Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 3.31.15

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

KanCare
Section 1115 Quarterly Report
Demonstration Year: 3 (1/1/2015-12/31/2015)
Federal Fiscal Quarter: 2/2015 (1/15-3/15)

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I. Introduction

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

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

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

This five year demonstration will:

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

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

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

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

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

II. Enrollment Information

The following table outlines enrollment activity related to populations included in the demonstration. It does not include enrollment activity for non-Title XIX programs, including the Children's Health Insurance Program (CHIP), nor does it include populations excluded from KanCare, such as Qualified Medicare Beneficiaries (QMB) not otherwise eligible for Medicaid. The table does include members retroactively assigned for the first quarter known as of March 31, 2015.

Demonstration Population	Enrollees at Close of Qtr. (03/31/2015)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	17,137	18,278	1,141
Population 2: ABD/SD Non Dual	28,831	29,606	775
Population 3: Adults	43,843	46,575	2,732
Population 4: Children	229,233	237,889	8,656
Population 5: DD Waiver	8,732	8,805	73
Population 6: LTC	20,560	21,951	1,391
Population 7: MN Dual	1,201	1,366	165
Population 8: MN Non Dual	1,096	1,231	135
Population 9: Waiver	3,844	3,956	112
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**354,477**	**369,657**	**15,180**

III. Outreach/Innovation

The KanCare website, www.kancare.ks.gov, is home to a wealth of information for providers, consumers, stakeholders and policy makers. Sections of the website are designed specifically around the needs of consumers and providers; and information about the Section 1115 demonstration and its operation is provided in the interest of transparency and engagement.

During the first quarter of 2015, Tribal Technical Advisory Group (TTAG) meetings with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations continued, on the following dates with attendees in person and by phone: February 3, 2015 (10 attendees) and March 3, 2015 (13 attendees).

During this quarter, the state's KanCare Advisory Council did not meet, but scheduled to meet on April 2, 2015. Related details will be reported in the next quarterly report.

The KanCare Consumer and Specialized Issues Workgroup met on March 26, 2015, in Leavenworth, Kansas. The agenda items included a report from the KanCare Ombudsman, and a follow up discussion on the Kancare MCOs' case managers and communication to members when a new case manager is assigned. The meeting also included an in-depth look at KDHE's KanCare January 2015 Executive Summary Report.

The KanCare Provider Operations Issues workgroup met March 12, 2015. The KDHE Dentist provided information on the programs within the KDHE Bureau of Oral Health. She discussed at length the two main programs, the Children's Program and the School Sealant Program.

- The Children's Program is a school screening program that is throughout the state. During the last school year, this program screened over 154,000 school children grades K-12, which is not billed to any insurance plan.
- The second program, the School Sealant Program, is a billable to insurance activity. KDHE assists dentists and hygienists to go to schools with mobile units to provide preventative services, fluoride varnish and sealants to students.

There was also mention that Kansas was one of five states chosen to participate in the CMS Oral Health Initiative. Some discussion of the anti-fluoridation movement in Kansas followed. This KDHE dental program overview and subsequent question-and-answer session comprised the majority of the workgroup meeting. In addition, all three MCOs provided general claims and operational updates to the group in the time remaining.

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)
- HCBS-IDD Provider Lunch and Learn teleconferences (1 hour, bi-weekly)
- HCBS-IDD Consumer Lunch and Learn teleconferences (1 hour, bi-weekly)
- Long-term Care Roundtable with Department of Children & Families (quarterly)
- Big Tent Coalition meetings (monthly) to discuss KanCare and stakeholder issues
- Interhab (CDDO Association) board meetings (as requested)
- 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 (monthly) to address billing and other concerns
- Series of workgroup meetings and committee meetings with the Managed Care Organizations and Community Mental Health Centers
- Quarterly Meetings with the Association of Community Mental Health Centers, including Managed Care Organizations
- Regular meetings with the Kansas Hospital Association KanCare implementation technical assistance group
- Series of meetings with behavioral health institutions, private psychiatric hospitals, and Psychiatric Treatment Residential Facilities (PRTFs) to address care coordination and improved integration
- State Mental Health Hospital mental health reform meetings (quarterly)
- DSM V Workgroups to discuss DSM 5 implementation in quarter 3

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

Health Homes

Kansas intends to implement the Medicaid Health Homes State Plan option that will include two target populations that are covered within the KanCare program. The following briefly describes the state's work on this initiative. The State Plan Amendment (SPA) to implement Health Homes for people with serious mental illness (SMI) was approved by CMS on July 28, 2014 with an effective date of July 1, 2014.

- Health homes for both target populations – people with serious mental illness (SMI) and people with other chronic conditions (likely diabetes and asthma, although the specific population is still being determined) – will be implemented at different times; Health Homes for people with chronic conditions has been delayed to allow for ensuring an adequate network of Health Home Partners
- The model Kansas will implement will be a partnership between the KanCare health plans and community providers, like CMHCs and FQHCs, and together, the partners will provide the six core health home services
- An interagency project team of KDADS and KDHE staff, along with KanCare health plan representatives, university partners, HP staff and actuary staff have been working on the project since Spring 2012

- A Steering Committee of KDADS and KDHE leadership provides direction to the project team
- Completed tasks include:
    - Defining the six health homes services
    - Identifying the first target group, approximately 36,000 adults and children with SMI
    - Determining the goals for health homes and selecting quality measures, including eight required by CMS
    - Defining the provider qualifications and standards
    - Determining that the health plans will be paid a per member per month (PMPM) rate outside of their KanCare PMPM and from this, they will pay their Health Home Partners (HHPs)
    - Obtaining federal planning money ($500,000 matched at the Medicaid service rate to be almost $885,000) to pay university partners at Kansas University Medical Center and Wichita State University (WSU) to analyze claims data to select the target populations and research provider learning collaboratives. Two-thirds of the money will also be used to pay actuaries to create the PMPM and to support stakeholder education, engagement and HIT readiness activities
    - Forming a Focus Group of 80+ stakeholders to provide advice and input. This group has been meeting since April 2012.
    - Consulting with the Substance Abuse and Mental Health Services Administration (SAMHSA) on our approach to health homes for the SMI population
    - Holding bi-weekly calls with the federal technical assistance provider, the Center for Health Care Strategies
    - Participating in monthly calls with CMS to work through issues before official submission of our state plan amendments (SPAs)
    - Holding two forums, attended by almost 400 people, to explain our model and obtain input on service definitions, proposed provider standards, quality goals and measures and other components of the project
    - Establishing a web page on the KanCare website to educate and inform stakeholders about the project (http://www.kancare.ks.gov/health_home.htm)
    - Publishing a monthly newsletter, the *Health Homes Herald*, to help inform stakeholders about the project and its progress
    - Developing consumer education materials, including a brochure, a booklet and a consumer PowerPoint presentation
    - Making project presentations at various provider association conferences and meetings
    - Holding an educational webinar for interested providers
    - Identifying the second target population, approximately 38,000 people who have asthma or diabetes and are at risk for a second chronic condition, including hypertension, substance use disorder, coronary artery disease, or depression
    - Deploying the Preparedness and Planning Tool to help providers assess their readiness to become HHPs

