Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 03.31.16

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: 2/2016 (01/16-03/16)

Table of Contents

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 March 31, 2016.

Demonstration Population	Enrollees at Close of Qtr. (03/31/2016)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	15,334	16,517	1,183
Population 2: ABD/SD Non Dual	27,917	28,362	445
Population 3: Adults	46,853	46,386	2,533
Population 4: Children	238,552	245,527	6,975
Population 5: DD Waiver	8,802	8,848	46
Population 6: LTC	20,411	21,130	719
Population 7: MN Dual	1,201	1,286	85
Population 8: MN Non Dual	1,134	1,198	64
Population 9: Waiver	4,111	4,182	71
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**364,315**	**376,436**	**12,121**

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 this quarter, the state's KanCare Advisory Council met on March 31, 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 March meeting:

I. Welcome
II. Review and Approval of Minutes from Council meeting, November 20, 2015
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. Status on Health Homes
    b. Status on I/DD
    c. Update on contract renewals/bids
    d. Update on financial status for MCOs – profit and loss
    e. Update on proposed changes and improvements to KanCare
    f. Update on the 1115 Integrated Waiver
VIII. Next Meeting of KanCare Advisory Council – June 30, 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 March 1, 2016, there were 26,126 KanCare members identified as eligible for the SMI HH. The opt-out rate for March 2016 was 37%, leaving 24,198 enrolled in SMI HHs. The opt-out rate has increased considerably, reflecting the state's decision to terminate the Health Homes program effective July 1, 2016. The engagement rate, calculated through March 2016, (due to encounter data lag), was 36.8%. Engagement is calculated by dividing the number of enrolled HH members by the number for whom a payment was made.

For those served in the SMI HH, total payments through March 2016 were $38,305,230.28. Payments are made on a per-member per-month basis, but can only be triggered if a service is actually provided.

Waiver Integration Stakeholder Engagement (WISE) Workgroup

In March, KDHE and KDADS hosted another Waiver Integration Stakeholder Engagement (WISE) 2.0 Workgroup meeting. Recommendations from several focus groups that worked through February were reviewed and discussed. The focus groups provided recommendations on waitlist management, supported employment, education and communication, and support broker/navigator service. These recommendations have been posted on the KanCare website.

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 the first quarter of 2016, members reviewed the unified declaration of ownership form and critiqued a live demonstration of the fiscal agent's provider enrollment portal. This workgroup is scheduled to meet again in summer 2016.

KanCare Consumer and Specialized Issues (CSI) Workgroup

The CSI Workgroup met on March 31, 2016, at the KanCare MCO Amerigroup offices in Overland Park, Kansas. Topics included HCBS waiver updates including waiver waiting list numbers, as well as an update on the Waiver Integration from KDADS. We had a final update from the Health Home program. A robust conversation took place about dental benefits for adults on Medicaid and how the KanCare MCOs deliver dental benefits. The group as a whole asked for the state leadership of the CSI workgroup to recommend expanding the dental package for adults to the KanCare Steering Committee. A report for the KanCare Ombudsperson was presented along with a discussion on the Elderly and Disabled application and how we could make it clearer for people to apply for HCBS services.

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 100 events for the first 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 benefits of the KanCare program. Marketing activities Amerigroup supported in the first quarter include:

- Salina Family Healthcare Center
- Wichita Public Schools McKinney-Vento Christmas Distribution Exhibit
- USD 259 Brooks Magnet Middle School conferences
- The Treehouse Presentation

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 8,500 Kansans in the first 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: diabetes, well child visits, employment, high blood pressure, your PCP and you, and more. Outreach efforts during the first quarter include:

- Mission of Mercy Dental exhibit
- USD 500 exhibit
- 7Impact exhibit
- Stormont Vail Babies Jubilee
- Kidzfest El Dorado 2016 exhibit

Advocacy Activities: Amerigroup's advocacy efforts for first quarter continued 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 first 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. Advocacy activities this past quarter included:

- Kansas Mental Health & Aging Coalition
- Point in Time Homeless Count Event- Sedgwick County
- Cowley County Health Department-Arkansas City
- Hunter Health Clinic Interfaith
- Child Start Inc.

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

Marketing Activities: Sunflower Health Plan marketing activities for 1st Quarter 2016 involved attending and/or sponsoring 45 member and provider outreach events. Sunflower began distribution of new member collateral focused on healthy behaviors and incentives for 2016. This includes the 2016 version of the Member Welcome Packet and material related to Health Homes. Examples of marketing that generated support and attendance at sponsored events as well as health plan visibility in the community include:

- Kidzfest El Dorado
- Franklin Elementary School Health Fair
- Ellsworth County Health Fair
- Pioneer Electric and Pioneer Communications Area Health Fair

• Jewell County Health Fair
• Brain Injury Association of Kansas 8th Annual Beyond Rehab: Succeeding at Life Professional Conference
• Health Fair Wichita State
• American Heart Association Heart Ball, Wichita

Outreach Activities: In addition to Sunflower Health Plan's regularly scheduled health events such as Baby Showers and Health Fairs, the health plan's 1st quarter 2016 outreach activities involved efforts to get members vaccinated against influenza and to encourage members to make their regular doctor's visits based on periodicity or health status. Sunflower also held its 1st quarter 2016 Member and Community Advisory Committee (MAC/CAC) meeting with members, families and community partners.
- Sunflower continued to contact members in to encourage flu vaccinations, and the outreach has seen positive results:
• The rate of Sunflower members vaccinated against the flu this season – through March 2016 – is 21.68%, though this is a very conservative report since many vaccinations occur in hospital and other facility settings where the service is not billed (reported) as a separate service. This 2015-2016 rate is higher than the previous year's rate of 20.57%.
• Outreach strategies for flu vaccinations included phone calls, home/community visits, postcards, flyers, and Sunflower member flu clinics in partnership with Walgreens.
- Member Connections Representatives participated in a Community Baby Shower in Wichita, Kansas, in March.
- Other outreach opportunities to address prenatal care, well-child visits and proper ER usage included the following events (not all-inclusive):
• Breastfeeding 101 with the Kansas Breastfeeding Coalition
• Kansas Division for Early Childhood Conference
• Parent Teacher Conferences, various cities
• Clinic Visit, various clinics in Wichita
• Point in Time (PIT) Homeless Count
• Health Fairs (e.g., those listed in the Marketing section above)
- The first quarter meeting of the Sunflower Member and Community Advisory Committee was held February 24 in Lenexa. Approximately 20 people attended either in person or by phone.

Advocacy Activities: Sunflower's 1st quarter advocacy activities centered on competitive employment for people with disabilities. Sunflower Health Plan and its partner company, LifeShare, accepted the role of Statewide Coordinator for Project SEARCH, which is a one-year, school-to-work program for young adults with intellectual and developmental disabilities.
- Effective January 2016, Sunflower/LifeShare is the Statewide Coordinator for Project SEARCH. Project SEARCH has been in Kansas for five years and was previously managed by the Kansas Council on Developmental Disabilities. During 1st quarter 2016 Sunflower Health Plan also became an internship host site through the Project SEARCH program at Johnson County government.
- Sunflower/LifeShare sponsored the Sedgwick County Business Leadership Network Training in January

for Human Resources staff, which involved many local businesses supporting competitive employment for people with disabilities.
- Sunflower/LifeShare conducted 17 webinar sessions for members and providers on topics related to self-advocacy, physical health, nutrition, personal care attendants and integration.

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 their 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. Throughout the quarter, UnitedHealthcare hosted a number of meetings and presentation with key providers, hospitals and FQHCs throughout the state that involved discussions around exploring innovative and collaborative opportunities. Additional strategic endeavors continued to focus on working 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 belter 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, attendance at health fairs and disability mentoring 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 first quarter of 2016, UnitedHealthcare hosted two Community Baby Showers, one in Kansas City and one in Liberal. 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.
- During the first quarter of 2016, UnitedHealthcare staff personally met with approximately 3,378 individuals who were members or potential members at community events, at member orientation sessions, and at lobby sits held at key provider offices throughout Kansas.

- During the first quarter 2016, UnitedHealthcare staff personally met with approximately 2,070 individuals from community based organizations located throughout Kansas. These organizations work directly with United members in various capacities.
- During the first quarter 2016, UnitedHealthcare staff personally met more than 530 individuals from provider offices located throughout the State.

Advocacy Activities: UnitedHealthcare leverages one outreach specialist with a key focus on supporting persons with disabilities. The role of this individual, in addition to traditional member and provider outreach, is to provide information and education on KanCare and UnitedHealthcare benefits to Kansans with disabilities. The additional role of this outreach specialist is to be a direct resource to members with disabilities, and the individuals and agencies that support them, in order to facilitate appropriate response and follow up from UnitedHealthcare staff to concerns or issues.

-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. There is a continued need to assist members with disabilities to understand their KanCare benefits and who they can contact within the state to determine eligibility, along with the importance of communicating to the state about any changes in their circumstances. It is not uncommon for an outreach event to include meeting and talking with people who have a newly acquired disability and are in need of good referrals and basic information about programs and services available in Kansas. UnitedHealthcare remains committed to providing ongoing support and education to members and being supportive and responsive to member feedback.

- During this quarter, this outreach specialist attended Independent Living Day, or IL Day, hosted by the Kansas Association of Centers for Independent Living. Attendees were able to get information about UnitedHealthcare. UHC staff were also able to network with providers who work with members and are often the first place consumers go when trying to understand and access services specific to a disability. In addition, UHC staff attended Interhab Push Day where several hundred individuals with Intellectual and Developmental Disabilities came together to educate policy members about their services, along with the service providers who support them. Attendance at Push Day is an opportunity to demonstrate the company's support of self-advocates and validate the perspective of members who come to share their opinions and experiences. UnitedHealthcare does not participate in the advocacy or legislative activities, but does offer support to members to self-advocate and take personal responsibility for their healthcare.

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 20 on January 29, 2016. Amendment 20 implements capitation adjustments as well as defines the risk corridors tables, Pay for Performance program and the Privilege Tax adjustment effective January 1, 2015. Also approved on January 29, 2016 was the 19th Amendment to the Amerigroup managed care contract.

