were resolved within 30 business days. The two grievances not resolved within 30 business days were resolved within 60 business days.
- UnitedHealthcare reported that 181 (100%) of 181 grievances closed in Q2 were resolved within 30 business days.

Table 8. Timeliness of Resolution of Grievances, Q2 CY2016 and Year-to-Date (Q1-Q2) CY2013 to CY2016

	Q2	Year-to-date (Q1-Q2) CY2013-CY2016			
	CY2016	CY2013	CY2014	CY2015	CY2016
Number of Grievances Received in Quarter	**420**	941	999	1,175	**871**
Number of Grievances Closed in Quarter*	**423**	884	1,008	1,161	**855**
Number of Grievances Closed in Quarter Resolved within 30 Business Days*	**421**	884	989	1,133	**852**
Percent of Grievances Closed in Quarter Resolved within 30 Business Days	**99.5%**	100%	98.1%	97.6%	**99.6%**
Number of Grievances in Quarter Not Resolved within 30 Business Days	**2**	0	19	28	**3**
Number of Grievances Closed in Quarter Resolved within 60 Business Days*	**423**	884	1,001	1,153	**854**
Percent of Grievances Closed in Quarter Resolved within 60 Business Days	**100%**	100%	99.3%	99.3%	**99.9%**
Number of Grievances Closed in Quarter Not Resolved within 60 Business Days*	**0**	0	7	8	**1**

*The number of grievances closed in the quarter and the number and percent of grievances resolved in the quarter include grievances received in the previous quarter.

In Q2 CY2016, the number of grievances received (420) was lower than the number received in the previous nine quarters. The lower number of grievances this quarter may be due in part to the revisions in the grievance and appeal categories implemented in Q2 GAR reports, as several categories previously reported as grievances are not more accurately reported as "appeals."

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

All Grievances

The STC and GAR reports each have lists of specific grievance categories that have only a few categories with similar category names. The STC report includes 11 grievance categories, and the revised GAR Reason Summary Table has 13 categories (see Table 9).

Table 9. Grievance Categories - STC and GAR Reports

STC Categories	GAR Report Categories
Claims/Billing Issues	Billing and Financial Issues
Access to Service or Care	Access to Service or Care
Quality of Care or Service	Quality of Care (non-HCBS)
	Quality of Care - HCBS
Customer Service	Customer Service
Transportation	Transportation Issue
	Transportation Safety
	Transportation No Show
	Transportation Late
Other	Other
Member Rights/Dignity	Member's Rights/Dignity
	Pharmacy Issues
	Value-Added Benefit
Benefit Denial or LImitation	
Clinical/Utilization Management	
Health Plan Administration	
Service or Care Disruption	

- Five categories are the same in both reports – "Access to Service or Care," "Customer Service," "Member Rights/Dignity," "Transportation" (four subcategories in the GAR report), and "Other."
- Two categories in the GAR Report not in the STC report are "Pharmacy Issues" and "Value-Added Benefit."
- Four categories in the STC report not in the GAR report are "Benefit Denial or Limitation," "Service or Care Disruption," "Clinical/Utilization Management," and "Health Plan Administration."
- Two categories with similar wording, but that may be interpreted differently, include:
  - "Claims/Billing Issues" (STC) and "Billing and Financial Issues" (GAR) – "Claims/Billing Issues" may potentially be misinterpreted to include appeals related to claims; and
  - "Quality of Care or Service" (STC) and "Quality of Care - non-HCBS" and "Quality of Care – HCBS" (GAR) – In past GAR reports, "Quality of Service" has included a wide range of grievances – from not receiving a value-added rewards card timely to reports of perceived malpractice.

Using the same categories in both reports and/or providing guidance, criteria, and examples for the STC report categories would promote consistency and allow more complete assessment of grievances received and resolved over time. The STC categories should also be reviewed to assess whether any of

the categories (such as "Benefit Denial or Limitation" or "Service or Care Disruption") may be appeals rather than grievances.

In the STC and GAR reports, MCOs reported they received 420 grievances in Q2 CY2016. In the STC report, the MCOs reported that 357 of the 420 were resolved within the quarter. The total number of grievances described in the STC Q2 report (see Table 10) add up to 375 due to misinterpretations by the MCOs of what grievances should be included in the narrative – Amerigroup resolved 97 of 115 grievances received in Q2 and categorized the 115 grievances **received**; Sunflower resolved 94 of 128 grievances received in Q2 and categorized the 94 grievances **resolved**, as did UnitedHealthcare, who categorized 166 resolved grievances of the 177 resolved in Q2.

Table 10. Number of Grievances in STC Reports by Category , Q1 CY2015 to Q2 CY2016*

	CY2015				CY2016	
	Q1	Q2	Q3	Q4	Q1	Q2
Transportation	251	245	192	182	176	**125**
Claims/Billing Issues	217	56	44	62	90	**86**
Quality of Care or Service	53	40	57	22	36	**34**
Access to Service or Care	34	33	35	42	44	**34**
Health Plan Administration	13	19	11	9	16	**10**
Customer Service	49	67	36	42	27	**30**
Member Rights/Dignity	14	15	17	13	12	**17**
Benefit Denial or LImitation	24	10	12	8	10	**8**
Service or Care Disruption	6	4	3	6	14	**7**
Clinical/Utilization Management	4	2	0	2	5	**1**
Other	2	27	20	16	12	**23**
Total Grievances	**667**	**480**	**427**	**404**	**442**	**375**

*As reported by MCOs in STC reports.

Table 11 summarizes the numbers and categories of grievances resolved in Q2 CY2016 as reported in the GAR reports and illustrates the revisions in grievance categories beginning in Q2.