- Deploying a provider survey through Kansas Foundation for Medical Care to prioritize providers for assistance in planning to implement electronic health records (EHR)
- Transferring responsibility to WSU's Center for Community Support and Research (CCSR) for convening and facilitating the Health Homes Focus Group, now called the Health Homes Stakeholders Meeting
- Scheduling, through CCSR, twice monthly webinars for providers interested in becoming HHPs to be held from February through June 2014
- Developing a HHP network adequacy report format for the health plans to report their progress in establishing networks of Health Homes, beginning April 15, 2014
- Holding 32 meetings in 16 cities for consumers to introduce the Health Homes program
- Creating a referral form for providers and hospitals to use to refer potential Health Homes members to the MCOs
- Creating an informational brochure to help inform consumers about Health Homes
- Securing funding from the Sunflower Foundation and REACH Foundation to support the Health Homes Learning Collaborative beginning July 2014
- Developing the PMPM rate for SMI Health Homes
- Publishing a draft Program Manual for SMI Health Homes
- Issuing tribal notification to the four recognized American Indian tribes
- Holding six day-long provider training sessions across the state
- Publishing a draft Program Manual for Chronic Conditions (CC) Health Homes
- Developing PMPM rates for CC Health Homes
- Developing the components the State wants the health plans to include in their contracts with HHPs
- Consulting with SAMHSA for the second, chronic conditions, SPA
- Issuing public notice about the SPAs and their fiscal impact
- Submitting both SPAs to CMS officially on May 7, 2014
- Withdrawing the Chronic Conditions SPA on June 30, 2014 to allow us more time to ensure an adequate network of Health Home Partners is available
- Performing an operational readiness review of the MCOs May 20-22, 2014
- Reviewing network reports submitted by the MCOs
- Completing work to receive files from and pay the MCOs for Health Home services
- Scheduling SMI Health Homes Implementation calls weekly to hear from providers and address systemic issues and questions
- Scheduling weekly calls with stakeholders to provide updates on the progress toward implementation of the Chronic Conditions Health Home
- Developing reporting requirements
- Beginning Learning Collaborative activities, including establishing a schedule of monthly webinars and holding the first quarterly statewide in-person meeting
- Continual outreach and engagement with providers to help them understand Health Homes, encourage them to consider becoming a Health Home Partner and foster cooperation and collaboration with HHPs

- Updates from implementation:
    - 33,914 people are identified as eligible for SMI Health Homes and 28,087 were enrolled in Health Homes at the end of March 2015. A total of 5,827 people have opted out of Health Homes, for an opt out rate of 17% - less than our projected opt out percentage of 25%.
    - There are 80 contracted Health Home Partners (HHPs), although not all 80 contract with all three Lead Entities (managed care organizations - MCOs). Each MCO has at least 60 contracted HHPs.
    - The Learning Collaborative kicked off in August, with a monthly webinar. There have been monthly webinars and quarterly in-person meetings for HHPs, Lead Entities and state staff to support provider implementation of Health Homes and provide peer-to-peer learning and exchange of ideas.
    - A Health Homes Conference is being planned for later in 2015. This will bring together more HHP staff than participate in the Learning Collaborative and will provide information about healthy living , tobacco cessation, quality improvement, successful strategies to engage members and ways to collaborate with other health care providers.
    - A Health Homes Listening Tour will be held in 22 cities in April and May 2015. The information collected from the tour will be used to help improve processes in the program.
    - Currently, the two most frequently provided core services are Health Promotion and Care Coordination, followed by Comprehensive Care Management.
- Success Stories: There have been many early implementation successes. To share them, and inspire others, a booklet of successes has been developed and printed. A copy of that booklet can be found at http://www.kancare.ks.gov/health_home/download/HH-Success-Booklet-Proofout.pdf.

HCBS Educational Summit

In the first quarter, KDADS announced the upcoming 2015 HCBS Educational Summit "Systems at Work." This no cost event is provided to educate consumers, providers, families, professionals, staff and other stakeholders about the community resources available for Kansans who are aging or have disabilities. Some of the topics of interest include the HCBS Final Setting Rule Assessment, Self-Direction, Guardianship, Employment Programs, HCBS Programs, Health Homes, MFEI Assessment, APS/CPS, Social Security Disability/PMDT, Medicaid Fraud, and more. The announcement and information about the different sessions were posted on the KDADS Website. As of March 31, 2015, over 500 individuals had registered for one or both of the two day sessions for April 13 and April 14, 2015.

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 150 events for the first quarter of 2015. This included partner development, sponsorships, outreach and advocacy. In March of 2015, Amerigroup' s Community Relations Representatives met with various stakeholders across the state to better understand their respective objectives and operational plans for 2015. The Community Relations Representatives primary focus continues to be member education of services and benefits of the KanCare program. They constantly look to develop strong partnerships across the state by enhancing existing relationships and building new ones. Below is a sampling of Marketing activities Amerigroup supported in the first quarter:

- Parents as Teachers
- Family Conservancy Health Eating Presentation
- E.C Tyree Health and Dental Clinic
- Bonner Springs Head Start

Outreach Activities: Amerigroup's Outreach 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. For example, Amerigroup will call members to help them understand the benefits of calling their nurse line instead of using the emergency room for non-emergent services. Amerigroup's Community Relations team made available their new self-advocacy and wellness guides for men and women at most outreach events in the first quarter. They also introduced the new 'Pocket Resume' and 'Ace That Interview' documents to help with employment objectives for 2015. The Community Relations Representatives participated in a variety of community events reaching over 13,000 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. Below is a sampling of some of their outreach efforts this past quarter:

- KMOM Dental Event
- Point in Time Homeless Count Event
- Kidzfest El Dorado 2015 Event
- 7Project Family Event

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

- Wichita Public Schools
- The Bureau of Oral Health Kansas
- Mexican Consulate Exhibits
- Health Days USD 500
- Sedgwick County Health Department
- El Centro Promotoras Presentation

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

Marketing Activities: Sunflower Health Plan marketing activities for 1st Quarter 2015 included the development of new educational material for members and providers as well as the sponsorship of health-related fundraisers and events, which enhanced exposure of the KanCare brand. Examples of the marketing activities:

- Wichita Heart Ball, supporting the American Heart Association, February 21, 2015
- Sponsorship of TILRC Open House and ADA Legacy Tour Celebration facilitated by Topeka Independent Living Resource Center, March 18, 2015
- Sponsorship of Brain Injury Association of Kansas 7th Annual Beyond Rehab: Succeeding at Life Professional Conference, March 26-27, 2015
- Sunflower contributed $4,000 to the Special Olympics "New Hope" team in Pittsburg in support of their gymnasium. Health plan exposure is provided through logo placement on workout equipment as well as a large banner that will remain there for the life of the gym. The gym serves 300+ Special Olympic athletes a year. In the past, they've had 11 TV features filmed by 3 major networks in the gym, and 9 stories published in local newspapers. Recently, ESPN picked one of New Hope's athletes as a finalist for a story for the 2015 World Games.
- In consultation with Health Homes Partners, Sunflower developed a new flyer for Health Homes members.