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-March, 2016, follows:

MCO	Value Added Service	Units YTD	Value YTD
Amerigroup	Adult Dental Care	825	$108,820
	Member Incentive Program	2,306	$57,090
	Mail Order OTC	2,692	$47,452
	Total of all Amerigroup VAS Jan-Mar 2016	***7,134***	***$245,199***
Sunflower	CentAccount debit card	18,863	$377,260
	Dental visits for adults	2,348	$76,951
	Smoking cessation program	119	$28,560
	Total of all Sunflower VAS Jan-Mar 2016	***31,296***	***$537,633***
United	Baby Blocks Program and Rewards	306	36,720
	Adult Briefs	235	25,023
	Adult Dental Services	384	18,042
	Total of all United VAS Jan-Mar 2016	***4,322***	***$137,309***

c. Enrollment issues: For the first quarter of calendar year 2016 there were 17 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	0
KDHE - Administrative Change	32
WEB - Change Assignment	26
KanCare Default - Case Continuity	259
KanCare Default – Morbidity	296
KanCare Default - 90 Day Retro-reattach	144
KanCare Default - Previous Assignment	475
KanCare Default - Continuity of Plan	11,604
AOE – Choice	3,131
Choice - Enrollment in KanCare MCO via Medicaid Application	1,306
Change - Enrollment Form	253
Change - Choice	347
Change - Access to Care – Good Cause Reason	4
Change - Case Continuity – Good Cause Reason	1
Change – Quality of Care - Good Cause Reason	0
Assignment Adjustment Due to Eligibility	11
Total	**17,889**

d. Grievances, appeals and state hearing information

MCOs' Grievance Database
Members – CY16 1st quarter report

MCO	Access of ofc	Avail-ability	QOC	Attitude/ Service of Staff	Lack of Info from Prov	Billing/ Fin Issues	Transp-Timely & Qual Of Svc	Prior Auth	Level of Care	Pharm	VAS	Med Proc/ Inpt Trtmt	Waiver HCBS/ Home Health	Other
AMG	0	5	7	19	1	31	47	0	5	2	2	1	0	10
SUN	0	4	16	18	2	22	59	2	1	3	2	0	3	9
UHC	1	0	38	43	3	53	25	1	0	4	0	0	0	10
Total	1	9	61	80	6	106	131	3	6	9	4	1	3	29

MCOs' Appeals Database
Members – CY16 1st quarter report

MCO	Dental	DME	Phar-macy	OP/IP Surg/ Proc	Radio-logy/Gen Tests	Specialist Physician Ofc Visit	LTSS/HCBSPCA/LTC/RTC/TCM/CBS/MH PBS Svcs	HH/ Hospice Hrs	OT/PT ST	Inpt/ Outpt Covg	Other
AMG	1	1	7	8	1	0	23	0	0	0	1
SUN	2	19	51	8	10	0	23	4	18	0	1
UHC	15	13	103	55	0	1	21	6	0	0	1
Total	18	33	161	71	11	1	67	10	18	0	3

MCOs' Appeals Database
Providers - CY16 1st quarter report (appeals resolved)

MCO	MCO Auth	MCO Prov. Rel.	MCO Claim/ Billing	MCO Clin/ UM	MCO Plan Admin/ Other	MCO Quality of Care/Svc	MCO Other	Vision Claim/ Billing	Dent Auth	Dent Claim/ Billing	Transp Quality of Care/Svc
AMG	5	0	10,110*	67	0	0	0	27	1	29	0
SUN	35	7	129	16	2	19	11	39	4	30	0
UHC	0	0	578	0	0	0	0	9	0	27	0
Total	40	7	10,817	83	2	19	11	75	5	86	0

**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.*

State of Kansas Office of Administrative Fair Hearings
Members – CY16 1st 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					
Dismissed-Moot MCO reversed decision			1 1	1	1		1	 1		1
Dismissed-No Adverse Action										
Default Dismissal-Appellant did not appear		2	1				1			
Dismissed-Untimely			1	1				1	1	
OAH upheld MCO decision				1	1		1	3 1		
OAH reversed MCO decision					2			4		

Providers – CY16 1st 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	1		2	1 3		3		6 1	1	1 1
Dismissed-Moot MCO reversed decision		17 1 3		7 2 1	1 1	4 1		22 7 6	3 1	1
Dismissed-No internal appeal	1					4 1	1	3		18 2 1
Dismissed-No adverse action	1 1							4	1	
Default Dismissal-Appellant did not appear			1 1					2 2		2
Dismissed-Untimely				1				2		1
OAH upheld MCO decision							1	2	4	
OAH reversed MCO decision									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 Q1 of 2016, there were a total of 68 requests, which is an increase from 35 requests in fourth quarter of 2015.

The majority of good cause requests during the Q1 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. We are exploring educational materials or information to add to member enrollment packets to explain what would be considered 'good cause'. 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 again in the first quarter of 2016.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the first 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	January	February	March
Total GCRs filed	14	17	37
Approved	2	1	1
Denied	7	9	16
Withdrawn (resolved, no need to change)	2	4	12
Dismissed (due to inability to contact the member)	3	3	5
Pending	0	0	3

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 6/30/15	# of Unique Providers as of 9/30/15	# of Unique Providers as of 12/31/15	# of Unique Providers as of 1/31/16
Amerigroup	15,201	15,954	13,652	15,802
Sunflower	20,376	20,226	19,914	20,389
UHC	20,823	20,840	20,190	21,290

g. Proposed changes to payment rates: No changes were requested for the 1st quarter of 2016.

h. MLTSS implementation and operation: In the first 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.

j. 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 DY3. A DSRIP Learning Collaborative was held on February 3, 2016, at Children's Mercy Hospital with The University of Kansas Hospital, KFMC and the State in attendance. The DSRIP DY3 Annual Report was submitted to CMS on February 29, 2016.

k. Information on any issues regarding the concurrent 1915(c) waivers and on any upcoming 1915(c) waiver changes (amendments, expirations, renewals):
    - 1915(c) Amendments: CMS approved the proposed waiver amendments for all five waivers (which excluded SED/Autism), with an effective date of 2/25/2016 (2/26/16 for the FE Waiver). The purpose of the waiver amendments was to make an overall update to Sleep Cycle Support changing it to Enhanced Care Service (ECS) and to demonstrate compliance with the DOL ruling on overtime.
    - Kansas submitted a renewal application for the Serious Emotional Disturbance (SED) waiver program to CMS on June 30, 2015. The SED waiver was scheduled to expire on September 30, 2015, but CMS granted extensions which allow the SED waiver to continue operating through June 26, 2016. The SED waiver is currently operating on an extension. 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. Likewise, the Autism waiver has been granted extension through June 28, 2016. The Autism Waiver is currently in the process of being renewed. The State has been working with CMS through the RAI process and is currently awaiting a technical assistance call.

l. *Legislative activity:* The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight, a statutory joint legislative committee, met once during the first quarter, on January 22, 2016, to review the current state of KanCare and HCBS services. The committee received information from KDHE and each of the three KanCare MCOs about pending claims processing issues, from KDADS about personal care service updates, as well as from KDHE and KDADS responding to the committee's previous recommendation. The committee also received information from the KanCare Ombudsman, the Kansas Insurance Department, and took comments from stakeholders.

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 03.31.16 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	*2016-01*	*2016-02*	*2016-03*	*Grand Total*
Population 1: ABD/SD Dual	16,201	15,843	15,338	47,382
Population 2: ABD/SD Non Dual	28,198	28,091	27,923	84,212
Population 3: Adults	45,992	45,707	46,853	138,552
Population 4: Children	225,838	236,565	238,554	700,957
Population 5: DD Waiver	8,801	8,792	8,802	26,395
Population 6: LTC	20,737	20,504	20,458	61,699
Population 7: MN Dual	1,211	1,180	1,203	3,594
Population 8: MN Non Dual	1,103	1,150	1,134	3,387
Population 9: Waiver	4,014	4,058	4,112	12,184
Grand Total	**352,095**	**361,890**	**364,377**	**1,078,362**

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

VIII. Consumer Issues

Summary of consumer issues during the first 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.
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. MCOs are researching the issue.
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 over 2,800 consumers. OEW also assisted in resolving over 1,200 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 59 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. This group replaces the iAct (the Interagency Collaboration Team), incorporating quality monitoring as a key component of overall Medicaid enterprise planning and direction. 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). 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 includes both executive and operational leadership from both KDHE and KDADS and directs the policy initiatives of the KanCare Steering Committee.

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 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 first 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 will be 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. We will also have monitor for compliance with the state contract.
- 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.
- 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 being developed to document this process. In the manual, protocols and interpretive guidelines are being established with the goal of ensuring consistency in the reviews.

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-March 2016:

KanCare Customer Service Report - Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:19	2.11%	48,536
Sunflower	0:19	1.57%	44,362
United	0:12	0.99%	41,714
HP – Fiscal Agent	0:00	0.20%	7,589

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:18	1.17%	20,845
Sunflower	0:12	0.89%	25,138
United	0:01	0.13%	17,355
HP – Fiscal Agent	0:00	0.10%	1,744

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

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

e. Summary of ombudsman activities for the first quarter of 2016 is attached.

f. Summary of MCO critical incident report: The Adverse Incident Reporting (AIR) System is the system used for behavioral health and HCBS critical incidents. All behavioral health and HCBS providers submit critical incidents for individuals receiving services. The critical incidents are reviewed by quality management specialists (field staff) who may make unannounced visits and research critical incidents to determine if additional corrective action and monitoring are required to protect the health, safety and welfare of those served by the programs involved.