Whereas in previous quarterly GAR reports, transportation-related grievances were categorized as "Timeliness," "Availability," "Attitude/Service of Staff," Quality of Care or Service," "Other," "Lack of Information from Provider," "Accessibility of Office," and "Level of Care," the revised GAR template has specifically defined transportation categories: "Transportation – No Show," "Transportation – Safety," "Transportation – Late," and "Transportation Issues" (defined as transportation issues not related to the other specific transportation categories). Adding these transportation categories to the GAR report will allow better comparisons with STC reports and promote better consistency in MCO reporting. The revised categories also allow better tracking of progress is addressing specific transportation-related grievances; progress in tracking and addressing grievances related to transportation safety and "no shows," for example, can now be tracked much more closely.

Transportation-related grievances continued to be the most frequently reported grievances with 79 members reporting 122 grievances (28.8% of 423 resolved) from 115 members in Q2 CY2016; 53 of the transportation-related grievances (43.4%) were reported by UnitedHealthcare, 48 (39.3%) by Amerigroup, and 21 (17.2%) by Sunflower. Billing-related grievances continued to be the second most

frequently reported grievances, with 79 members reporting 108 grievances; 68 of the grievances (63.6%) were reported by UnitedHealthcare, 22 (20.6%) by Amerigroup, and 17 (15.9%) by Sunflower.

Table 11. Comparison of Grievances Resolved, Q1 CY2015 to Q2 CY2016*

	CY2015				CY2016	
	Q1	Q2	Q3	Q4	Q1	Q2
Billing and Financial Issues						108
Claims/Billing Issues	227	86	63	77	97	
Quality of Care - non-HCBS						42
Quality of Care - HCBS						11
Quality of Care or Service	40	56	96	71	65	
Attitude/Service of Staff	116	144	138	120	108	
Customer Service						41
Member's Rights/Dignity						14
Access to Service or Care						50
Pharmacy Issues	9	10	3	11	9	20
Other	23	33	35	33	17	9
Value-added Benefit						6
Transportation - Late						22
Transportation - No Show						39
Transportation - Safety						14
Transportation - Other Issues						47
Availability	83	99	82	83	79	
Timeliness	86	83	24	26	31	
Lack of Information from Provider	3	5	5	2	2	
Level of Care Dispute	5	4	2	8	4	
Prior or Post Authorization	5	3	7	6	1	
Accessibility of Office	3	1	1	2	4	
Criteria Not Met - Medical Procedure	6	6	2	1	2	
Criteria Not Met - Durable Medical Equipment	2	2	1	-	2	
Criteria Not Met - Inpatient Hospitalization	2	-	1	-	-	
HCBS	12	-	7	3	-	
Sleep Studies	-	-	1	-	-	
Sterilization	-	1	1	1	-	
Overpayments	-	-	-	-	1	
Quality of Office, Building	-	-	-	1	-	
"AOR"	13	9	7	12	10	
Total	635	542	542	457	432	423

* As reported in quarterly grievance (GAR) reports.

Despite the revised categories and the addition by KDHE of criteria descriptions and examples by category, KFMC found a number of grievances that, as described in the GAR report, were misclassified. For purposes of this report, 14 grievances that were clearly misclassified, based on the descriptions of the grievance and grievance resolution descriptions in the GAR report, were categorized as defined in the report definition criteria. This included three grievances related to value-added benefits classified as "Access to Service or Care" and "Quality of Care"; one transportation-related grievance classified as "Member Rights/Dignity"; two transportation safety grievances categorized as "Quality of Care (non-HCBS)," and "Other"; two QOC-related grievances categorized as "Transportation Issues" and "Pharmacy Issues"; one billing-related grievance categorized as "Other"; one access-related grievance categorized as QOC; and four grievances related to "Customer Service" classified as QOC.

The descriptions UnitedHealthcare provided for most grievances were, as in previous GAR reports, very limited and/or cut off mid-sentence, making it difficult or impossible to determine whether the grievances are categorized appropriately. Of 181 grievances, 146 resolution descriptions were limited to, "*Upon review of the grievance, a decision was made to send resolution letter"; 12 were limited to, "Upon review of the grievance, a decision was made to respond to member"; and two had no resolution description.*

Table 12 reports the types of grievances resolved in Q2 CY2016 in total and by waiver, the number of members reporting grievances, and the number of transportation-related grievances. In Table 13 waiver-related grievances are reported by quarter, Q1 CY2015 to Q2 CY2016.

Table 12. Comparison by Waiver for Grievances Resolved in Quarter 2 CY2016*

	All members		Waiver members		Number of Grievances by Waiver Type					
	# grievances	# members	# grievances	# members	FE	I/DD	PD	SED	TA	TBI
Billing and Financial Issues	108	79	48	22	33	2	10		1	2
Access to Service or Care	50	39	28	17	1	2	13			12
Quality of Care (non-HCBS)	42	39	11	11	1	1	5	2		2
Quality of Care - HCBS	11	11	10	9	2		4	1		3
Customer Service	41	40	12	11	1	2	9			
Pharmacy Issues	20	20	5	5	1	2	2			
Member's Rights/Dignity	14	9	9	4			1			8
Value-Added Benefit	6	6	3	3	1		1			1
Transportation Issue	47	42	17	14		1	13	1		2
Transportation Safety	14	14	7	7	3		3			1
Transportation No Show	39	38	12	11	5		6			1
Transportation Late	22	21	10	10	4		4	1		1
Other	9	9	2	2		1		1		
Total Grievances Resolved Q4	423	367	174	126	52	11	71	6	1	33
Transportation-Related	122	115	46	42	12	1	26	2	0	5