Outreach Activities: In addition to regularly scheduled Adopt-a-School events and Baby Showers facilitated by Sunflower's MemberConnections department, the health plan's 1st Quarter 2015 outreach activities involved efforts to educate young adults about competitive employment.

- Project SEARCH, January 16, 2015 - Sunflower Health Plan hosted interns participating in Johnson County's Project SEARCH program, which is an employment training program that partners with local businesses to teach marketable, transferrable work skills with the outcome of competitive employment. The participants are young adults with I/DD. The interns tour businesses to learn about various work environments, employee responsibilities and expectations in the workplace. The visiting group received information about various jobs at Sunflower, such as reception, customer service and case management. Once the tour was completed, the interns each presented their goals and work experience through PowerPoint slides.
- The Member Connections staff organized the following outreach events throughout the state of Kansas in the first quarter of 2015:

- Adopt-a-School events were held at Head Start locations in Wichita and Ulysses for approximately 40 children at each event. Each child received a health-related children's book and a healthy snack. Topics covered included healthy eating and the benefits of exercise.
- A teen event was held at "The City on a Hill" in Garden City. Health-related games were led by the MemberConnections representative.
- An Adopt-a-School event was held at Lincoln Elementary School in Lincoln. A children's book, Splotch the Madpole does a Whole Lot of Bullying, was read to approximately 25 children. They had healthy snacks and were each given the book and a Parent Guide to take home.
- A "Start Smart for Your Baby" baby shower was held in Hutchinson. Sunflower's MemberConnections staff talked about labor and delivery, finding a pediatrician, care after delivery for mom and dad, post-partum depression, WIC and breastfeeding. A Sunflower Health Plan RN was in attendance to address any member questions related to pregnancy and childbirth.

Advocacy Activities: During the first quarter 2015, Sunflower employees advocated for people with disabilities by participating in and sponsoring events held in the capital city.

• Employees from Sunflower Health Plan and its partners LifeShare participated in a march to the State Capitol facilitated by Topeka Independent Living Resource Center in celebration of the anniversary of the passing of the Americans with Disabilities Act.

• Sunflower and its behavioral health partner, Cenpatico, sponsored and participated in Mental Health Advocacy Day at the Capitol.

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

Marketing Activities: United's primary focus during this reporting period included continued emphasis around member, provider and community education along with health and benefit literacy. United has accomplished this through participation and support for a variety of community events, as well as through activities such as new member welcome calls, various targeted member call campaigns, mailing new member welcome kits and communicating via UnitedHealthcare's quarterly Member Newsletter. United hosted a number of meetings and presentations with key providers, hospitals and FQHCs throughout the state that involved discussions around exploring innovative and collaborative opportunities. Additional outreach to providers encompassed training and education on the Population Registry and Joint Operating Committee meetings with statewide Health Home Partners where data was reviewed and program effectiveness validated. Additional strategic endeavors this quarter involved working with providers to ensure accurate panel assignments and attribution, where appropriate.

Outreach Activities: United's Bilingual Community Outreach Specialists continue to focus on activities targeted within their respective geographical areas of Kansas for both English and Spanish language speaking members. Their key responsibilities involve conducting educational outreach to members, community based organizations and targeted provider offices about United, the KanCare program, the features and benefits of United health plan and how to access benefits. United's Provider Marketing

Manager interacts with key provider offices and the provider community to assist with issue resolution and to ensure that providers are educated on the features and benefits of the United for our members who visit their offices. Several key outreach initiatives this period included lobby sits, lunch and learns and "Food for Thought Programs" hosted on-site at provider offices; "Community Computers" donations; attendance at health fairs held throughout the state; and participation at a number of community stakeholder committee meetings. In addition:

• During the first quarter 2015, United staff personally met with approximately 1,467 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 2015, United staff personally met with approximately 1,214 individuals from community based organizations located throughout Kansas. These organizations work directly with United members in various capacities.

• During the first quarter 2015, United staff personally met more than 600 individuals from provider offices located throughout the State.

Advocacy Activities: United's efforts continue to be focused on educational efforts surrounding KanCare and the benefits of UnitedHealthcare to members across the state. This includes ongoing outreach to persons with intellectual and developmental disabilities and those that support them. United is also working to educate those individuals receiving services on the Physically Disabled (PD) and Frail Elderly (FE) waiver programs, as well as the other HCBS waiver programs.

United has one Outreach Specialist who has extensive experience in and focused on supporting persons with disabilities. That specialist provides information and education on KanCare and UnitedHealthcare benefits to advocates for persons with disabilities across the state. The specialist has also continued to be a direct resource to members with disabilities and those that support them, to see that any concerns or issues reach the appropriate UnitedHealthcare staff for an appropriate response or resolution.

This same outreach specialist also worked in conjunction with the Empower Kansas steering committee to award 6 new Empower Kansans grants this quarter to community partners who are focused on employment of Kansans with disabilities. This 3rd round of Empower Kansans RFP included a system change option and as a result one grantee is focused on service system change regarding the employment supports available to Kansans with disabilities. Their efforts will include an analysis of the current services system, learning about other state models and holding focus groups and individual interviews to gain insight from a variety of stakeholders, including consumers, on their experience and suggestions for possible change. The grant will engage a large number of stakeholders and will also create a website for interested persons to provide their input and to read about ongoing activities. UnitedHealthcare is excited to support efforts to look at options to improve employment outcomes for persons with disabilities, in addition to the specific projects that will address individual employment goals.

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 worked either internally, with our MMIS Fiscal Agent, with the operating state agency and/or with the MCOs and other contractors to address and resolve the issues.

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

b. Benefits: All pre-KanCare benefits continue, and the program includes value-added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value added benefit utilization, per each of the KanCare MCOs, by top three value-added services and total for January-March, 2015, follows:

MCO	Value Added Service	Units YTD	Value YTD
Amerigroup	Adult Dental Care	880	$106,258
	Member Incentive Program	3,048	$66,625
	Mail Order OTC	2,488	$41,559
	Total of all Amerigroup VAS January-March 2015	***7,717***	***$252,083***
Sunflower	CentAccount debit card	16,991	$339,820
	Dental visits for adults	6,391	$210,627
	Smoking cessation program	166	$39,840
	Total of all Sunflower VAS January-March 2015	***37,816***	***$664,283***
United	Join for Me - Pediatric Obesity Classes	14	$35,000
	Additional Vision Services	693	$30,799
	Membership to Youth Organizations	407	$20,350
	Total of all United VAS January-March 2015	***5,534***	***$179,315***

c. Enrollment issues: For the first quarter of calendar year 2015 there were nine Native Americans who chose to not enroll in KanCare and who are still eligible for KanCare. There were an additional five Native Americans who chose to not enroll in KanCare and who are no longer eligible for KanCare. There were an additional two Native Americans who chose to not enroll in KanCare, then reversed their decision and chose to enroll in KanCare.