AIR is not intended to replace the State reporting system for abuse, neglect and exploitation (ANE) of individuals who are served on the behavioral health and HCBS programs. ANE substantiations 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 March 31, 2016, follows:

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

**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.*

In addition, during the fourth quarter of 2015, the Cross-Agency Adverse Incident Management Team met to review and make recommendations to the draft Incident Report Guide. The team finished all substantive revisions, discussed next steps following distribution of the Incident Reporting Guide and came to consensus on a meeting schedule for the next year. After distribution of the guide, the team will shift focus to opportunities for process and system improvement related to adverse incidents. The team obtained approved from the KanCare Steering Committee to post the Incident Reporting Guide to the KanCare website and the guide will be provided to KDADS and the Department of Children and Families to post to their websites. The team developed suggestions to improve communication of critical incidents between the State, MCOs and providers. These suggestions are under consideration as improvements to the AIR system are underway

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 quarter payments will be made in June. The LPTH/BCCH Pool first quarter payments were processed on March 10, 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 first 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; Money Follows the Person)

a. Claims Adjudication Statistics

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

b. Waiting List Management

PD Waiting List Management

In the quarter ending March 31, 2016, 622 individuals waiting for HCBS-PD services were offered services. Of those offers:

- 358 have accepted services
- 15 had other results (declined services, unable to contact, deceased)
- 249 have not responded

I/DD Waiting List Management

In the quarter ending March 31, 2016, 57 individuals waiting for HCBS-I/DD services were offered services. Of those offers:

- 45 have accepted services
- 7 did not respond
- 5 declined

The current point-in-time limit for HCBS-I/DD is 8,900. KDADS is currently serving 8,772 individuals. Based upon appropriations, KDADS will continue to offer services until waiver membership has reached 8,900 participants.

c. Money Follows the Person:

During the quarter ending Marchr 31, 2016, there were 66 initial requests.

2016 Initial Request	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
Amerigroup	17				
Sunflower	26				
United	23				
Total	**66**				

Individuals continue to be found eligible and transition from qualifying institutions into the community on the Money Follows the Person Program. KDADS, with the help of the three Managed Care Organizations, will continue to improve the efforts to identify and follow up with the individuals who may be eligible to transition. The revised 2016 MFP budget has been approved. MFP staff continue to approve MCO transition fund requests. As of March 31, 2016, there have been 66 MFP approvals at the program level and 33 new individuals coded for the MFP Program.

XIV. Enclosures/Attachments

Section of Report Where Attachment Noted	Description of Attachment
VI	KanCare Budget Neutrality Monitoring Spreadsheet for QE 03.31.16
X(e)	Summary of KanCare Ombudsman Activities for QE 03.31.16
XI	KanCare Safety Net Care Pool Reports for QE 03.31.16
XII	KFMC KanCare Evaluation Report for QE 03.31.16
XIII(a)	KDHE Summary of Claims Adjudication Statistics for QE 03.31.16

XV. State Contacts

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XVI. Date Submitted to CMS

May 31, 2016

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

Quarter 1
Start Date: 1/1/2016
End Date: 3/31/2016

	Total Expenditures	Total Member-Months
Jan-16	$242,250,568	350,833
Feb-16	$237,961,925	350,510
Mar-16	$242,185,270	358,007
PCP	$0	
Q1 Total	$722,397,762	1,059,350

ADMIN SUMMARY	
	Expenditures
DY4Q1	

	Population 1: ABD/SD Dual	Population 2: ABD/SD Non Dual	Population 3: Adults	Population 4: Children	Population 5: DD Waiver	Population 6: LTC	Population 7: MN Dual	Population 8: MN Non Dual	Population 9: Waiver
Jan-16									
Expenditures	$4,054,289	$34,483,504	$28,871,098	$53,104,735	$39,365,384	$68,156,043	$710,490	$2,089,515	$11,415,510
Member-Months	16,245	28,448	47,208	222,888	8,764	20,891	1,224	1,219	3,946
Feb-16									
Expenditures	$1,704,944	$36,334,890	$23,606,555	$53,835,527	$39,730,955	$68,200,615	$694,160	$2,059,168	$11,795,110
Member-Months	7,807	36,084	46,252	224,629	8,747	20,603	1,179	1,179	4,030
Mar-16									
Expenditures	$1,680,504	$36,693,862	$25,801,881	$54,642,964	$40,456,749	$69,051,187	$728,584	$1,897,053	$11,232,484
Member-Months	7,488	36,175	48,541	229,615	8,826	20,834	1,244	1,176	4,108
PCP									
Expenditures	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Q1 Total									
Expenditures	$7,439,738	$107,512,256	$78,279,534	$161,583,226	$119,553,089	$205,407,845	$2,133,234	$6,045,736	$34,443,104
Member-Months	31,540	100,707	142,001	677,132	26,337	62,328	3,647	3,574	12,084
DY 4 - Q1 PMPM	$236	$1,068	$551	$239	$4,539	$3,296	$585	$1,692	$2,850

Note:

1. For DY4 Member-Months are CAP + RETRO combined.
2. PCP expired at the end of DY2.
3. 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.

KanCare Ombudsman Quarterly Report

KDHE 1st Quarter Report, 2016

Kerrie J. Bacon, KanCare Ombudsman

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 first quarter of 2016. There were 1130 contacts through these various means, 250 of which were related to an MCO issue (22.1 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				

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

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

- Goodwill Industries Presentation, January 18, 2016
- Volunteer Fair at Wichita State University, January 28, 2016
- Women's Recovery Center presentation, February 18, 2016
- Attended KDHE Spec Health Care Needs Program Regional Meeting in Topeka, KS – February 24, 2016.
- Wichita State University social work practicum class presentation, March 10, 2016 and March 17, 2016
- Health Fair in Wichita, KS, March 30, 2016
- Provided report and requested feedback from the KanCare Consumer Specialized Interest (CSI) Workgroup – March 31, 2016
- Provided quarterly and annual Ombudsman report to the KanCare Advisory Committee – March 31, 2016
- The Ombudsman's office sponsors the KanCare (I/DD) Friends and Family Advisory Council which met two times during the first 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.
- Created an explanation for the KanCare application process as an outreach tool.
- Revised/Updated the appeal and state fair hearing information provided to members needing assistance.

KanCare Ombudsman Volunteer Program Update

- The Ombudsman's office is in the process of hiring a new Ombudsman Volunteer Coordinator. The first priority after orientation and training will be to launch the Kansas City volunteer program during the second quarter.
- The Wichita volunteer office is in its second quarter of providing assistance to KanCare members. It has assisted approximately 303 consumers. There are five active volunteers.
- Volunteer Applications 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
phone	415	378	462	438	862
email	94	82	112	83	265
letter	1	1	0	2	2
in person	0	1	5	1	0
online	0	0	0	0	1
Total	**510**	**462**	**579**	**524**	**1130**

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

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

	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16
Avg. Days to Resolve Issue	6	7	11	6	7
% files resolved in one day or less	54%	38%	36%	45%	50%
% files closed	85%	88%	93%	83%	77%

The most frequent calls regarding home- and community-based services (HCBS) waivers during the first 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**
PD	57	48	33	28	48
I/DD	35	25	29	28	48
FE	15	12	16	18	23
AUTISM	4	3	4	5	1
SED	1	7	5	4	4
TBI	10	9	7	9	10
TA	11	13	11	13	10
MFP	2	2	3	1	8
PACE	0	0	1	1	0
MENTAL HEALTH	5	9	7	11	8
SUB USE DIS	0	0	0	2	0
NURSING FACILITY	12	28	33	29	47
Other	512	320	443	391	941
Total	**664**	**476**	**592**	**540**	**1148**

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

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

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

Managed Care Organization Issues: by Category, by Quarter

Highlighted are the top four- five issues for each quarter over the last two years 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.

Amerigroup

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

KanCare Ombudsman

Sunflower

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

United

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

Next Steps for Ombudsman's Office

KanCare Ombudsman Volunteer Program

- Creating and delivering volunteer training in the second quarter on how to assist consumers to fill out Medicaid applications.
- 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 March 2016

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

Paid 03/10/2016

Provider Name	1st Qtr Amt Paid	State General Fund 1000 *	Federal Medicaid Fund 3414
Children's Mercy Hospital	1,241,034.00	546,551.37	694,482.63
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

May 16, 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 1, January - March

Dear Ms. Phelps:

Enclosed is the 1st Quarter 2016 KanCare Evaluation quarterly 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

2016 KanCare Evaluation

Quarterly Report

Year 4, Quarter 1, January - March

Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**May 16, 2016**
Review Team:	**Janice Panichello, PhD, MPA, Director of Quality Review & Epidemiologist**

Prepared for:

KanCare

Table of Contents

2016 KanCare Evaluation Quarterly Report

Year 4, Quarter 1, January - March

List of Tables

Tables:

2016 KanCare Evaluation Quarterly Report
Year 4, Quarter 1, January – March 2016
May 16, 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 first quarter (Q1) 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 health care services are coordinated by three managed care organizations (MCOs): Amerigroup of Kansas, Inc. (Amerigroup), Sunflower State Health Plan (Sunflower), and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare). For the KanCare Quarterly and Annual Evaluations, data from the three MCOs are combined wherever possible to better assess the overall impact of the KanCare program.

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 Q1 CY2016 KanCare Quarterly Evaluation Report 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 2, 5, 8, 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 Q1 CY2016, 99.996% of the customer service inquiries received by the MCOs were resolved within two business days (see Table 1). In Q1 CY2016, and in nine of the ten previous quarters, the MCOs' reported results have met or exceeded contractual requirements for timeliness of resolution of customer service inquiries. (Q4 CY2014 is 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, Q1 CY2016 compared to Q1 CY2015

	Q1			
	Member Inquiries		Provider Inquiries	
	Q1 CY2015	Q1 CY2016	Q1 CY2015	Q1 CY2016
Number of Inquiries Received	103,160	**102,747**	49,252	**48,921**
Number of Inquiries Resolved Within 2 Business Days	103,155	**102,743**	49,252	**48,921**
Number of Inquiries Not Resolved Within 2 Business Days	5	**4**	0	**0**
Percent of Inquiries Resolved Within 2 Business Days	99.995%	**99.996%**	100%	**100%**
Number of Inquiries Resolved Within 5 Business Days	103,160	**102,747**	49,252	**48,921**
Number of Inquiries Not Resolved Within 5 Business Days	0	**0**	0	**0**
Percent of Inquiries Resolved Within 5 Business Days	100%	**100%**	100%	**100%**
Number of Inquiries Resolved Within 15 Business Days	103,160	**102,747**	49,252	**48,921**
Number of Inquiries Not Resolved Within 15 Business Days	0	**0**	0	**0**
Percent of Inquiries Resolved Within 15 Business Days	100%	**100%**	100%	**100%**

In Q1 CY2016, the four inquiries not resolved within two business days were resolved within five business days. The inquiries not resolved within two business days were from members; all provider

inquiries were identified as resolved within two business days. During each quarter to date the two-day resolution rate exceeded 99.7%.