*Includes grievances received in Quarter 1 CY2016 resolved in Quarter 2 CY2016

Table 13. Waiver-Related Grievances Resolved by Quarter*	CY2015				CY2016	
Physical Disability (PD) Waiver	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Number of Grievances	98	58	69	51	60	**71**
Number of Members Reporting Grievances	94	54	62	44	55	**66**
Number of Transportation-Related Grievances	58	39	29	22	22	**26**
% Transportation-Related Grievances	59.2%	67.2%	42.0%	43.1%	36.7%	**36.6%**
Frail Elderly (FE) Waiver	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Number of Grievances	31	24	34	20	15	**52**
Number of Members Reporting Grievances	26	23	26	18	13	**24**
Number of Transportation-Related Grievances	14	10	24	11	4	**12**
% Transportation-Related Grievances	45.2%	41.7%	70.6%	55.0%	26.7%	**23.1%**
Intellectual/Developmental Disability (I/DD) Waiver	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Number of Grievances	17	16	11	14	15	**11**
Number of Members Reporting Grievances	17	16	11	13	15	**11**
Number of Transportation-Related Grievances	4	4	3	4	5	**1**
% Transportation-Related Grievances	23.5%	25.0%	27.3%	28.6%	33.3%	**9.1%**
Traumatic Brain Injury (TBI) Waiver	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Number of Grievances	11	9	16	19	12	**33**
Number of Members Reporting Grievances	11	9	11	14	8	**18**
Number of Transportation-Related Grievances	5	3	3	7	6	**5**
% Transportation-Related Grievances	45.5%	33.3%	18.8%	36.8%	50.0%	**15.2%**
Technology Assisted (TA) Waiver	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Number of Grievances	6	4	2	6	-	**1**
Number of Members Reporting Grievances	5	4	2	5	-	**1**
Number of Transportation-Related Grievances	1	2	1	4	-	**0**
% Transportation-Related Grievances	16.7%	50.0%	50.0%	66.7%	-	**0.0%**
Serious Emotional Disturbance (SED) Waiver	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Number of Grievances	6	6	3	5	5	**6**
Number of Members Reporting Grievances	6	6	3	5	4	**6**
Number of Transportation-Related Grievances	2	1	1	1	0	**2**
% Transportation-Related Grievances	33.3%	16.7%	33.3%	20.0%	0.0%	**33.3%**
Total (Waiver-Related)	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Number of Grievances	170	118	135	115	107	**174**
Number of Members Reporting Grievances	160	113	112	99	95	**126**
Number of Transportation-Related Grievances	84	59	61	52	37	**46**
% Transportation-Related Grievances	49.4%	50.0%	45.2%	45.2%	34.6%	**26.4%**
All Grievances (Waiver and Non-Waiver)	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Number of Grievances	630	525	474	457	432	**423**
Number of Members Reporting Grievances	589	479	444	412	399	**367**
Number of Transportation-Related Grievances	218	271	213	206	173	**122**
% Transportation-Related Grievances	34.6%	51.6%	44.9%	45.1%	40.0%	**28.8%**

*The number of grievances resolved in the quarter includes grievances received in the previous quarter.

As shown in Table 13, the number of all grievances, the number and percentage of members reporting grievances, and the number and percentage of transportation-related grievances have been decreasing each quarter, with the lowest numbers and percentages reported in Q2 CY2016. The number and percentage of waiver-related grievances and the number of waiver members reporting grievances, however, were higher in Q2 CY2016 than in the previous five quarters. Of 423 grievances resolved in Q2 CY2016 reported by 367 members, 174 (41.1%) were from 126 members receiving waiver services.

Of the 174 grievances received from 126 waiver members in Q2 CY2016, 46 (26.4%) were transportation-related. In CY2015, 47.6% of 538 waiver-related grievances were transportation related.

- Physical Disability (PD) waiver members had the most grievances in Q2, with 66 members reporting 71 grievances, 26 (36.6%) transportation-related. In Q1 CY2016, 55 PD waiver members reported 60 grievances, 22 (36.7%) transportation-related.
- Frail Elderly (FE) waiver members reported 52 grievances (24 members), 12 (23.1%) transportation-related. In Q1 CY2016, 15 grievances were reported by 13 members, four (26.7%) transportation-related.
- Intellectual/Developmental Disability (I/DD) waiver members in Q2 reported 11 grievances (11 members), one (9.1%) transportation-related. In Q1 CY2016, 15 members reported 15 grievances, five (33.3%) transportation-related.
- Traumatic Brain Injury (TBI) waiver members reported 33 grievances (18 members), five (15.2%) transportation-related. In Q1 CY2016, eight members reported 12 grievances, six (50.0%) transportation-related.
- Serious Emotional Disturbance (SED) waiver members reported six grievances (six members) in Q2, two that were transportation-related. In Q1 CY2016, four members reported five grievances, none transportation-related.
- One Technical Assistance (TA) waiver member reported a grievance in Q2 CY2016 related to Billing and Financial Issues.

Access-Related Grievances

Of 375 grievances categorized in the STC report as received in Q2 CY2016, 34 (9.1%) were categorized as "Access to Service or Care" (see Table 10); and, of the 423 grievances resolved in Q2 CY2016, 50 (11.8%) were categorized in the GAR report as "Access to Service or Care" (see Table 11).

Until this quarter there was no specific "Access to Service or Care" grievance category in the GAR report, which made it difficult to compare quarterly changes in the number of access-related grievances resolved. In Q1 CY2016, for example, 44 grievances identified in the STC report as "Access to Service or Care" could potentially have been categorized in the GAR report (based on grievance descriptions) as "Accessibility of Office," "Availability," "Quality of Care," "Level of Care Dispute," "Attitude/Service of Staff," and/or "Timeliness." Adding the "Access to Service or Care" this quarter will allow much more consistent and accurate trend assessments of access-related grievances.

In the STC report, MCOs are asked to "insert a brief summary of trends and any actions taken to prevent recurrence."