The table below represents the enrollment reason categories for the 1st quarter of calendar year 2015 (January, February, March). All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Newborn Assignment	2
KDHE - Administrative Change	79
WEB - Change Assignment	15
KanCare Default - Case Continuity	175
KanCare Default – Morbidity	417
KanCare Default - 90 Day Retro-reattach	125
KanCare Default - Previous Assignment	306
KanCare Default - Continuity of Plan	2,064
AOE – Choice	5,435
Choice - Enrollment in KanCare MCO via Medicaid Application	887
Change - Enrollment Form	342
Change - Choice	452
Change - Access to Care – Good Cause Reason	6
Change - Case Continuity – Good Cause Reason	0
Assignment Adjustment Due to Eligibility	3
Total	**10,308**

d. Grievances, appeals and state hearing information

MCOs' Grievance Database
Members - CY15 1st quarter report

	Access of ofc	Avail-ability	QOC	Attitude/ Service of Staff	Lack of Info from Prov	Billing/ Fin Issues	Transp-Timely	Prior Auth	Level of Care	Pharm	DME	Med Proc/ Inpt Trtmt	Waiver HCBS/ Home Health	Other
AMG	0	25	22	26	1	33	7	0	3	2	0	2	12	13
SUN	3	58	5	46	2	21	38	5	2	5	2	6	0	10
UHC	0	0	16	57	0	194	55	1	0	2	1	0	1	9

MCOs' Appeals Database
Members - CY15 1st quarter report

MCO	PA Dental	PA DME	PA Phar-Macy	PA OP/IP Surg/ Proc	LTSS/HCBS PCA/LTC/RTC/ TCM/MH Svcs	HH/ Hospice Hrs	OT/ PT/ ST	Inpt Covg	Genetic Testing
AMG	1	2	1	4	2	0	0	4	0
SUN	0	20	26	31	14	9	4	7	1
UHC	4	12	25	33	12	2	0	18	0

MCOs' Appeals Database

Providers - CY15 1st quarter report (appeals resolved)

MCO	MCO Auth	MCO Prov. Rela-tions	MCO Claim/ Billing	MCO Clin/ UM	MCO Plan Admin / Other	MCO Quality of Care/ Service	Vision Claim/ Billing	Dent Auth	Dent Claim/ Billing	Transp Quality of Care/ Service	Other
AMG	3	24	6,627	90	0	0	13	2	12	0	0
SUN	26	0	100	19	1	36	102	0	0	0	36
UHC	0	0	344	0	0	0	40	0	9	1	0

State of Kansas Office of Administrative Fair Hearings

Members - CY15 1st quarter report

AMG-Red SUN-Green UHC-Purple	PA Dental Denied/ Not Covered	PA CT/ MRI/ X-ray Denied	PA Pharm Denied	PA DME Denied	PA Home Health Hours Denied	PA Comm Psych Support/ BH Svcs Denied	PA PT/OT Inpt Rehab Denied	LTSS/ HCBS/ WORK PCA Hrs Denied	PA Med Proc Denied	Genetic Testing Denied
Withdrawn								1		
Dismissed-Moot MCO reversed denial		1	1					3 5		
Dismissed-No Adverse Action				1			1			
Default Dismissal Plaintiff no-show										
Dismissed-Untimely								1 2		
FH in process										
OAH upheld MCO decision		1	1	2	1			6 2		1
OAH reversed MCO decision					1			1		
FH dec pending										

Providers - CY15 1st quarter report

AMG-Red SUN-Green UHC-Purple	Claim Denied (Claim Contained Errors)	Claim Denied By MCO In Error	Dental Denied (No PA)	DME Denied (No PA)	Radiology Denied (No PA)	Home Health/ Hospice/ LTC Denied (No PA)	PT/ST Denied (No PA)	Inpt/ Rehab Denied (No PA)	Mental Health Svcs Denied (No PA)
Withdrawn	4		1		1				
Dismissed-Moot **MCO reversed denial**	2 1	26 7 19							
Dismissed-No internal appeal	9 4 8		1	1		1		1	
Dismissed-No adverse action									1
Dismissed-Untimely									
OAH upheld MCO decision	2 2 2			1				1	
OAH reversal of MCO decision								1	
FH dec pending									

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 Q4 of 2014, there were a total of 98 requests, and there was a slight increase up to 107 requests in first quarter of 2015. As in previous quarters, GCRs (member "Good Cause Requests" for change in MCO assignment) 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 good cause requests during the first quarter of 2015 were mainly due to two large clinics withdrawing from one network. These GCR requests have been denied due to network adequacy in the area. The remaining requests show varied reasons and causes for changing plans.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the first quarter of 2015, there were two state fair hearings filed for a denied GCR. One case was withdrawn, and the other was dismissed. A summary of GCR actions this quarter is as follows:

Status	January	February	March
Total GCRs filed	27	18	62
Approved	1	0	5
Denied	12	13	31
Withdrawn (resolved, no need to change)	7	3	8
Dismissed (due to inability to contact the member)	6	1	7
Pending	1	1	11

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

KanCare MCO	# of Unique Providers as of 6/30/14	# of Unique Providers as of 9/30/14	# of Unique Providers as of 12/31/14	# of Unique Providers as of 3/31/15
Amerigroup	13,455	13,682	13,997	14,863
Sunflower	16,314	17,728	18,056	19,131
UHC	19,911	19,747	19,476	20,482

h. Proposed changes to payment rates: No proposed changes in capitated payment rates were proposed during this quarter.

i. MLTSS implementation and operation: In the first quarter, Kansas offered services to several hundred individuals on the HCBS-PD and HCBS-IDD Program waiting lists (additional details included in Section XIII below). Additionally, KDADS has concentrated efforts to work with MCOs to move individuals out of institutional settings into their homes and communities using the Money Follows the Person federal grant, which has resulted in a significant increase in referrals and transitions from institutions. The State will submit a comprehensive sustainability plan for Money Follows the Person by April 30, 2015.

Also during the first quarter, the State submitted the Statewide Transition Plan for the HCBS Final Settings Rule, which impacts the Autism, Frail Elderly (FE), Intellectual/Developmental Disability (IDD), Physical Disability (PD), Technology Assisted (TA), Traumatic Brain Injury (TBI), and Severe Emotional Disturbance (SED) Programs. The Statewide Transition Plan, program specific transition plans, and summary of public comments are available online at

www.kdads.ks.gov. Additionally, in the first quarter of 2015, KDADS submitted and received approval for temporary extensions for FE, IDD, PD and TBI 1915(c) waiver renewals through June 30, 2015, to allow time for CMS to review the renewals and provide the State the opportunity to address questions and comments received in a formal request for additional information from CMS.