On an annual basis, there were 22.6% fewer inquiries in CY2015 than in CY2013 and 6.9% more inquiries than in CY2014. The percentage of inquiries resolved within two business days has improved each year, with only 41 inquiries not resolved within two business days in CY2015, compared to 425 in CY2014 and 1,259 in CY2013. In CY2015, all inquiries were resolved within five business days, compared to 53 not resolved within five business days in CY2014 and 114 in CY2013.

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 95 grievances reported in Q1 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 Q1 CY2016

	CY2015				CY2016
	Q1	Q2	Q3	Q4	Q1
Member Inquiries	#	#	#	#	#
1. Benefit Inquiry – regular or VAS	20,775	19,702	18,611	18,031	**21,924**
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**
3. Care management or health plan program	2,309	2,976	3,008	2,882	**1,597**
4. Claim or billing question	7,107	6,983	7,383	6,396	**6,416**
5. Coordination of benefits	3,437	3,079	3,030	2,898	**3,280**
6. Disenrollment request	632	561	634	544	**606**
7. Eligibility inquiry	13,330	12,750	15,214	14,423	**18,002**
8. Enrollment information	2,141	2,210	2,838	2,371	**3,203**
9. Find/change PCP	15,586	13,407	12,823	11,765	**12,893**
10. Find a specialist	4,070	3,875	3,835	3,469	**3,512**
11. Assistance with scheduling an appointment	46	36	26	40	**30**
12. Need transportation	1,812	1,789	1,402	1,220	**1,326**
13. Order ID card	7,653	6,348	6,240	5,797	**6,958**
14. Question about letter or outbound call	1,013	898	1,175	1,319	**1,322**
15. Request member materials	1,080	1,112	1,511	1,056	**1,083**
16. Update demographic information	13,404	12,639	13,481	11,967	**12,944**
17. Member emergent or crisis call	938	834	717	661	**699**
18. Other	5,768	6,641	5,388	4,801	**5,018**
Total	**103,160**	**97,594**	**99,007**	**91,237**	**102,747**

- Of the 102,747 member customer service inquiries in Q1 CY2016, 42.2% were received by Sunflower, 37.9% by UnitedHealthcare, and 19.9% by Amerigroup.
- The number of member customer service inquiries was higher in Q1 CY2016 than in the previous three quarters; compared to Q4 CY2015, there were 11,510 more inquiries in Q1 CY2016. However, the number of inquiries in Q1 CY2016 (102,747) is comparable to Q1 CY2015 (103,160). The higher

number in Q1 would seem to be likely due to open enrollment and federal timing for acquiring health insurance coverage. Categories with the greatest increases in Q1 CY2016 (compared to the previous four quarters) were "Eligibility inquiry" and "Benefit inquiry."

- Benefit inquiries continue in Q1 to be the highest percentage (21.3%) 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. 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 in five or more quarters include:
  - "Member emergent or crisis call" – 99.7% of 699 inquiries in Q1 CY2016 were reported by Sunflower. (CY2015: Q4 – 99.4%; Q3 – 99.4%; Q2 - 99.8%; Q1 – 99.7%; CY2014: Q4 – 99.7%)
  - "Update demographic information" – 78.1% of 12,944 inquiries in Q1 CY2016 were reported by Sunflower. (CY2015: Q4 – 81.4%; Q3 – 82.1%; Q2 - 82.3%; Q1 – 82.1%; CY2014: Q4 – 71.0%)
  - "Enrollment information" – 85.4% of 3,203 inquiries were reported in Q1 CY2016 by Amerigroup. (CY2015: Q4 – 80.5%; Q3 – 76.8%; Q2 - 76.4%; Q1 CY2015 - 76.6%; CY2014: Q4 – 80.5%)
  - "Need transportation" – 69.2% of 1,326 inquiries were reported in Q1 CY2016 by Amerigroup. (CY2015: Q4 – 70.0%; Q3 – 73.7%; Q2 - 67.2%; Q1 - 75.8%; CY2014: Q4 – 80.8%)

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 14 grievances reported in Q1 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 increased somewhat in Q1 CY2016 compared to the previous three quarters but were lower than in Q1 CY2015.

- Of the 48,921 provider inquiries received by MCOs in Q1 CY2016, Amerigroup received 37.0%, Sunflower 46.9%, and UnitedHealthcare 16.1%.
- For providers, claim status inquiries were again the highest percentage (48.3%) of the 48,921 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 five or more quarters were reported by one MCO included:

- "Authorization – New" – 99.0% of 1,942 inquiries in Q1 CY2016 were reported by Amerigroup. (CY2015: Q4 – 98.6%, Q3– 98.0%; Q2– 99.1%; Q1– 99.1%; CY2014: Q4 – 98.1%)
- "Authorization – Status" – 69.7% of 2,773 inquiries in Q1 CY2016 were reported by Amerigroup. (CY2015: Q4 – 69.9%, Q3– 67.4%; Q2 - 71.0%; Q1 - 70.8%; CY2014: Q4 - 72.0%)
- "Update demographic information" – 95.3% of 744 inquiries were reported in Q1 CY2016 by Sunflower. (CY2015: Q4 – 93.7%, Q3 – 96.2%; Q2 - 91.4%; Q1 - 95.5%; CY2014: Q4 - 99.5%)
- "Coordination of benefits" – 73.7% of 373 inquiries were reported in Q1 CY2016 by UnitedHealthcare. (CY2015: Q4 – 87.9%, Q3– 85.5%; Q2 - 76.8%; Q1 - 90.7%; CY2014: Q4 - 91.0%)
- "Verify/Change participation status" – 71.9% of 345 inquiries in Q1 CY2016 were reported by Sunflower. (CY2015: Q4 – 72.2%, Q3 – 77.8%; Q2 - 68.1%; Q1 - 67.6%; CY2014: Q4 - 66.4%)

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

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 varied greatly by MCO over the last five quarters.

Table 4. Maximum and Minimum Numbers of Provider Inquiries by MCO										
	CY2015								CY2016	
	Q1		Q2		Q3		Q4		Q1	
	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
Authorization - Status	1,739	335	1,718	298	1,565	176	1,814	141	1,932	66
Benefit Inquiry	2,621	318	2,163	265	2,017	489	1,865	477	1,648	755
Claim Denial Inquiry	3,169	0	2,098	0	1,905	0	2,644	0	3,593	0
Claim Status Inquiry	7.09	5,941	8,399	6,273	8,209	5,174	10,466	5,720	14,458	2,473
Claim Payment Question/Dispute	4,142	990	3,303	785	2,772	669	2,404	570	2,276	293
Billing Inquiry	650	19	223	4	195	6	184	2	426	0

Amerigroup
Sunflower
UnitedHealthcare

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 Q1 CY2016 with Q1 CY2015:

- UnitedHealthcare had 6,940 fewer claims-related inquiries reported in Q1 CY2016 (7,284) than in Q1 CY2015 (14,224), and the number of inquiries decreased each quarter in between.
- Sunflower had an increase of 7,284 claims-related inquiries in Q1 CY2016 (18,706) compared to Q1 CY2015 (11,454).
- Amerigroup's claims-related inquiries were comparable in Q1 CY2016 (16,373) and Q1 CY2015 (16,035).

Table 5. Combined Totals for Claim-Related Provider Inquiries

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

Recommendations

The State should work with the MCOs to develop consistent criteria for classifying the member and provider customer service inquiries. Categories where over two-thirds of the inquiries were reported by one MCO in each of the last four quarters include the following:

- Member customer service inquiries: "Update demographic information" (Sunflower), "Member emergent or crisis call" (Sunflower), "Enrollment information" (Amerigroup), and "Need transportation" (Amerigroup).
- Provider customer service inquiries: "Authorization – New" (Amerigroup), "Update demographic information" (Sunflower), "Coordination of benefits" (UnitedHealthcare), "Authorization – Status" (Amerigroup), and "Verify/Change participation status" (Sunflower). Table 4 shows the maximum and minimum numbers of inquiries each quarter and the MCO reporting these.

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 Q1 CY2016 assesses timeliness of processing clean, non-clean, and all claims reports received through Q4 CY2015.

Table 6 . Timeliness of Claims Processing, CY2015

	Q1	Q2	Q3	Q4	Q1-Q4
Clean Claims					
Number of clean claims received in quarter	4,286,318	4,289,698	4,293,070	**4,265,406**	**17,134,492**
Number of claims excluded	0	149	332	**2,269**	**2,750**
Number of clean claims not excluded	4,286,318	4,289,549	4,292,738	**4,263,137**	**17,131,742**
Number of clean claims received within quarter processed within 30 days	4,285,468	4,286,617	4,289,231	**4,261,301**	**17,122,617**
Number of clean claims received within quarter **not** processed within 30 days	850	2,932	3,507	**1,836**	**9,125**
Percent of clean claims processed within 30 days	**99.980%**	**99.932%**	**99.918%**	**99.957%**	**99.947%**
Non-Clean Claims					
Number of non-clean claims received in quarter	180,925	164,617	150,266	**176,809**	**672,617**
Number of claims excluded	352	306	1,310	**1,849**	**3,817**
Number of non-claims not excluded	180,573	164,311	148,956	**174,960**	**668,800**
Number of non-clean claims received within quarter processed within 60 days	180,544	164,251	148,753	**174,079**	**667,627**
Number of non-clean claims received within quarter **not** processed within 60 days	29	60	203	**881**	**1,173**
Percent of non-clean claims processed within 60 days	**99.984%**	**99.963%**	**99.864%**	**99.496%**	**99.825%**
All Claims					
Number of claims received in quarter	4,467,243	4,454,315	4,443,336	**4,442,215**	**17,807,109**
Number of claims excluded	352	455	1,642	**4,118**	**6,567**
Number of claims not excluded	4,466,891	4,453,860	4,441,694	**4,438,097**	**17,800,542**
Number of claims received within quarter processed within 90 days	4,466,812	4,453,606	4,441,634	**4,437,790**	**17,799,842**
Number of claims received within quarter **not** processed within 90 days	79	254	60	**307**	**700**
Percent of claims processed within 90 days	**99.998%**	**99.994%**	**99.999%**	**99.993%**	**99.996%**

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.