- Amerigroup reported seven access-related grievances received in Q2 CY2016. As in previous STC reports, these were described as follows: "*Members had difficulty or were unable to obtain services or supplies. Plan continues to monitor grievances filed for Access to Service or Care for possible quality of care issues and repeat providers. Plan provider relations staff continues to monitor our network to identify service gaps and work with providers to contract with Amerigroup to perform key services for our members*."

- Sunflower reported 18 access-related grievances received in Q2. In the STC trend summary, as in previous quarters, Sunflower reported, *"There are no trends identified in this area in this quarter."*
- UnitedHealthcare reported nine access-related grievances received in Q2. These were described in this quarter's STC report and the two previous quarterly STC reports as, "*Service or care disruptions are tracked and trended monthly. Grievances related to service or care disruption this quarter occurred due to members having difficulty obtaining services from providers."* It should be noted that UHC included this same wording for the "Service or Care Disruption" category that follows the "Access to Service or Care" category in the STC report.

Sunflower categorized 43 grievances this quarter as "Access to Service or Care"; two of these, however, were specifically related to Safelink, one of Sunflower's value-added benefits. For purposes of this report, these two grievances were categorized in this report instead as "Value-added Benefits" grievances. The 41 remaining "Access to Service or Care" Sunflower grievances were 82% of the total number of grievances in this category.

Of the 50 grievances from 39 members reported in the GAR report as "Access to Service or Care" in Q2 CY2016, 28 grievances (56% of the 50 grievances) were from 17 members (43.5% of the 39 members) receiving waiver services, including: three members receiving TBI waiver services (12 grievances), 11 members receiving PD waiver services (13 grievances), two members receiving I/DD waiver services, and one member receiving FE waiver services.

Quality-Related Grievances

In Q2 CY2016, 34 (9.1%) of 375 grievances received were categorized in the STC report as being related to "Quality of Care or Service" (QOC). In the GAR report, 53 (12.5%) of 423 grievances reported as resolved in Q2 were categorized as QOC, 42 as "Quality of Care (non-HCBS)" and 11 "Quality of Care - HCBS.

In prior quarterly reports, grievances related to transportation and customer service were often categorized as QOC. In Q1CY2016, for example, 38% (25) of the 65 QOC grievances were transportation-related. The revised GAR grievance categories, criteria, and examples provided by KDHE now track all transportation-related grievances separately, add a category for customer service, and allow separate tracking of QOC grievances related to HCBS.

In the STC report, MCOs are asked to "insert a brief summary of trends and any actions taken to prevent recurrence."

- UnitedHealthcare did not provide descriptions of the nine QOC grievances received in Q2. As in previous STC reports, they included the following language: "*Quality of Service or Care issues represented a wide variety of issues from unprofessional behavior to allegations of misdiagnosis. Provider relations advocates work together with facilities and physicians offices to ensure member satisfaction and quality care is being provided. Quality of care grievances go through the MCOs confidential peer review process.*"
- Amerigroup reported 17 QOC grievances and that "2 of the 17 *were referred to Quality Management for a Quality of Care Investigation*." As in previous STC reports, Amerigroup summarized this quarter's grievance with the following language: "*Members felt they received inappropriate treatment from their treating provider*. *These issues were monitored by Quality Management Nurses as potential Quality of Care concerns. Plan continues to monitor providers and concerns for possible trends. Concerns that were investigated and substantiated were elevated to the medical director who followed up with providers on corrective action."*

- Sunflower reported eight QOC grievances received in Q2, and that, "*There are no trends identified in this area in this quarter.*"

Of the 53 QOC-related grievances reported (by 50 members) in the GAR report as resolved in Q2 CY2016, 21 were from 20 members receiving waiver services, including:

- 11 QOC (non-HCBS) grievances from 11 members – five PD waiver members, two TBI waiver members, two SED waiver members, one FE waiver member, and one I/DD waiver member; and
- 10 HCBS-related QOC grievances from 10 members – four PD waiver members, three TBI waiver members, one FE waiver member (two grievances), and one SED waiver member.

In reviewing the descriptions of resolved grievances in the three MCOs' GAR reports for Q2, KFMC found at least seven grievances categorized as QOC that would, based on the category criteria, be better categorized as "Customer Service" (four UHC grievances), "Access to Service or Care" (one UHC grievance), "Transportation – Safety" (one SSHP grievance), and "Value-added Benefit" (one SSHP grievance). One SSHP grievance related to bed sores while in the hospital was mistakenly categorized as "Transportation Issues." Due to the limited information and cut-off text descriptions of UHC grievance and resolution descriptions, it is not possible to assess whether grievances categorized by UnitedHealthcare are or are not related to QOC.

Recommendations

- MCOs should, as directed by the instructions for the STC reports, "insert a brief summary of trends and any actions taken to prevent recurrence" for specific grievances and trends rather than repeating standard language each quarter.
- UnitedHealthcare should provide more detailed descriptions of the grievances resolved each quarter and should ensure that text descriptions are not cut off mid-sentence. Resolution details should not be limited to verification that a letter of resolution was sent.
- MCOs should ensure details on resolution of grievances in the GAR report are provided for each grievance. State staff should review the GAR report and request additional details be provided where resolution details are blank or do not include enough detail to determine grievance resolution.
- MCOs should ensure their staff categorizes grievances using the revised categories and criteria. MCOs should contact KDHE staff to request clarification for any grievance or appeals categories where criteria are not clearly understood.

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 Q2CY2016 is the quarterly KanCare Ombudsman Update report.

Current Quarter and Trend over Time

The Ombudsman Office staff includes the Ombudsman, a part-time assistant, and a full-time volunteer coordinator.

The volunteer coordinator's responsibilities include recruitment of volunteers statewide to provide information and assistance to KanCare members, and referral as needed, to the Ombudsman or other State agency staff through the KanCare Ombudsman Volunteer Program. Recruitment of volunteers began in June 2015. The volunteer training includes three days of on-line training and two days of in-person training that include case studies and practice. Volunteers then receive three weeks of in-person mentoring by the Ombudsman and program coordinator. As of Q2 CY2016, the Wichita volunteer office had five active volunteers and provided assistance to over 223 individuals. A second satellite office opened in July in Johnson County; the Ombudsman's Office reported that two volunteers had completed training, and additional volunteer training was scheduled to begin in August 2016.