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). Children's Mercy Hospital has chosen to do the following projects: Complex Care for Children and Patient Centered Medical Homes (PCMH). Kansas University Medical Center will be completing Sepsis and Self-Management and Care (SMAC) Resiliency for their projects. Kansas Foundation for Medical Care (KFMC) is working with the State on improving healthcare quality in KanCare. CMS approved the hospitals' four projects on February 5, 2015 with suggestion of several measures that may be added to enhance the projects. The hospitals have been working toward meeting their first performance measures in the timeline.

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

- FE, PD, TBI & IDD 1915(c) Renewal: In the third quarter, CMS requested that the State not submit the renewal applications for the Intellectual and Developmental Disability (IDD), Traumatic Brain Injury (TBI), Physical Disability (PD) and Frail Elderly (FE) 1915(c) waivers until additional guidance from CMS was provided about the HCBS Transition Plan and new requirements of the CMS Final Rule, including conflict of interest. Temporary extensions were granted until June 30, 2015.
- CMS Final Rule on HCBS Settings: For the purpose of the transition plan, KDADS is working with Wichita State University to develop a statewide assessment process to identify potential providers who may not be in compliance with the HCBS Final Settings Rule. The electronic survey will be reviewed with HCBS Providers in the second quarter to assist them in completing the survey. The survey will include a self-assessment and attestation statement of compliance. From this survey, KDADS will identify providers requiring further scrutiny. Once the development is finalized, the survey can be completed online via a link on the KDADS website or by submitting the survey form and attestation. This link will be made available in May, 2015, and providers who fail to complete the survey will be targeted for onsite assessment in the first round of onsite assessments to determine compliance. KDADS has ensured that all information is posted and available on the new KDADS website. Kansas has requested technical assistance from CMS to ensure compliance with the HCBS Final Settings Rule and included proposed changes in the HCBS Program 1915(c) waiver renewals.

- Other 1915(c) Amendments and Renewals: In the first quarter, Kansas hosted several public information sessions across Kansas regarding proposed amendments for the Autism, TA, and SED Programs related to standardizing information and including the HCBS Transition Plan in the waivers. The Autism Workgroup provided information regarding proposed changes for the Autism program. After consultation with CMS and submission of the Statewide Transition Plan, the State postponed the proposed waiver amendments for the Autism, TA and SED programs and has begun working on the 1915(c) renewals for the SED program, which expires September 30, 2015, and the Autism program, which expires December 31, 2015. In the second quarter, Kansas will post public notice, summary of proposed changes, the renewal waiver application, and the public comment period for the HCBS SED Program in the second quarter for submission to CMS by June 30, 2015. In the third quarter, Kansas will post public notice, summary of proposed changes, the renewal waiver application, and the public comment period for the HCBS Autism Program in the third quarter for submission to CMS by September 30, 2015.

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 23, 2015, to review the current state of KanCare and the implementation of IDD long-term supports and services into KanCare. The committee received reports from KDHE, KDADS, the KanCare Ombudsman, each of the three KanCare MCOs, and took comments from stakeholders, including providers, advocacy groups, associations and other interested stakeholders. The committee also received information from the Kansas Insurance Commissioner.

Also during the first quarter, KDHE and KDADS made KanCare-related informational presentations to House and Senate authorizing and budget committees.

V. Policy Developments/Issues

a. **General Policy Changes**

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.

b. **HCBS Program Policy Changes**

During the fourth quarter of 2014, Kansas continued negotiations with contracted assessors for the HCBS-IDD Program. As a result of negotiations, it was agreed that the policy related to approval for extraordinary funding for individuals with IDD who needed additional or extraordinary support and who would otherwise be institutionalized because of the medical or behavioral health needs would be transferred to the MCOs, effective January 1, 2015. Previously, the community developmental disability organizations were responsible for reviewing and approving extraordinary funding for community service providers of day and residential supports. A temporary, transition policy was developed and presented for public comment in December 2014. This policy includes procedural steps for providers to submit requests and renewal packets directly to the MCOs for review and approval. KDADS and the MCOs will be developing a final extraordinary funding policy to be effective July 1, 2015.

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 03.31.15 is attached. Utilizing the HP-provided monthly financial summary, the data is filtered by MEG excluding CHIP and Refugee, and retro payments in the DY are included.

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 the other Medicaid agencies regarding any needed changes.

VII. Member Month Reporting

Sum of Member Unduplicated Count	Member Month			Totals
MEG	*2015-01*	*2015-02*	*2015-03*	*Grand Total*
Population 1: ABD/SD Dual	17,501	17,324	17,167	51,992
Population 2: ABD/SD Non Dual	29,280	29,094	28,849	87,223
Population 3: Adults	42,953	43,911	43,847	130,711
Population 4: Children	229,149	230,172	229,245	688,566
Population 5: DD Waiver	8,758	8,757	8,741	26,256
Population 6: LTC	21,094	21,015	20,899	63,008
Population 7: MN Dual	1,307	1,257	1,212	3,776
Population 8: MN Non Dual	1,126	1,122	1,097	3,345
Population 9: Waiver	3,889	3,845	3,845	11,579
Grand Total	**355,057**	**356,497**	**354,902**	**1,066,456**

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

VIII. Consumer Issues

Summary of consumer issues during the first quarter of 2015:

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. Customer Service unable to consistently explain authorization requirements.	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.	The MCOs created informational provider bulletins and reminders regarding authorizations. Some internal procedures were adjusted for clarity and a few requirements were relaxed. The plans also created informational talking points for the MCO customer representatives, and provided in-house training.
Authorization denials due to mapping between the claim system and the authorization system.	Home nursing visits were denied due to a system issue at the MCO. Providers reluctant to continue services without authorizations and without payments.	MCO has made the system correction and initiated reprocessing projects.
Retroactively eligible members are denied authorizations.	Members are denied authorization due to retroactive eligibility. The determination date of eligibility is not loaded by the MCOs into their systems, and they cannot determine if this determination date is before or after the authorization request date.	There are plans to utilize a field in the new eligibility system KEES when it becomes available.

Continued consumer support was conducted by KDHE's out-stationed eligibility workers (OEWs). OEW staff assisted in determining eligibility for 589 consumers; OEW also assisted with 311 consumers with urgent medical needs; provided information for application/cases pending at the KanCare Clearinghouse; and assisted in review for Medicaid eligibility on 1661 pending FFM applications.

During the first quarter of 2015, OEW staff participated in 130 community events providing KanCare program outreach, education and information at various events including: Health Fairs, Mexican Consulate meetings, Hispanic Health Fairs, Community Resource Fairs, Tribal Coordination Council, Early Head Start and Head Start Collaboration, and Parent as Teacher meetings. OEW have also been involved with community collaborative activities, part of the Bureau of Maternal and Child

Health. Notably, in Riley county OEW is assisting with "Delivering Change" by expediting pregnant women applications, identifying non-citizen applicants who are not Medicaid eligible and referring these women for prenatal care services under other funded programs to assist them to obtain and maintain prenatal care.