Sunflower revised their claims reporting, which now allows more consistent, accurate, and comparable reporting of aggregated claims data from all three MCOs. The data reported in previous quarters of CY2015 have been updated to reflect these changes. It should be noted, as well, however, that the differences in Sunflower's monthly reporting did not substantively alter the overall percentages of claims processed within the contractually-required time periods.

For claims received in Q4 CY2015:

- Clean claims: 99.957% of 4,263,137 clean claims received in Q4 CY2015 were reported by the MCOs as processed within 30 days.
  - In Q4 CY2015, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days.
  - In Q4 CY2015, the number of clean claims not processed within 30 days decreased compared to Q2 and Q3 CY2015, but was higher than in Q1 CY2015. In Q4, 1,836 clean claims were not processed within 30 days, compared to 3,506 in Q3, 2,933 in Q2, and only 850 in Q1 CY2015.
  - Of the 1,836 clean claims not processed within 30 days – 1,707 (93.0%) were claims received by Sunflower; 103 (5.6%) were claims received by Amerigroup; and 26 (1.4%) were claims received by UnitedHealthcare.
- Non-clean claims: 99.496% of 174,960 non-clean claims received in Q4 CY2015 were reported by the MCOs as processed within 60 days.
  - In Q4 CY2015, all of the MCOs met the contractual requirement of processing at least 99% of the non-clean claims within 60 days.
  - In Q4 CY2015, the numbers and percentages of non-clean claims not processed within 60 days were higher than in the three preceding quarters. In Q4 CY2015, 881 non-clean claims were not processed within 60 days, compared to 203 in Q3, 60 in Q2, and 29 in Q1 CY2015.
  - Of the 881 "non-clean claims" not processed within 60 days – 679 (77.1%) were claims received by Amerigroup; 198 (22.5%) were claims received by Sunflower; and 4 (0.5%) were claims received by UnitedHealthcare.
- All claims: 99.993% of 4,438,097 "all claims" received in Q4 CY2015 were reported by the MCOs as processed within 90 days.
  - In Q4 CY2015, none of the MCOs met the requirement of processing 100% of claims within 90 days. UnitedHealthcare, however, reported only one claim not processed within 90 days in Q4.
  - Of the 307 claims not processed within 90 days – 166 (54.1%) were claims received by Amerigroup; 140 (45.6%) were claims received by Sunflower; and one (0.3%) claim received by UnitedHealthcare.
  - In Q4 CY2015, the number and percentage of "all claims" not processed within 90 days were higher than the three preceding quarters. The MCOs reported 60 claims not processed within 90 days in Q3, 254 in Q2, and 79 claims in Q1 CY2015, compared to 307 in Q4.

Average Turnaround Time for Processing Clean Claims

As indicated in Table 7, the MCOs reported 4,409,846 clean claims processed in Q1 CY2016 (includes claims received prior to Q1). Excluding pharmacy claims (which are processed same day) there were 2,646,703 claims, 65,171 fewer claims processed in Q1 compared to Q4 CY2015. Comparing year-to-date, there were 139,493 fewer clean claims (excluding pharmacy claims) processed in Q1 CY2016 compared to Q1 CY2015.

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."

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

	CY2016	Average TAT Monthly Ranges by Year (CY2014 & CY2015)	
	Q1	CY2014	CY2015
Hospital Inpatient	8.1 to 15.1	5 to 19.2	6.4 to 15.9
Hospital Outpatient	4.4 to 10.5	3.6 to 12.8	3.5 to 10.8
Pharmacy	same day	same day	same day
Dental	7.0 to 13.0	2 to 21	4 to 13.1
Vision	7.0 to 12.6	7 to 12.5	9 to 12.5
Non-Emergency Transportation	9.0 to 16.9	10.9 to 18	10.4 to 16
Medical (Physical health not otherwise specified)	4.5 to 9.9	3.3 to 10.6	3.4 to 10.5
Nursing Facilities	4.9 to 9.0	4.3 to 11.5	4.1 to 9.7
HCBS	6.5 to 9.7	3.2 to 15.6	4.1 to 10.2
Behavioral Health	4.2 to 10.3	3.4 to 8.6	2.7 to 10.5
Total Claims (Including Pharmacy)	4,409,846	16,763,501	17,820,402
Total Claims (Excluding Pharmacy)	2,646,703	10,370,998	10,999,807
Average TAT (Excluding Pharmacy)	5.3 to 10.0	4.3 to 11.5	4.3 to 10.3

While the average time to process clean claims averaged less than two weeks for all services, the average monthly TAT for processing clean claims has changed only slightly over the past two years for most of the services. The average TAT for Total Services (excluding pharmacy claims processed same day) was 5.3 to 10.0 days in Q1 CY2016.

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 Q1 CY2016 ranging from 8.1 to 15.1 days, an increase compared to Q4 CY2015 (7.7 to 11.7 days). Amerigroup had the shortest TATs in Q1 (8.1 to 8.9); Sunflower had the highest (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 CY2016. Sunflower had the shortest TATs each month, ranging from 7.0 to 8.0 days; Amerigroup and UnitedHealthcare had TATs of 13.0 days for each month in Q1 CY2016 and Q4 CY2016.
- Non-emergency transportation - Clean claims for non-emergency transportation had longer TATs for all MCOs, with monthly average TATs ranging from 9.0 to 16.9 days.
- Vision – The average TATs were consistently a week or longer in Q1 and previous quarters for all of the MCOs. In Q1 CY2016, the average monthly TATs ranged from 7.0 to 12.7 days.
- Nursing Facilities – Nursing Facility claims had TATs ranging from 4.9 to 9.0 days, an increase compared to 4.7 to 7.8 days in Q4 CY2015.
- HCBS – HCBS claims had TATs ranging from 6.5 to 9.7 days in Q1, an increase compared to Q4 (5.4 to 7.9 days).
- Behavioral Health – BH claims TATs ranged from 4.2 to 10.3 days in Q1 CY2016. Amerigroup had the shortest TATs (4.2 to 4.6 days), and UnitedHealthcare had the longest (8.8 to 10.3 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.

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.

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.

Current Quarter Compared to Previous Quarters

As shown in Table 8, 99.8% (431) of the 432 grievances reported by the MCOs as closed in Q1 CY2016 were reported as resolved within 30 business days.

Table 8. Timeliness of Resolution of Grievances, Year-to-Date (Q1) and Annual (CY2013-CY2015)

	Year-to-date, CY2013-CY2016				Annual, CY2013-CY2015		
	Q1 CY2013	Q1 CY2014	Q1 CY2015	Q1 CY2016	CY2013	CY2014	CY2015
Number of Grievances Received in Quarter	445	498	684	**442**	1,786	2,287	2,021
Number of Grievances Closed in Quarter*	422	501	636	**432**	1,723	2,307	2,046
Number of Grievances Closed in Quarter Resolved Within 30 Business Days*	422	499	625	**431**	1,723	2,283	2,006
Percent of Grievances closed in Quarter Resolved Within 30 Business Days	100%	99.6%	98.3%	**99.8%**	100.0%	99.0%	98.0%
Number of Grievances Closed in Quarter Resolved Within 60 Business Days*	422	501	630	**431**	1,723	2,299	2,035
Percent of Grievances Closed in Quarter Resolved Within 60 Business Days	100%	100%	99.8%	**99.8%**	100.0%	99.7%	99.5%
Number of Grievances Closed in Quarter Not Resolved Within 60 Business Days*	0	0	6	**1**	0	8	11

*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.

- Amerigroup reported 130 (100%) of 130 grievances closed in Q1 were resolved within 30 business days.
- Sunflower reported 140 (97.96%) of 141 grievances closed in Q1 were resolved within 30 business days.
- UnitedHealthcare reported that 156 (100%) of 156 grievances closed in Q1 were resolved within 30 business days.

The one grievance not resolved within the State-required 60 business days was a grievance received by Sunflower.

In Q1 CY2016, the number of grievances received (442) was lower than the number received in the previous eight quarters. In the first 11 quarters of KanCare to date, the number of grievances received ranged from 404 (Q4 CY2013) to 684 (Q1 CY2015). The number of grievances closed by quarter ranged from 412 (Q3 CY2013) to 684 (Q3 CY2014).

The number of grievances received by Sunflower is based only on the "Reason Summary" tab of the GAR report. On the "Grievance Resolution Timeframe" tab of the GAR report, however, Sunflower changed the column heading from "# of grievances received in quarter" to "# of grievances resolved in quarter."

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

Data Sources

The data sources used for comparing and tracking over time the access-related and quality-related grievances, by population, are the quarterly STC and GAR reports described above.

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 GAR Reason Summary Table has 20 categories. Only three of the categories overlap clearly - Claims/Billing Issues, Quality of Care or Service, and Other. The GAR report also includes grievance details, including categorization of each grievance using the categories listed in the GAR report Reasons Summary Table.

Table 9 summarizes the number and types of grievances received (as reported to the State in the STC reports). In the Q1 CY2016 STC and GAR reports, MCOs reported they received 442 grievances.

Table 9. Number of Grievances Received, Q1 CY2015 to Q1 CY2016*

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

*As reported by MCOs in STC reports.

Transportation-related grievances continued to be the most frequently reported grievance received, with 176 in Q1 CY2016, 39.8% of the 442 grievances. In the last five quarters, the number of transportation-related grievances received has dropped somewhat each quarter, ranging from a 251 in Q1 CY2015 to 176 in Q1 CY2016. Grievances related to "Claims/Billing Issues" increased from 62 in Q4 CY2015 to 90 in Q1 CY2016, but down from 217 in Q1 CY2015.

Table 10 summarizes the numbers and types of grievances resolved (as reported in the GAR reports) by category.