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

In Q1 CY2016, the number of contacts to the Ombudsman's office more than doubled; in Q1 there were 1,130 total contacts, compared with 462 to 579 in the previous eight quarters, primarily due to requests for assistance related to Medicaid eligibility (see Table 14). In Q2 CY2016, the number of contacts dropped by 25% to 846, but was over 54% higher than in the previous eight quarters. In Q1 CY2016, 22.1% (250 of 1,130) of the contacts were MCO-related, compared to 17.7% (150 of 846) in Q2 CY2016.

Table 14. Ombudsman's Office Contacts - Total and MCO-Related

CY2016			
	All Contacts	MCO-Related Contacts	% MCO-Related Contacts
Q1	1,130	250	22.1%
Q2	846	150	17.7%
CY2015			
	All Contacts	MCO-Related Contacts	% MCO-Related Contacts
Q1	510	224	43.9%
Q2	462	208	45.0%
Q3	579	187	32.3%
Q4	524	139	26.5%
CY2014			
	All Contacts	MCO-Related Contacts	% MCO-Related Contacts
Q1	545	214	39.3%
Q2	474	210	44.3%
Q3	526	256	48.7%
Q4	547	210	38.4%

Since some contacts include more than one issue, the Ombudsman's Office tracks the number of certain issues addressed during contacts. Table 15 includes the counts of issue types, comparing Q2 CY2016 with Q1CY2016. Two of the top three issues in Q1 and Q2 CY2016 were the same –"Medicaid Eligibility Issues" and HCBS-related issues. In Q2 CY2016, however, there were 71 HCBS-related issues compared to 144 in Q1 CY2016. The number of "Medicaid Eligibility Issues" also dropped from 512 in Q1 CY2016 to 244 in Q2 CY2016.

Table 15. Issues Submitted to Ombudsman's Office - All and MCO-Related, Q1 to Q2 CY2016

	Q1 CY2016				Q2 CY2016			
	All Sources		MCO-Related		All Sources		MCO-Related	
	#	% of 895	#	% of 895	#	% of 470	#	% of 470
Medicaid Eligibility Issues	512	57.2%	72	8.0%	244	51.9%	19	4.0%
Appeals, Grievances	49	5.5%	29	3.2%	42	8.9%	20	4.3%
Medical Service Issues	29	3.2%	15	1.7%	20	4.3%	11	2.3%
Billing	43	4.8%	20	2.2%	39	8.3%	18	3.8%
Durable Medical Equipment	7	0.8%	7	0.8%	7	1.5%	5	1.1%
Pharmacy	24	2.7%	14	1.6%	13	2.8%	4	0.9%
HCBS						0.0%		0.0%
HCBS General Issues	69	7.7%	39	4.4%	32	6.8%	17	3.6%
HCBS Eligibility Issues	45	5.0%	17	1.9%	33	7.0%	15	3.2%
HCBS Reduction in Hours of Service	12	1.3%	8	0.9%	4	0.9%	4	0.9%
HCBS Waiting List	18	2.0%	3	0.3%	2	0.4%	1	0.2%
Care Coordinator Issues	7	0.8%	6	0.7%	3	0.6%	2	0.4%
Transportation	6	0.7%	4	0.4%	8	1.7%	3	0.6%
Nursing Facility Issues	40	4.5%	7	0.8%	7	1.5%	5	1.1%
Housing Issues	8	0.9%	1	0.1%	2	0.4%	1	0.2%
Change MCO	15	1.7%	7	0.8%	3	0.6%	2	0.4%
Dental	4	0.4%	2	0.2%	5	1.1%	5	1.1%
Access to Providers	7	0.8%	4	0%	6	1.3%	3	0.6%
Total Issues	895		285	31.8%	470		135	28.7%

Beginning in Q3 CY2014, due to improvements in the tracking system, the Ombudsman's Office began reporting contact issues by waiver-related type as well. As shown in Table 16, 87 contacts were reported as waiver-related in Q2 CY2016, a 42.8% decrease compared to Q1 CY2016 (152 contacts). From Q3 CY2014 through Q2 CY2016, the number of waiver-related inquiries ranged from 87 this quarter (Q2 CY2016) to 152 in Q1 CY2016. The most frequent waiver-related issues were again for/from KanCare members receiving waiver services for Intellectual/Developmental Disability (I/DD) and Physical Disability (PD); of 87 waiver-related inquiries in Q2 CY2016, 27 were from members receiving I/DD waiver services (compared to 48 in Q1 CY2016) and 22 were from members receiving PD waiver services (compared to 48 in Q1 CY2016).

Table 16. Waiver-Related Inquiries to the Ombudsman's Office, Q3 CY2014 to Q2 CY2016								
	CY2014		CY2015				CY2016	
Waiver	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Intellectual/Developmental Disability (I/DD)	42	36	35	25	29	28	48	**27**
Physical Disability (PD)	43	29	57	48	33	28	48	**22**
Technology Assisted (TA)	8	15	11	13	11	13	10	**9**
Frail Elderly (FE)	16	11	15	12	16	18	23	**19**
Traumatic Brain Injury (TBI)	19	10	10	9	7	9	10	**3**
Serious Emotional Disturbance (SED)	5	4	1	7	5	4	4	**0**
Autism	4	1	4	3	4	5	1	**2**
Money Follows the Person (MFP)	6	4	2	2	3	1	8	**5**
Total	**143**	**110**	**135**	**119**	**108**	**106**	**152**	**87**