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 iACT (the Interagency Collaboration Team) for comprehensive oversight and monitoring. This group replaces the KanCare Interagency Monitoring Team (IMT) as the oversight management team. iACT is a review and feedback body partly focusing on the monitoring and implementation of the State's KanCare Quality Improvement Strategy (QIS). iACT 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. iACT includes 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 iACT's review of and feedback regarding the overall KanCare quality plan. This combined information assists iACT 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 2015, 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 will be automated starting in Q2 of 2015 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 2015, 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 2015 review will address both MCO regulatory requirements and many key state contract requirements, as well as monitoring resolution of identified compliance issues found in previous audits.
- Bi-weekly Technical Assistance meetings with MCOs related to nursing facilities, transitions from institutions, HCBS programs, and behavioral health issues. These meetings allow the State and the MCOs to discuss specific topics as they arise and ensure consistency and comprehensive review of policies that impact programs under KDADS.
- Complex Case staffing of HCBS and Behavioral Health staff from the State with the MCOs. Each MCO brings complex cases for State review and consideration, and the State provides technical assistance and insight into program policies, integration, and other alternatives to address identified needs. These are held biweekly and integrated the State's behavioral health and long-term supports and services teams.
- 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 on-going provider and member issues, and troubleshoot operational problems. Monitor progress 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 scheduled monthly meetings to discuss trends and progress.

- Bi-weekly Technical Assistance meetings with MCOs related to nursing facilities, transitions from institutions, HCBS programs, and behavioral health issues. These meetings allow the State and the MCOs to discuss specific topics as they arise and ensure consistency and comprehensive review of policies that impact programs under KDADS. During the second quarter, the HCBS portion of the TA meetings will focus on compliance with the HCBS Final Rule and quality assurance measures.
- Complex Case staffing of HCBS and Behavioral Health staff from the State with the MCOs. Each MCO brings complex cases for State review and consideration, and the State provides technical assistance and insight into program policies, integration, and other alternatives to address identified needs. These are held biweekly and integrated the State's behavioral health and long-term supports and services teams.
- HCBS Quality Assurance Audits: MCO HCBS audits for 2013 were held onsite for 2 ½ days for each MCO during the first quarter. The reviews supplemented previous reporting/survey tools to ensure all HCBS benchmarking measures were complete. The MCOs provided a brief overview of the data and identified any challenges or changes in 2013 that would be reflected in the data. Additionally, the MCOs provided a brief overview of the documents being reviewed, where to find certain data points, and the changes made in 2013 that will be identified in 2014 files. Each MCO made care coordinators and other staff available to answer questions, gather additional documentation, address the person-centered planning and assessment process, review policies and procedures, and demonstrate systems or tools as needed.

X. Managed Care Reporting Requirements

a. A description of network adequacy reporting including GeoAccess mapping: Each MCO submits a monthly network adequacy report. The State uses this report to monitor the quality of network data and changes to the networks, drill down into provider types and specialties, and extract data to respond to requests received from various stakeholders. In addition, each MCO submits monthly network reports that serve as a tool for KanCare managers to monitor accessibility to certain provider types. Each MCO also submits a separate report on I/DD 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:

KanCare Customer Service Report - Member

MCO/Fiscal Agent January-September 2014	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:14	1.1%	49,507
Sunflower	0:34	2.7%	46,013
United	0:23	4.5%	35,757
HP – Fiscal Agent	:02	0.1%	33,445

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:15	1.0%	22,450
Sunflower	0:12	.77%	28,269
United	:05	0.4%	19,522
HP – Fiscal Agent	:05	0.04%	10,773

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 2015 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, therefore, are reported separately to KDADS from the Department of Children and Families (DCF) and monitored by the KDADS program integrity team. That team ensures individuals with reported ANE are receiving adequate supports and protections available through KDADS programs, KanCare and other community resources. A summary of first quarter 2015 AIRS reports follows:

2015 Critical Incidents	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	TOTALS
Total # Received	282				**282**
Total # Reviewed	196				**196**
Total # Pending Resolution	86				**86**
APS Substantiations*	66				**66**

** Note: 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 first quarter of 2014, KDHE established the Cross-Agency Adverse Incident Management Team, including representatives from KDHE (the single state Medicaid agency), KDADS (the state operating agency for disability and behavioral health services) and DCF (Department for Children and Families, where adult and child protective services are managed), and from all three KanCare MCOs. Work by that team continued through the fourth quarter, and next steps include publishing of an incident reporting guide developed from the team's work, as well as shaping the team for a long-term evaluation and collaboration focus. The charter and expected outcomes of the team are as follows:

Charter:

The purpose of the Adverse Incident Management Team is to establish a statewide strategy to delineate and structure multi-agency efforts related to critical/adverse incident reporting. Several State agencies including DCF (Department of Children and Family Services), KDADS (Kansas Department of Aging and Disability Services) and KDHE (Kansas Department of Health and Environment) operate systems to receive, respond to manage and resolve incidents with the potential to impact members' health, welfare and safety. Some adverse incidents may be instances of abuse, neglect or exploitation by another person or the member themselves and some are the result of avoidable and unavoidable accidents such as medication errors and falls. Further, each agency utilizes a different data system to collect and warehouse adverse incident documentation, investigations, remediation and findings and distinct policies and procedures for numerous State and Federal reporting purposes. With the addition of the three KanCare Managed Care Organizations to these long-standing systems of care, the potential for competing and conflicting strategies to safeguards, monitoring, investigation and resolution is compounded. While there are some identifiable linkages between different state agencies, and between state agencies and stakeholders, each of these systems works fairly independent of the others.

Expected Outcomes:

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

A final draft of the Incident Report Guide was developed and a meeting was scheduled for the team to reconvene in the third quarter of 2015 for finalization. The Incident Report Guide delineates multi-agency, statewide critical incident reporting policies and processes and will provide internal and external stakeholders an instructional guide for reporting critical incidents. The Cross-agency Adverse Incident Management Team will revisit and update the guide, annually, or as necessary.

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 HCAIP Pool payments for quarter one have been delayed as the State made a technical correction to Attachment J and we are waiting on approval for the correction. The HCAIP first quarter payments will be made on May 7, 2015. The LPTH/BCCH Pool first quarter payments were processed on February 3, 2015. The attached Safety Net Care Pool Reports identify 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 1st quarter of 2015, 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 real-time enhancements to the state's oversight and monitoring of the KanCare program, and to improve outcomes for members utilizing KanCare services.