Table 10. Comparison of Grievances Resolved, Q1 CY2015 to Q1 CY2016*

	CY2015				CY2016
	Q1	Q2	Q3	Q4	Q1
Claims/Billing Issues	227	86	63	77	97
Quality of Care or Service	40	56	96	71	65
Attitude/Service of Staff	116	144	138	120	108
Availability	83	99	82	83	79
Timeliness	86	83	24	26	31
Pharmacy	9	10	3	11	9
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	-
Other	23	33	35	33	17
"AOR"	13	9	7	12	10
Total	635	542	542	457	432

* As reported in quarterly grievance (GAR) reports.

In reviewing the detailed grievances in the GAR report, KFMC found, as in previous reviews, many of the grievances do not appear to be based on specific or consistent criteria by the MCOs, and some grievances appeared to be misclassified. Beginning in Q2 CY2016, grievance and appeal categories are planned to be reported using categories updated by KDHE staff that provided training to MCO staff to clarify criteria for each category. A number of categories (including "Criteria Not Met – DME," "Criteria Not Met – Medical Procedure," and "Level of Care Dispute") will now be tracked as "appeals" instead of "grievances."

While in the STC report transportation-related grievances have been identified separately, in the GAR report transportation-related grievances are reported in a number of categories, varying in interpretation by MCO (see Table 11). Of 173 transportation-related grievances resolved in Q1 CY2016, 33.5% were categorized as "Availability"; 25.4% as "Attitude/Service of Staff"; 14.5% as "Quality of Care or Service"; 14.5% as "Timeliness; 3.5% as "Billing and Financial Issues"; 1.7% as "Other"; 3.5% as "AOR" (not one of the State-identified categories); 1.2% as "Lack of Information from Provider"; 1.2% as "Accessibility of Office"; 0.6% (1 grievance) as "Level of Care"; and 0.6% as "Overpayments." With the revised categories, transportation-related grievances will be tracked as a separate category, with subcategories to track transportation issues related to safety, no-shows, and lateness. Safety issues

reported this quarter, in addition to speeding and unsafe driving, included a driver texting and accessing Facebook while driving, a driver that fell asleep at the wheel, and minor injuries from faulty anchoring of a wheel chair. Descriptions of no-shows, in addition to miscommunication or timing of requests, included no drivers available from MCO transportation vendors to provide service to members.

Table 11. Transportation-Related Grievances Resolved by Category, Q1 CY2016

	Amerigroup		Sunflower		United		Total	
	#	%	#	%	#	%	#	%
Availability	36	69.2%	22	32.8%			58	33.5%
Timeliness	10	19.2%	15	22.4%			25	14.5%
Attitude/Service of Staff	4	7.7%	17	25.4%	23	42.6%	44	25.4%
Billing and Financial Issues	1	1.9%	4	6.0%	1	1.9%	6	3.5%
Quality of Care or Service	1	1.9%			24	44.4%	25	14.5%
Lack of Information from Provider			2	3.0%			2	1.2%
Level of Care			1	1.5%			1	0.6%
Accessibility of Office			2	3.0%			2	1.2%
Overpayments			1	1.5%			1	0.6%
Other			3	4.5%			3	1.7%
AOR "Appointment of Representation"					6	11.1%	6	3.5%
Transportation-Related Total	52		67		85		173	

An additional complication is the addition of an “AOR” category, not one of the categories the State has identified for categorizing grievances, in the GAR report by UnitedHealthcare. Inclusion of AOR by UnitedHealthcare first occurred in Q1 CY2015 when 13 grievances were categorized as “AOR.” At that time, KFMC contacted UnitedHealthcare and was told that “AOR” refers to “Appointment of Representation.” In Q4 CY2015, UnitedHealthcare categorized 12 grievances as “AOR”; in Q1 CY2016, 10 grievances were categorized as “AOR.” The descriptions UnitedHealthcare provides for most grievances were, as in previous quarterly reports, very limited and/or cut off mid-sentence (or mid-word), making it difficult to determine whether the grievances are categorized appropriately or to determine appropriate categories for grievances, particularly where grievances are labeled as “AOR.” Most of the 161 grievances reported in Q1 by UnitedHealthcare in the GAR report again did not include descriptions of the grievance or grievance resolution adequate to assess whether grievances were appropriately categorized.

Table 12 reports the types of grievances resolved in Q1 CY2016 in total and by waiver, the number of members reporting grievances, and the number of transportation-related grievances based on grievance narrative details.

Of 432 grievances resolved in Q1 CY2016 reported by 399 members, 107 (24.8%) were from 95 members receiving waiver services. Compared to the previous quarter, the number and percentage of grievances reported by members receiving waiver services decreased; in Q4 CY2015, 115 (25.2%) of 457 grievances were reported by 99 members receiving waiver services. As shown in Table 13, the number of all grievances, the number of grievance by waiver, and the number and percentage of transportation-related grievances, have, for the most part, been decreasing each quarter.

Table 12. Comparison by Waiver of Grievances Resolved in Q1 CY2016*									
	Grievances		Grievances by Waiver Type						
	All Members	Waiver Members	FE	I/DD	PD	SED	Autism	TA	TBI
Billing and Financial Issues	97	19	6	4	7	2			
Quality of Care or Service	65	12	3		8	1			
Attitude/Service of Staff	108	35	3	5	25				2
Timeliness	31	9		1	6				2
Availability	79	23	2	3	12	1			5
Pharmacy	9	3	1	1	1				
Lack of Information from Provider	2	0							
Level of Care Dispute	4	2			1	1			
Prior or Post Authorization	1	0							
Accessibility of Office	4	0							
Criteria not met - Medical Procedure	2	0							
Criteria not met - Durable Medical Equipment	2	0							
Overpayments	1	0							
"AOR" (Appointment of Representation)	10	0							
Other	17	4		1					3
Total Grievances Resolved Q1	432	107	15	15	60	5	0	0	12
Transportation-Related	173	37	4	5	22	0			6
# of Members with Grievances Resolved Q1	399	95	13	15	55	4	0	0	8

*Includes grievances received in Quarter 4 CY2015 resolved in Quarter 1 CY2016

Of the 107 grievances received from waiver members in Q1 CY2016, 37 (34.6%) 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 Q1, with 55 members reporting 60 grievances, 22 (36.7%) transportation-related. In Q4 CY2015, PD waiver members reported 51 grievances, 22 (43.1%) transportation-related.
- Frail Elderly (FE) waiver members reported 15 grievances (13 members), four (26.7%) transportation-related. In Q4 CY2015, 20 grievances were reported by 18 members, 11 (55.0%) transportation-related.
- Intellectual/Developmental Disability (I/DD) waiver members in Q1 reported 15 grievances (15 members), five (33.3%) transportation-related. In Q4 CY2015, 13 members reported 14 grievances, four (28.6%) transportation-related.
- Traumatic Brain Injury (TBI) waiver members reported 12 grievances (eight members), six (50%) transportation-related. In Q4 CY2015, 14 members reported 19 grievances, seven (36.8%) transportation-related.
- Serious Emotional Disturbance (SED) waiver members reported five grievances (four members) in Q1, none that were transportation-related. In Q4 CY2015, five members reported five grievances, one transportation-related.

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

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

Access-Related Grievances

Of the 442 grievances received in Q1 CY2016, 44 (10.0%) were categorized in the STC report as "Access to Service or Care" (see Table 9). Access-related grievances have consistently been one of the least frequently categorized grievances. The number of "Access to Service or Care" grievances has ranged from 13 reported in Q2 and Q3 of CY2013 to 44 reported this quarter.

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

- Amerigroup reported 16 access-related grievances received in Q1 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*."
- UnitedHealthcare reported seven access-related grievances received in Q1. These were described last quarter and this quarter 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."*
- Sunflower reported 21 access-related grievances received in Q1. In the STC trend summary, Sunflower reported, *"There are no trends identified in this area in this quarter."*

As there is no "Access to Service or Care" grievance category in the GAR report, it is not possible to compare quarterly changes in the number of access-related grievances resolved. The 44 grievances identified in the STC report as "Access to Service or Care" could potentially be 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."

Quality-Related Grievances

In Q1 CY2016, 36 (8.1%) of grievances received were categorized in the STC report as being related to "Quality of Service or Care" (QOC). In the GAR report, 65 (15.0%) of 432 grievances reported as resolved in Q1 were categorized as QOC. At least 38% (25) of the 65 QOC grievances were transportation-related.

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 22 QOC grievances received in Q1. 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 four QOC grievances and that only one of the four *was 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 10 QOC grievances received in Q1, and that, "*There are no trends identified in this area in this quarter however, 30% were forwarded to QOC coordinator*," adding, as in previous STC reports, "*These items are regarding how the member felt they were not being cared for by the provider and/or provider staff. 40% were forwarded to QOC coordinator*."

Of the 65 QOC grievances reported in the GAR report as resolved in Q1 CY2016, 12 were from members receiving waiver services including: eight members receiving PD waiver services, three members receiving FE waiver services, and one member receiving SED waiver services.

In reviewing the descriptions of resolved grievances in the three MCOs' GAR reports for Q1, KFMC found several grievances that could potentially be considered to be related to QOC that were categorized as "Attitude/Service of Staff." Due to the limited information and cut-off text descriptions of grievances, it is not possible to assess how many of the 49 grievances categorized by UnitedHealthcare are related to QOC.

In addition to the 12 transportation-related grievances categorized as QOC, descriptions of several grievances categorized as QOC could instead have potentially been categorized as "Availability," "Level of Care Dispute," "Timeliness," "Billing and Financial Issues," "HCBS," or "Attitude/Service of Staff."

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.
- 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 not revise column headings on reporting templates, particularly where the revisions change the parameters of the data requested by the State.
- In the timeframe identified by the State for implementing the revised grievance templates, MCOs should categorize grievances using the revised categories and criteria.
- Grievance categories (such as "AOR") not defined by the State, should not be added by MCOs.
- MCOs should ensure their staff understand the revised grievances and appeals categories and should contact the State to request clarification for any grievance or appeals categories where criteria are not clearly understood by MCO staff.