Conclusions Summary

Timely Resolution of Customer Service Inquiries

- In Q2 CY2016, 99.8% of the 96,632 member customer service inquiries received by the MCOs and 99.99% of the 43,315 provider customer service inquiries were resolved within two business days. All three MCOs in Q2 CY2016 met contractual requirements for resolving at least 98% of customer service inquiries within five business days. Two of the three MCOs (AGP and SSHP) met the contractual requirements to resolve 100% of inquiries within 15 business days; UHC reported 39 member customer inquiries not resolved within 15 business days.
- In Q2 CY2016, 64 of the 194 inquiries not resolved within two business days were resolved within five business days, and an additional 91 were resolved within 15 business days. Three of the inquiries not resolved within two business days were from providers; all provider inquiries were identified as resolved within five business days. During each quarter to date the two-day resolution rate exceeded 99.7%.
- In comparison to Q1 CY2016, the number of member customer service inquiries decreased by about 5.9% in Q2 CY2016, primarily due to a decrease of 4,524 in the number of calls related to eligibility. The number of provider customer service inquiries decreased by 11.5% in Q2 CY2016 compared to Q1 CY2016, primarily due to fewer inquiries related to claim status and claim denial.
- The criteria used by the MCOs to categorize member and provider inquiries vary by MCO. As a result, aggregated data for certain categories are more representative of one MCO rather than all three.
- Member customer service inquiries
  - Of the 96,632 member customer service inquiries in Q2 CY2016, 42.2% were received by Sunflower, 39.6% by UnitedHealthcare, and 18.2% by Amerigroup.
  - Benefit inquiries were the highest percentage (23.1%) of member inquiries.
  - As in previous quarters, there were five categories where two thirds or more of the inquiries in the quarter were reported by one MCO; three of the five with over 70% of the inquiries reported by one MCO for the past seven quarters. This seems likely to be due to differing interpretations of the criteria for several of the categories in the reporting template. The categories where over two thirds of the reported inquiries were from one MCO include:

  - "Member emergent or crisis call" – 99.6% of 687 inquiries in Q2 CY2016 were reported by Sunflower. (CY2016: Q1 99.7%; CY2015: Q4 – 99.4%; Q3 – 99.4%; Q2 - 99.8%; Q1 – 99.7%; CY2014: Q4 – 99.7%)
  - "Update demographic information" – 78.9% of 13,343 inquiries in Q2 CY2016 were reported by Sunflower. (CY2016: Q1 – 78.1%; CY2015: Q4 – 81.4%; Q3 – 82.1%; Q2 - 82.3%; Q1 – 82.1%; CY2014: Q4 – 71.0%)
  - "Enrollment information" – 75.8% of 2,396 inquiries were reported in Q2 CY2016 by Amerigroup. (CY2016: Q1 – 85.4%; CY2015: Q4 – 80.5%; Q3 – 76.8%; Q2 - 76.4%; Q1 CY2015 - 76.6%; CY2014: Q4 – 80.5%)
  - "Concern with access to service or care; or concern with service or care disruption" – 69.7% of 1,716 inquiries were reported in Q2 CY2016 by Sunflower.
  - "Care management or health plan program" – 82.1% of 1,584 inquiries in Q2 CY2016 were reported by Amerigroup.
- Provider customer service inquiries
  - Of the 48,921 provider inquiries received by MCOs in Q2 CY2016, Amerigroup received 38.1%, Sunflower 44.7%, and UnitedHealthcare 17.3%.
  - For providers, claim status inquiries were again the highest percentage (50.1%) of the 43,315 provider inquiries.
  - Categories where two thirds or more of the provider inquiries in six or more quarters were reported by only one MCO included:
    - "Authorization – New" – 99.0% of 1,812 inquiries in Q2 CY2016 were reported by Amerigroup. (CY2016: Q1 – 99.0%; CY2015: Q4 – 98.6%, Q3– 98.0%; Q2– 99.1%; Q1– 99.1%; CY2014: Q4 – 98.1%)
    - "Authorization – Status" – 67.6% of 2,373 inquiries in Q2 CY2016 were reported by Amerigroup. (CY2016: Q1 – 69.7%; CY2015: Q4 – 69.9%, Q3– 67.4%; Q2 - 71.0%; Q1 - 70.8%; CY2014: Q4 - 72.0%)
    - "Update demographic information" – 95.4% of 710 inquiries were reported in Q2 CY2016 by Sunflower. (CY2016: Q1 – 95.3%; CY2015: Q4 – 93.7%, Q3 – 96.2%; Q2 - 91.4%; Q1 - 95.5%; CY2014: Q4 - 99.5%)
    - "Coordination of benefits" – 77.5% of 396 inquiries were reported in Q2 CY2016 by UnitedHealthcare. (CY2016: Q1 – 73.7%; CY2015: Q4 – 87.9%, Q3– 85.5%; Q2 - 76.8%; Q1 - 90.7%; CY2014: Q4 - 91.0%)
    - "Verify/Change participation status" – 77.7% of 103 inquiries in Q2 CY2016 were reported by Sunflower. (CY2016: Q1 – 71.9%; CY2015: Q4 – 72.2%, Q3 – 77.8%; Q2 - 68.1%; Q1 - 67.6%; CY2014: Q4 - 66.4%)
  - Of the 17 provider inquiry categories, seven are focused on claims; the range of inquiries for each of the seven varied greatly by MCO. The combined total number of inquiries for these seven categories may allow better comparison of overall claims-related inquiries.

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**
  - In Q1 CY2016, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days. Of 4,380,115 clean claims received in Q1 CY2016, 99.955% were processed within 30 days. Of the 1,956 clean claims not processed within 30 days, 85.4% (1,671) were claims received by Sunflower; 10.4% (203) were claims received by UnitedHealthcare; and 4.2% (82) were claims received by UnitedHealthcare.