XIII. Other (Claims Adjudication Statistics; Plan of Care Reduction Requests; Waiting List Management; and Money Follows the Person)

a. Claims Adjudication Statistics

KDHE's summary of the numerous claims adjudication reports for the KanCare MCOs, covering January-March, 2015, is attached.

b. Plan of Care Reduction Requests – HCBS/IDD – 1/1/15-3/31/15

REQUEST STATUS	AMERIGROUP	SUNFLOWER	UNITED	Totals
UNDER REVIEW	2	28	3	**33**
APPROVED	0	0	0	**0**
DENIED	0	0	0	**0**
RETURNED FOR MORE INFORMATION	1	15	0	**16**
TOTAL	**3**	**43**	**3**	**49**

c. Waiting List Management

PD Waiting List Management

In the first quarter of 2015:

- 252 individuals waiting for HCBS-PD services were offered services (as of March 31, 2015). Of those offers: 55 have accepted services; 41 had other results (declined services, unable to contact, deceased, referred); and 156 have not responded
- 437 individuals started services in the first quarter of 2015
    - 184 individuals started services in January
    - 116 individuals started services in February
    - 99 individuals started services in March
    - 38 individuals moved from institutions into services on MFP

The current point-in-time limit for HCBS-PD is 5,900. KDADS is currently serving approximately 5,400 individuals and offering services monthly. On December 31, 2014, KDADS submitted a renewal for the PD waiver, which includes a proposed increase in the point-in-time limit to 6,100. Based upon appropriations, KDADS will continue to offer services until waiver membership has reached 6,100 participants, once the increased point-in-time number for the HCBS-PD Program is approved by CMS. The PD renewal is pending approval from CMS and has received its second temporary extension through June 30, 2015.

I/DD Waiting List Management

In the first quarter of 2015:

- 25 individuals waiting for HCBS-IDD services were offered services (as of March 31, 2015). Of those offers: 9 have accepted services; 2 have declined; and 14 have not responded
- 150 individuals started services in the first quarter of 2015
    - 45 individuals started services in January
    - 65 individuals started services in February
    - 35 individuals started services in March
    - 5 individuals moved from institutions into services on MFP

The current point-in-time limit for HCBS-IDD is 8,700. KDADS is currently serving 8,648 individuals. KDADS submitted a renewal for the IDD waiver, which includes a proposed increase

in the point-in-time limit to 8,900. Based upon appropriations, KDADS will continue to offer services until waiver membership has reached 8,900 participants, once the increased point-in-time number for the HCBS-IDD Program is approved by CMS. The IDD renewal is pending approval from CMS and has received its fourth temporary extension through June 30, 2015.

d. Money Follows the Person:

During the first quarter of 2015 there were 182 initial requests.

2015 Initial Request	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
Amerigroup	47				47
Sunflower	43				43
United	92				92
Total	182				182

XIV. Enclosures/Attachments

Section of Report Where Attachment Noted	Description of Attachment
VI	KanCare Budget Neutrality Monitoring Spreadsheet for QE 03.31.15
X(e)	Summary of KanCare Ombudsman Activities for QE 03.31.15
XI	KanCare Safety Net Care Pool Report for QE 03.31.15
XII	KFMC KanCare Evaluation Report for QE 03.31.15
XIII(a)	KDHE Summary of Claims Adjudication Statistics for QE 03.31.15

XV. State Contacts

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XVI. Date Submitted to CMS

May 29, 2015

DY 3
Start Date: 1/1/2015
End Date: 12/31/2015

Quarter 1
Start Date: 1/1/2015
End Date: 3/31/2015

	Total Expenditures	Total Member-Months
Jan-15	226,410,928.01	368,704
Feb-15	223,038,612.61	375,278
Mar-15	223,896,319.44	362,628
PCP	0.00	
Q1 Total	673,345,860.06	1,106,610

	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-15									
Expenditures	4,131,778.42	30,390,454.60	24,177,566.72	50,350,395.53	38,443,470.28	64,943,581.76	1,248,633.68	1,423,395.41	11,301,651.61
Member-Months	19,437	31,602	45,016	232,115	9,202	23,606	2,043	1,503	4,180
Feb-15									
Expenditures	3,831,669.41	31,038,147.33	23,053,349.09	48,647,673.23	37,895,914.80	65,519,060.95	727,182.03	1,385,138.71	10,940,477.06
Member-Months	19,311	34,772	47,129	233,082	9,842	22,745	1,492	1,252	5,653
Mar-15									
Expenditures	3,924,116.26	31,092,647.74	21,542,686.35	49,593,530.93	38,209,980.19	65,915,476.18	785,356.48	1,597,161.98	11,235,363.33
Member-Months	18,213	30,092	45,105	230,966	9,232	21,991	1,558	1,335	4,136
PCP									
Expenditures	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Q1 Total									
Expenditures	11,887,564.09	92,521,249.67	68,773,602.16	148,591,599.69	114,549,365.27	196,378,118.89	2,761,172.19	4,405,696.10	33,477,492.00
Member-Months	56,961	96,466	137,250	696,163	28,276	68,342	5,093	4,090	13,969
DY 3 - Q1 PMPM	208.6965	959.1074	501.0827	213.4437	4,051.1163	2,873.4617	542.1504	1,077.1873	2,396.5561

Note:

1. For DY3 Member-Months are CAP + RETRO combined.
2. PCP expired at the end of DY2.
3. Meg 7, MN Dual, retro assignments significantly increased for January; high level of spend down dollars therefore determined higher retro dollar amount.

KanCare Ombudsman KDHE Quarterly Report

Kerrie J. Bacon, KanCare Ombudsman
1st Quarter, 2015

Accessibility

The KanCare Ombudsman was available to members and potential members of KanCare (Medicaid) through the phone, email, letters and in person during the first quarter of 2015. There were 510 contacts through these various means, 221 of which were related to an MCO issue. First quarter had a decrease in contacts compared to the fourth quarter and to first quarter last year.

1st Qtr. Contacts	
January	185
February	165
March	160
Total	**510**

MCO related	
Amerigroup	53
Sunflower	96
United Health	75
Total	**221**

Contacts	Q1	Q2	Q3	Q4	Comments
2013	615	456	436	341	this year does not include emails
2014	545	474	526	547	
2015	510				

The KanCare Ombudsman webpage on the KanCare website (www.kancare.ks.gov/ombudsman.htm) has information regarding the Ombudsman contact information, resources for and information about applying for KanCare, contact information for the three Managed Care Organizations, the grievance process, the appeal process and state fair hearing process, the three managed care organization (MCO) handbook links, quarterly and annual reports by the Ombudsman and a resource providing a four-page document with medical, prescription, vision and dental assistance for those without insurance or with high spend downs (www.kancare.ks.gov/download/Medical_Assistance.pdf).

Outreach

- Shared report at the Consumer Specialized Issues meeting in Leavenworth; 3/26/15
- Presented to the Bob Bethel KanCare Oversight Committee; 1/24/15
- Mailed a letter of introduction from the Ombudsman and a package of Ombudsman brochures to all Centers of Independent Living, Aging and Disability Resource Centers and the four Families Together Resource Centers. .
- The Ombudsman's office sponsors the KanCare (I/DD) Friends and Family Advisory Council which met three times during first quarter.
- Hosted the HCBS Lunch-and-Learn bi-weekly conference calls for all HCBS members, parents, guardians and other consumers. 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.