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 Q1 CY2016 is the quarterly KanCare Ombudsman Update report, with follow-up discussions with Kerrie Bacon, KanCare Ombudsman.

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 most volunteer applications were from the Wichita area, training began in Wichita. As of Q1 CY2016, the Wichita volunteer office had five active volunteers and provided assistance to over 300 individuals.

The Ombudsman's Office is conducting additional marketing to recruit additional volunteers in the Kansas City metropolitan area, including Johnson County, with plans to expand statewide in 2016.

Next steps include developing and implementing volunteer training to provide assistance in filling out Medicaid applications and training (goal: Q4 CY2016) to assist KanCare members one-on-one with the grievance, appeal, and/or State Fair Hearing process.

A primary task for the Ombudsman's Office has been to provide information to KanCare members and assist them in reaching MCO staff that can provide additional information and assistance in resolving questions and concerns. This quarter, the Ombudsman's office has developed and updated materials available on the Ombudsman's office website (www.kancare.ks.gov/ombudsman.htm) that provide detailed explanations of the KanCare eligibility process, KanCare enrollment information, and information on the grievance, appeals, and State Fair Hearings processes.

Contacts with the Ombudsman's office are primarily by phone and email, but also include face-to-face contacts. Ombudsman staff participated in a number of outreach activities in Q1 CY2016, including the Volunteer Fair at Wichita State University, a health fair in Wichita, and presentations at Goodwill Industries and the Women's Recovery Center.

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 contacts, compared to 462 to 579 in the previous four quarters, primarily due to requests for assistance related to Medicaid eligibility. Of 1,130 contacts to the Ombudsman's Office in Q1, 866 (76.6%) were from consumers (compared to 385 the previous quarter); 179 (15.8%) from providers, seven were from MCO employees, and 78 were categorized as "other."

In Q1 CY2015, 250 of the 1,130 contacts were related to an MCO issue. As shown in Table 14, the number of MCO-related contacts in Q1 CY2016 was the highest since Q3 CY2014.

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

	All Contacts	MCO-Related Contacts	% MCO-Related Contacts
CY2016			
Q1	1,130	250	22.1%
CY2015			
Q1	510	224	43.9%
Q2	462	208	45.0%
Q3	579	187	32.3%
Q4	524	139	26.5%
CY2014			
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 Q1 CY2016 with Q1 CY2014 and Q1 CY2015. Two of the top three issues in Q1 CY2014-CY2016 were the same ("Medicaid Eligibility Issues" and HCBS-related issues). In Q1 of this year and last year, "Appeals, Grievances," was the third highest contact issue, compared to and "Billing" in Q1 CY2014. In addition to the greatly increased number of "Medicaid Eligibility Issues" in Q1 CY2016, the number of HCBS-related contacts increased by 57-58% compared to Q1 CY2014 and Q1 CY2015; there were 144 HCBS-related contacted in Q1 CY2016 compared to 91 and 92 in Q1 CY2014 and Q1 CY2015, respectively.

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, 152 contacts were reported as waiver-related in Q1 CY2016, higher than the previous six quarters. From Q3 CY2014 through Q1 CY2016, the number of waiver-related inquiries ranged from 106 (Q4 CY2015) to 152 (this quarter). The most frequent waiver-related issues were again for/from KanCare members receiving waiver services for Physical Disability (PD) and Intellectual/Developmental Disability (I/DD); of 873 waiver-related inquiries from July 2014 through March 2016, 286 (32.8%) were from members receiving PD waiver services, and243 (27.8%) were from members receiving I/DD waiver services.

Table 15. Issue Types Submitted to the Ombudsman's Office, Q1 of CY2014 to CY2016

	Quarter 1					
	CY2014		CY2015		CY2016	
	#	%	#	%	#	%
Medicaid Eligibility Issues	81	25%	139	35%	512	57.2%
Appeals, Grievances	22	8%	42	8%	49	5.5%
Medical Service Issues	14	9%	20	5%	29	3.2%
Billing	51	10%	36	8%	43	4.8%
Durable Medical Equipment	25	5%	25	3%	7	0.8%
Pharmacy	38	5%	25	5%	24	2.7%
HCBS						
HCBS General Issues	11	7%	60	10%	69	7.7%
HCBS Eligibility Issues	55	5%	11	4%	45	5.0%
HCBS Reduction in Hours of Service	22	3%	10	3%	12	1.3%
HCBS Waiting List	3	2%	11	2%	18	2.0%
Care Coordinator Issues	10	3%	10	2%	7	0.8%
Transportation	11	3%	12	2%	6	0.7%
Nursing Facility Issues	8	3%	15	6%	40	4.5%
Housing Issues	3	2%	1	1%	8	0.9%
Change MCO	6	2%	8	2%	15	1.7%
Dental	16	3%	7	1%	4	0.4%
Access to Providers	16	3%	3	1%	7	0.8%
Guardianship Issues	16	1.3%	5	0.5%	0	0.0%
Total Issues	408		440		895	

Table 16. Waiver-Related Inquiries to the Ombudsman's Office, Q3 CY2014 to Q1 CY2016

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

Conclusions Summary

Timely Resolution of Customer Service Inquiries

- In Q1 CY2016, 99.996% of the customer service inquiries received by the MCOs were resolved within two business days. The four inquiries not resolved within two business days, were resolved within five business days.
- During each quarter to date the two-day resolution rate exceeded 99.7%.
- Based on the wide range of reported number of inquiries in some of the categories, particularly provider inquiries that are claims-related, the criteria used by the MCOs to categorize member and provider inquiries varies by MCO. As a result, aggregated data for certain categories are more representative of one MCO rather than all three.
- Member customer service inquiries
  - MCOs received 102,747 member customer service inquiries – 11,510 more than the previous quarter, but comparable to Q1 CY2015.
  - Of the 102,747 member customer service inquiries in Q1 CY2016, 42.2% were received by Sunflower, 37.9% by UnitedHealthcare, and 19.9% by Amerigroup.
  - Benefit inquiries were the highest percentage (21.3%) of member inquiries
  - There are four categories where two thirds or more of the inquiries in the last five or more quarters were reported by only one MCO:
    - "Member emergent or crisis call" – 99.7% of 699 inquiries in Q1 CY2016 were reported by Sunflower. (CY2015: Q4 – 99.4%; Q3 – 99.4%; Q2 - 99.8%; Q1 – 99.7%; CY2014: Q4 – 99.7%)
    - "Update demographic information" – 78.1% of 12,944 inquiries in Q1 CY2016 were reported by Sunflower. (CY2015: Q4 – 81.4%; Q3 – 82.1%; Q2 - 82.3%; Q1 – 82.1%; CY2014: Q4 – 71.0%)
    - "Enrollment information" – 85.4% of 3,203 inquiries were reported in Q1 CY2016 by Amerigroup. (CY2015: Q4 – 80.5%; Q3 – 76.8%; Q2 - 76.4%; Q1 CY2015 - 76.6%; CY2014: Q4 – 80.5%)
    - "Need transportation" – 69.2% of 1,326 inquiries were reported in Q1 CY2016 by Amerigroup. (CY2015: Q4 – 70.0%; Q3 – 73.7%; Q2 - 67.2%; Q1 - 75.8%; CY2014: Q4 – 80.8%)
- Provider customer service inquiries
  - Similar to member inquiries, the number of provider inquiries increased somewhat in Q1 CY2016 compared to the previous three quarters, but were lower than in Q1 CY2015.
  - Of the 48,921 provider inquiries received by MCOs in Q1 CY2016, Amerigroup received 37.0%, Sunflower 46.9%, and UnitedHealthcare 16.1%.
  - For providers, claim status inquiries were again the highest percentage (48.3%) of the 48,921 provider inquiries.
  - Categories where two thirds or more of the provider inquiries in five or more quarters were reported by only one MCO included:
    - "Authorization – New" – 99.0% of 1,942 inquiries in Q1 CY2016 were reported by Amerigroup. (CY2015: Q4 – 98.6%, Q3– 98.0%; Q2– 99.1%; Q1– 99.1%; CY2014: Q4 – 98.1%)
    - "Authorization – Status" – 69.7% of 2,773 inquiries in Q1 CY2016 were reported by Amerigroup. (CY2015: Q4 – 69.9%, Q3– 67.4%; Q2 - 71.0%; Q1 - 70.8%; CY2014: Q4 - 72.0%)
    - "Update demographic information" – 95.3% of 744 inquiries were reported in Q1 CY2016 by Sunflower. (CY2015: Q4 – 93.7%, Q3 – 96.2%; Q2 - 91.4%; Q1 - 95.5%; CY2014: Q4 - 99.5%)

- "Coordination of benefits" – 73.7% of 373 inquiries were reported in Q1 CY2016 by UnitedHealthcare. (CY2015: Q4 – 87.9%, Q3– 85.5%; Q2 - 76.8%; Q1 - 90.7%; CY2014: Q4 - 91.0%)
- "Verify/Change participation status" – 71.9% of 345 inquiries in Q1 CY2016 were reported by Sunflower. (CY2015: Q4 – 72.2%, Q3 – 77.8%; Q2 - 68.1%; Q1 - 67.6%; CY2014: Q4 - 66.4%)
- Of the 17 categories, 7 are focused on claims; the range of inquiries for each of the 7 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 Q4 CY2015, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days. Of 4,263,137 clean claims received in Q4 CY2015, 99.957% were processed within 30 days. Of the 1,836 clean claims not processed within 30 days, 93.0% (1,707) were claims received by Sunflower; 5.6% (103) were claims received by Amerigroup; and 1.4% (26) were claims received by UnitedHealthcare.
  - In Q4 CY2015, all of the MCOs reported that they met the contractual requirement of processing at least 99% of non-clean claims within 60 days. Of 174,960 non-clean claims received in Q4 CY 2015, 99.496% were processed within 60 days. In Q4 CY2015, the numbers and percentages of non-clean claims not processed within 60 days were higher than in the three preceding quarters.
  - Of 4,438,097 "all claims" received in Q4 CY2015, 99.993% were processed within 90 days. Of the 881 claims not processed within 90 days, 679 (77.1%) were claims received by Amerigroup; 198 (22.5%) were claims received by Sunflower; and 4 (0.5%) were claims received by UnitedHealthcare. In Q3 CY2015, the numbers and percentages of "all claims" not processed within 90 days were higher than in the three preceding quarters.