- In Q1 CY2016, all of the MCOs reported that they met the contractual requirement of processing at least 99% of non-clean claims within 60 days. Of 195,584 non-clean claims received in Q1 CY 2016, 99.873% were processed within 60 days. Of the 249 non-clean claims not processed within 60 days, 131 (52.6%) were claims received by Sunflower, 116 (46.6%) were claims received by Amerigroup; and 2 (0.8%) were claims received by UnitedHealthcare.
- Of 4,575,699 "all claims" received in Q1 CY2016, 99.997% were processed within 90 days. Of the 147 claims not processed within 90 days, 63 (42.9%) were claims received by Amerigroup; 76 (51.7%) were claims received by Sunflower; and 8 (0.5%) were claims received by UnitedHealthcare.

- **Turnaround time (TAT) ranges for processing clean claims**
  - In Q2 CY2016, the average TAT for total services (excluding pharmacy claims) was 5.2 to 9.1 days, compared with 5.3 to 10.0 days in Q1 CY2016 and 5.3 to 10.2 days in Q2 CY2015.
  - The average TAT for processing clean claims for individual service types again varied by service type and by MCO.
    - Pharmacy - Clean pharmacy claims had the shortest turnaround times and were consistently processed on a same day basis by each of the three MCOs.
    - Hospital Inpatient – Hospital Inpatient claims had TATs in Q2 CY2016 ranging from 7.1 to 12.4 days, a decrease compared to Q1 CY2016 (8.1 to 15.1 days). Amerigroup had the shortest TATs in Q2 (7.1 to 8.3 days); Sunflower had the highest TATs (11.6 to 12.4 days), which represented, however, an improvement compared to Q1 CY2016 (13.4 to 15.1).
    - Dental - Dental claims TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 7.0 to 13.0 days in Q1 and Q2 CY2016. Sunflower had the shortest TATs each month (7.0 days); Amerigroup and UnitedHealthcare had monthly TATs of 13.0 days.
    - Non-emergency transportation (NEMT) - Clean claims for NEMT had longer TATs for all MCOs, with monthly average TATs ranging from 9.5 to 14.4 days, compared to 9.0 to 16.9 days in Q1 CY2016. Amerigroup had the longest TATs in Q2, ranging from 13.4 to 14.4 days, compared to 9.6 to 9.9 for Sunflower and 9.5 to 10.0 for UnitedHealthcare.
    - Vision – The average TATs were consistently a week or longer in Q2 and previous quarters for all of the MCOs. In Q2 CY2016, the average monthly TATs ranged from 7.0 to 12.0 days, compared to 7.0 to 12.7 in Q1.
    - Nursing Facilities – Nursing Facility claims had TATs ranging from 4.7 to 9.0 days, comparable to 4.9 to 9.0 days in Q1 CY2016.
    - HCBS – HCBS claims had TATs ranging from 6.0 to8.7 days in Q2, a decrease compared to Q1 (6.5 to 9.7 days).
    - Behavioral Health (BH) – BH claims' TATs ranged from 4.2 to 9.3 days in Q2 CY2016, compared to 4.2 to 10.3 days in Q1. Amerigroup had the shortest TATs (4.2 to 4.9 days), compared to Sunflower (8.4 to 9.3 days) and UnitedHealthcare (8.7 to 9.1 days).

Grievances

- Beginning in Q2 CY2016, grievances were reported using categories revised by State staff. The revised categories, defined criteria, and examples provided in the template and in the MCO staff training should result in clearer, more accurate, and more consistent reporting over time.
- In Q2 CY2016, the number of grievances received (420) was lower than the number received in the previous nine quarters.

- Of 423 grievances reported as closed in Q2 CY2016, 99.5% (421) were resolved within 30 business days. Two grievances, received by Sunflower, not resolved within 30 days were resolved within 60 business days.
- The grievance categories with the highest number of grievances were those related to transportation - 122 (28.8% of 423) grievances received in Q2. Billing-related grievances were second highest with 108 grievances (25.5% of 423).
- The total number of grievances, the number and percentage of members reporting grievances, and the number and percentage of transportation-related grievances have been decreasing each quarter, with the lowest numbers and percentages reported in Q2 CY2016. The number and percentage of waiver-related grievances and the number of waiver members reporting grievances, however, were higher in Q2 CY2016 than in the previous five quarters. Of 423 grievances reported by 367 members as resolved by MCOs in Q2 CY2016, 174 (41.1%) were reported by 126 members receiving waiver services.
- While the STC report has included an "Access to Service or Care" category, Q2 CY2016 is the first quarter where this category is included in the GAR report, which will allow much more consistent and accurate trend assessments of access-related grievances. Of the 423 grievances resolved in Q2 50 (11.8%) were categorized in the GAR report as "Access to Service or Care."
- The revised GAR grievance categories now include reporting of QOC by whether or not the grievances are HCBS-related. In Q2 CY2016, 53 grievances (12.5% of 423) from 50 members were categorized as QOC, 42 as non-HCBS and 11 HCBS-related. Of the 53 QOC-related grievances, 21 were from 20 members receiving waiver services.
- UnitedHealthcare again this quarter provided only limited descriptions of grievances and grievance resolutions in the GAR report, making it difficult to assess whether other grievances are categorized appropriately.
- Descriptions in the STC report of "trends and any actions taken to prevent recurrence" for most of the grievance categories include the same language each quarter whether there were three grievances or 33 grievances in the category that quarter.