- **Turnaround time (TAT) ranges for processing clean claims**
  - In Q1 CY2016, the average TAT for Total Services was 5.3 to 10.3 days, an increase from the previous quarter.
  - 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 Q1 CY2016 ranging from 8.1 to 15.1 days, an increase compared to Q4 CY2015 (7.7 to 11.7 days). Amerigroup had the shortest TATs in Q1 (8.1 to 8.9); Sunflower had the highest (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 CY2016. Sunflower had the shortest TATs each month, ranging from 7.0 to 8.0 days; Amerigroup and UnitedHealthcare had TATs of 13.0 days for each month in Q1 CY2016 and Q4 CY2016.
    - Non-emergency transportation - Clean claims for non-emergency transportation had longer TATs for all MCOs, with monthly average TATs ranging from 9.0 to 16.9 days.
    - Vision – The average TATs were consistently a week or longer in Q1 and previous quarters for all of the MCOs. In Q1 CY2016, the average monthly TATs ranged from 7.0 to 12.7 days.

- Nursing Facilities – Nursing Facility claims had TATs ranging from 4.9 to 9.0 days, an increase compared to 4.7 to 7.8 days in Q4 CY2015.
- HCBS – HCBS claims had TATs ranging from 6.5 to 9.7 days in Q1, an increase compared to Q4 (5.4 to 7.9 days).
- Behavioral Health – BH claims TATs ranged from 4.2 to 10.3 days in Q1 CY2016. Amerigroup had the shortest TATs (4.2 to 4.6 days), and UnitedHealthcare had the longest (8.8 to 10.3 days).

Grievances

- In Q1 CY2016, the number of grievances received (442) was lower than the number received in the previous eight quarters.
- Of 432 grievances closed in Q1 CY2016, 99.8% (431) were resolved within 30 business days. One grievance, received by Sunflower, was not resolved with the State-required 60 business days.
- The grievance categories with the highest number of grievances were those related to transportation; 176 of 442 (39.8%) of grievances received in Q1.
- UnitedHealthcare again this quarter categorized grievances (10) as "AOR" (Appointment of Representation), which is not one of the GAR categories. UnitedHealthcare provides only limited descriptions of grievances, and most descriptions are cut off, making it difficult to determine how these 10 grievances should be categorized and/or to assess whether other grievances are categorized appropriately.
- Of 432 grievances reported by 399 members as resolved by MCOs in Q1 CY2016, 107 (34.6%) were reported by 95 members receiving waiver services.
- The number of access-related grievances each quarter is a relatively small percentage of grievances reported; MCOs categorized 44 (10.0%) of 442 grievances received in Q1 CY2016 as "Access to Service or Care."
- In Q1 CY2016, 36 (8.1%) of grievances received were categorized in the STC report as being related to "Quality of Service or Care" (QOC). In the GAR report, 65 of 432 (15.0%) grievances reported as resolved in Q1 were categorized as QOC; approximately 38% were transportation-related.
- 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 32 grievances in the category that quarter.
- When categorizing grievance in the GAR and STC reports, MCOS continue to use inconsistent criteria. Transportation-related grievances, in particular, continue to be categorized differently by each MCO for similarly described situations. In Q4, 43 of 71 grievances categorized as "Quality of Care" were related to quality of transportation services. In Q4 CY2015, KDHE staff, with input from the EQRO, reviewed and revised grievance and appeals categories and defined criteria for each category. Trainings were held with MCO staff to discuss the changes. A number of categories that had been included in the GAR report as "grievances" were re-assessed and determined to be more appropriately categorized as "appeals." The GAR report, which previously did not include a "transportation" category, will in the revised template have a transportation category with subcategories to include tracking of "no shows," lateness, and safety issues. Developing standardized category criteria, and ensuring consistent use of categories and criteria in the GAR and STC reports, should greatly improve the ability to assess the number and types of grievances received and resolved each quarter and to assess trends over time. Templates with revised grievance and appeal categories were planned to be implemented in Q2 CY2016, which allowed MCOs adequate time to put the new reporting processes into place.

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.
- Of the 1,130 contacts, 250 (22.1%) were MCO-related, the highest number since the Ombudsman's Office began tracking these contacts in CY2014.
- 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. The greatest increase was in Medicaid Eligibility Issue contacts – 512 in Q1 CY2016, compared to 139 in Q1 CY2015 and 81 in Q1 CY2014. HCBS-related contacts also increased by 57-58% in Q1 CY2016 compared to Q1 in the previous two years.
- There were 152 waiver-related inquiries, an increase compared to the previous six quarters. From Q3 CY2014 through Q1 CY2016, the number of waiver-related inquiries ranged from 106 (Q4 CY2015) to 152 (this quarter). The most frequent waiver-related issues were again for/from KanCare members receiving waiver services for Physical Disability (PD) and Intellectual/Developmental Disability (I/DD); of 873 waiver-related inquiries from July 2014 through March 2016, 286 (32.8%) were from members receiving PD waiver services, and243 (27.8%) were from members receiving I/DD waiver services.
- This quarter, the Ombudsman's office developed and updated materials available on the Ombudsman's office website (www.kancare.ks.gov/ombudsman.htm) that provide detailed explanations of the KanCare eligibility process, KanCare enrollment information, and information on the grievance, appeals, and State Fair Hearings processes.
- Recruitment of volunteers for the KanCare Ombudsman Volunteer Program began in June 2015. As most volunteer applications were from the Wichita area, training began in Wichita. As of Q1 CY2016, the Wichita volunteer office had five active volunteers and provided assistance to over 300 individuals. Additional volunteers are being recruited in the Kansas City and Johnson County areas.
- Next steps include developing and implementing volunteer training to provide assistance in filling out Medicaid applications and training (goal: Q4 CY2016) to assist KanCare members one-on-one with the grievance, appeal, and/or State Fair Hearing process.

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. Categories where over two-thirds of the inquiries were reported by one MCO in each of the last four quarters include the following:

- Member customer service inquiries: "Update demographic information" (Sunflower), "Member emergent or crisis call" (Sunflower), "Enrollment information" (Amerigroup), and "Need transportation" (Amerigroup).
- Provider customer service inquiries: "Authorization – New" (Amerigroup), "Update demographic information" (Sunflower), "Coordination of benefits" (UnitedHealthcare), "Authorization – Status" (Amerigroup), and "Verify/Change participation status" (Sunflower).

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, 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.
- 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.
- In the timeframe identified by the State for implementing the revised grievance templates, MCOs should categorize grievances using the revised categories and criteria.
- Grievance categories (such as "AOR") not defined by the State, should not be added by MCOs.
- MCOs should not revise column headings on reporting templates, particularly where the revisions change the parameters of the data requested by the State.
- MCOs should ensure their staff understand the revised grievances and appeals categories and should contact the State to request clarification for any grievance or appeals categories where criteria are not clearly understood by MCO staff.

End of report

KDHE Summary of Claims Adjudication Statistics –

January through March 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	11,117	$356,796,920.86	1,671	$57,938,624.43	15.03%
Hospital Outpatient	88,746	$200,724,601.96	12,974	$20,928,810.22	14.62%
Pharmacy	521,510	$34,214,502.67	143,186	Not Applicable	27.46%
Dental	30,331	$8,113,156.48	2,382	$629,931.04	7.85%
Vision	17,886	$4,782,627.96	3,528	$1,042,345.93	19.72%
NEMT	29,699	$938,086.69	82	$3,555.80	0.28%
Medical (physical health not otherwise specified)	519,222	$350,505,610.76	65,351	$36,789,226.71	12.59%
Nursing Facilities-Total	24,208	$56,953,994.39	3,170	$5,993,353.11	13.09%
HCBS	50,148	$28,231,317.43	2,907	$1,537,659.01	5.80%
Behavioral Health	164,236	$21,440,603.79	18,404	$2,113,035.06	11.21%
Total All Services	1,457,103	$1,062,701,422.99	253,655	$126,976,541.31	17.41%

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	9,621	$362,665,072	1,981	$96,838,233	20.59%
Hospital Outpatient	92,192	$194,372,541	13,654	$27,976,833	14.81%
Pharmacy	814,325	$77,285,074.31	208,317	$38,824,881.56	25.58%
Dental	39,389	$10,060,177.50	3,153	$700,590.02	8.00%
Vision	25,859	$6,054,868.15	3,115	$801,842.93	12.05%
NEMT	33,402	$944,543.98	123	$2,566.99	0.37%
Medical (physical health not otherwise specified)	467,077	$240,427,224	67,936	$53,960,405	14.54%
Nursing Facilities-Total	33,625	$75,942,688	4,456	$11,668,131	13.25%
HCBS	136,904	$58,809,440	7,111	$3,525,650	5.19%
Behavioral Health	154,452	$24,221,956	16,422	$3,090,533	10.63%
Total All Services	1,806,846	1,050,783,586	326,268	237,389,667	18.06%

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	6,618	$238,196,155.64	1,702	$87,516,342.87	25.71%
Hospital Outpatient	75,469	$177,146,702.74	11,740	$33,711,624.57	15.55%
Pharmacy	434,282	$39,117,496.59	89,441	$14,145,700.02	20.60%
Dental	20,138	$4,072,499.04	2,146	$505,012.32	10.66%
Vision	31,215	$8,760,176.37	2,431	$727,592.19	7.79%
NEMT	36,190	$1,002,658.34	62	$2,048.65	0.17%
Medical (physical health not otherwise specified)	496,160	$201,105,650.68	76,133	$44,925,431.82	15.34%
Nursing Facilities-Total	22,878	$54,599,691.53	3,320	$8,953,402.54	14.51%
HCBS	85,571	$20,470,238.15	6,419	$1,581,819.85	7.50%
Behavioral Health	58,512	$22,373,802.23	4,174	$3,414,009.43	7.13%
Total All Services	1,267,033	$766,845,071	197,568	$195,482,984	15.59%