Ombudsman's Office

- In Q1 CY2016, the Ombudsman's Office tracked issues in 1,130 contacts and calls received, more than double the number of contacts in the previous six quarters, primarily due to requests for assistance related to Medicaid eligibility. In Q2 CY2016, the number of contacts dropped by 25% to 846, but was over 54% higher than in the previous eight quarters.
- In Q1 CY2016, 22.1% (250 of 1,130) of the contacts were MCO-related, compared to 17.7% (150 of 846) in Q2 CY2016.
- The highest number of issues and inquiries in Q1 CY2016 and Q1 the previous two years were related to Medicaid Eligibility and HCBS-related issues. . In Q2 CY2016, however, there were 71 HCBS-related issues compared to 144 in Q1 CY2016. The number of "Medicaid Eligibility Issues" also dropped from 512 in Q1 CY2016 to 244 in Q2 CY2016.
- In Q2 CY2016, 87 contacts were reported as waiver-related, a 42.8% decrease compared to Q1 CY2016 (152 contacts). From Q3 CY2014 through Q2 CY2016, the number of waiver-related inquiries ranged from 87 this quarter to 152 in Q1 CY2016. The most frequent waiver-related issues were again for/from KanCare members receiving waiver services for Intellectual/Developmental Disability (I/DD) and Physical Disability (PD); of 87 waiver-related inquiries in Q2 CY2016, 27 were from members receiving I/DD waiver services (compared to 48 in Q1 CY2016) and 22 were from members receiving PD waiver services (compared to 48 in Q1 CY2016).
- As of Q2 CY2016, the Wichita volunteer office had five active volunteers and provided assistance to over 223 individuals. A second satellite office opened in July 2016 in Johnson County; the

Ombudsman's Office reported that two volunteers had completed training, and additional volunteer training was scheduled to begin in August 2016.

Recommendations Summary

Timely Resolution of Customer Service Inquiries

The State should work with the MCOs to develop consistent criteria for classifying the member and provider customer service inquiries.

Timeliness of Claims Processing

MCOs should continue to work to reduce the turnaround times for clean claims, particularly for processing claims where other MCOs have much lower average monthly turnaround times.

Grievances

- MCOs should ensure their staff categorizes grievances using the revised categories and criteria, particularly categories related to access and quality of care. MCOs should contact KDHE staff to request clarification for any grievance or appeals categories where criteria are not clearly understood.
- The State should consider using the same grievance and appeals categories in the STC and GAR reports to promote consistency and allow more complete assessment of grievances over time.
- For consistency between MCOs, the State should provide guidance as to whether grievance category counts to be reported in the STC report are based on grievances received or are based on grievances resolved of those received in the quarter.
- MCOs should, as directed by the instructions for the STC reports, "insert a brief summary of trends and any actions taken to prevent recurrence" for specific grievances and trends rather than repeating standard language each quarter.
- UnitedHealthcare should provide more detailed descriptions of the grievances resolved each quarter and should ensure that text descriptions are not cut off mid-sentence. Resolution details should not be limited to verification that a letter of resolution was sent.

End of report

KDHE Summary of Claims Adjudication Statistics –

January through June 2016 – 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	22,180	$724,966,598.86	3,270	$111,201,354.83	14.74%
Hospital Outpatient	175,028	$411,910,804.72	23,709	$47,940,561.95	13.55%
Pharmacy	1,011,259	$67,015,481.72	270,070	Not Applicable	26.71%
Dental	65,693	$17,582,302.38	5,107	$1,290,426.33	7.77%
Vision	37,753	$9,955,808.90	6,910	$2,073,547.75	18.30%
NEMT	55,216	$1,843,516.87	167	$9,980.00	0.30%
Medical (physical health not otherwise specified)	1,012,487	$616,312,115.29	133,671	$77,664,701.71	13.20%
Nursing Facilities-Total	48,695	$113,158,233.95	6,068	$10,695,585.33	12.46%
HCBS	98,944	$57,098,600.63	5,336	$2,988,826.46	5.39%
Behavioral Health	323,871	$43,177,966.83	32,528	$4,101,425.02	10.04%
Total All Services	2,851,126	$2,063,021,430.15	486,836	$257,966,409.38	17.08%

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	20,163	$705,489,410	5,118	$194,950,057	25.38%
Hospital Outpatient	186,136	$423,024,748	31,731	$69,422,804	17.05%
Pharmacy	1,589,067	$154,031,207.63	419,452	$81,824,939.23	26.40%
Dental	78,828	$20,353,467.78	6,587	$1,412,369.43	8.36%
Vision	49,007	$11,360,844.35	6,008	$1,459,443.64	12.26%
NEMT	71,779	$1,976,328.13	265	$5,682.96	0.37%
Medical (physical health not otherwise specified)	914,922	$473,592,147	129,565	$92,944,530	14.16%
Nursing Facilities-Total	69,256	$151,440,114	9,141	$25,571,763	13.20%
HCBS	276,728	$117,400,280	13,663	$6,242,827	4.94%
Behavioral Health	313,193	$49,144,819	35,812	$7,121,735	11.43%
Total All Services	3,569,079	2,107,813,366	657,342	480,956,150	18.42%

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	13,680	$492,747,212.33	3,468	$166,047,113.42	25.35%
Hospital Outpatient	153,186	$364,808,603.89	24,984	$74,232,923.61	16.30%
Pharmacy	873,429	$86,075,827.61	175,351	$31,480,418.80	20.08%
Dental	67,613	$18,912,298.66	5,193	$1,504,344.81	7.68%
Vision	38,943	$7,779,040.70	4,178	$933,673.15	10.73%
NEMT	76,867	$2,097,703.85	184	$5,724.94	0.24%
Medical (physical health not otherwise specified)	989,474	$429,100,099.84	151,970	$102,293,818.56	15.35%
Nursing Facilities-Total	45,358	$108,834,358.15	6,586	$18,801,269.92	14.52%
HCBS	175,531	$42,660,880.05	11,847	$2,868,635.30	6.74%
Behavioral Health	123,104	$45,309,373.32	8,218	$7,079,749.96	6.67%
Total All Services	2,557,185	$1,598,325,398	391,979	$405,247,672	15.33%