KanCare Ombudsman Volunteer Program

Start-up Information

- Planned start date August 1, 2015
- Soft start-up in most populous areas of Kansas
    - Kansas City Metro Area, then Wichita

Training and Education

- Online and in-person regional training
- Pre and Post testing for competency
- Subjects
    - Medicaid history and agencies, federal to state
    - Processes – applications, benefits, processes and claims
    - Resources
    - Handling of calls and levels of inquiries
    - Practice and case studies

Volunteer Applications – sending out mid-May through June

For those interested in applying as a volunteer, applications will be available mid-May on the KanCare Ombudsman webpage at www.kancare.ks.gov/ombudsman.htm.

Data

Contact Method – Qtr. 1, 2015	AmeriGroup	Sunflower	United	none	Total
Email	10	14	12	58	94
Face-to-Face Meeting	0	0	0	0	0
Letter	0	0	0	1	1
ONLINE	0	0	0	0	0
Other	0	0	0	0	0
Telephone	43	82	63	227	415
Total	**53**	**96**	**75**	**286**	**510**

Caller Type – Qtr. 1, 2015	AmeriGroup	Sunflower	United	none	Total
Consumer	43	78	63	182	366
MCO Employee	0	1	2	0	3
Other type	0	1	1	28	30
Provider	10	16	9	76	111
not identified	0	0	0	0	0
Total	**53**	**96**	**75**	**286**	**510**

Sub Caller Type – Qtr. 1, 2015	AmeriGroup	Sunflower	United	none	Total
HCBS RELATED	20	29	21	17	87
LTC RELATED	1	5	4	10	20
OTHER	19	38	36	140	233
not identified	13	24	14	119	170
Total	**53**	**96**	**75**	**286**	**510**

Contact Information for 1st Qtr. The average number of days to resolve an issue was 6 days; 276 files were resolved in one day or less (54 percent)

Open	Contact date entered, but no response or closed	0
Responded	Contact date entered and first response, but not closed.	68
Closed	Closed dated is entered.	442
Total		**510**
% closed		87%

	Q3/14	Q4/14	Q1/15
Avg. Days to Resolve Issue	9	7	7
% files resolved in one day or less	47%	56%	54%
% files closed	86%	82%	87%

There are 20 issue categories. The top three concerns for 1st quarter are HCBS General Issues, Appeals/Grievances and Billing.

Issue Category – Qtr. 1, 2015	AmeriGroup	Sunflower	United	none	Total
HCBS General Issues	14	22	11	13	60
Appeals / Grievances	3	22	11	6	42
Billing	10	13	5	8	36
Durable Medical Equipment	2	10	6	7	25
Pharmacy	1	7	8	9	25
Medical Services	1	5	6	8	20
Nursing Facility Issues	2	3	4	6	15
Transportation	1	3	5	3	12
HCBS Eligibility issues	0	2	3	6	11
HCBS Waiting List	2	0	3	6	11
Care Coordinator Issues	1	2	5	2	10
HCBS Reduction in hours of service	0	4	4	2	10
Change MCO	2	3	2	1	8
Dental	2	1	2	2	7
Guardianship	1	0	1	3	5
Questions for Conference Calls/Sessions	0	1	1	3	5
Access to Providers (usually Medical)	0	0	2	1	3
Housing Issues	0	0	0	1	1
Medicaid Eligibility Issues	9	17	11	102	139
X-Other	10	14	16	90	130
Z Thank you.	0	4	2	8	14
Z Unspecified	2	3	0	26	31
Total	**63**	**136**	**108**	**313**	**620**

The Issue Categories below are listed for the last five quarters in alphabetical order. You will note that although Durable Medical Equipment dipped down in 4th quarter it is back up to the consistent range in 1st quarter of 2015.

Issues	Q1/14	Q2/14	Q3/14	Q4/14	Q1/15
Access to Providers	16	16	6	15	3
Appeals, Grievances	22	22	46	46	42
Billing	51	33	40	42	36
Care Coordinators	10	9	18	14	10
Change MCO	6	11	10	9	8
Dental	16	15	8	9	7
Durable Medical Equipment	25	35	25	8	25
Guardianship Issues	16	3	1	2	5
HCBS Eligibility issues	55	14	10	11	11
HCBS General Issues	11	25	45	49	60
HCBS Reduction in hours of service	22	11	15	8	10
HCBS Waiting List issues	3	8	19	7	11
Housing issues	3	8	12	10	1
Medicaid Eligibility Issues	81	73	90	194	139
Medicaid Service Issues	14	31	41	70	20
Nursing Facility Issues	8	12	16	24	15
Pharmacy	38	15	20	19	25
Questions for Conf Calls/sessions	13	5	15	2	5
Transportation	11	8	18	13	12
Other	49	75	103	112	130
Unspecified	73	44	33	27	31
Thank you	2	1	10	13	14
Total	**545**	**474**	**600**	**704**	**620**

Resource Category shows what resources were used in resolving 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 called to find the help needed, or referred the member to, or possibly a document was provided. There are many times when multiple resources are provided to a member/contact.

Resource Category – Qtr. 1, 2015	AmeriGroup	Sunflower	United	none	Total
QUESTION/ISSUE RESOLVED	13	11	14	46	84
USED RESOURCES/ISSUE RESOLVED	19	51	44	148	262
KDHE RESOURCES	10	19	13	53	95
DCF RESOURCES	2	2	6	10	20
MCO RESOURCES	19	28	25	7	79
HCBS TEAM	6	5	6	15	32
CSP MH TEAM	0	0	0	0	0
OTHER KDADS RESOURCES	4	6	3	18	31
PROVIDED RESOURCES TO MEMBER	4	11	9	61	85
REFERRED TO STATE/COMMUNITY AGENCY	0	2	0	20	22
REFERRED TO DRC AND/OR KLS	0	11	8	7	26
CLOSED	1	2	0	11	14
Total	**78**	**148**	**128**	**396**	**750**

Resource Category	Q3/14	Q4/14	Q1/15
QUESTION/ISSUE RESOLVED	118	81	84
USED RESOURCES/ISSUE RESOLVED	177	260	262
KDHE RESOURCES	107	87	95
DCF RESOURCES	22	15	20
MCO RESOURCES	98	55	79
HCBS TEAM	57	33	32
CSP MH TEAM	2	0	0
OTHER KDADS RESOURCES	38	17	31
PROVIDED RESOURCES TO MEMBER	23	20	85
REFERRED TO STATE/COMMUNITY AGENCY	20	18	22
REFERRED TO DRC AND/OR KLS	27	9	26
CLOSED	55	18	14
Total	**744**	**613**	**750**

The waiver information explains waiver-related type information that may have been discussed on a call or email. The topics listed below are broader than the HCBS waivers and include Behavior Health and nursing facility concerns.

Waiver – Qtr. 1, 2015	AmeriGroup	Sunflower	United	none	Total
PD	14	14	16	13	57
I/DD	6	10	7	12	35
FE	5	4	3	3	15
AUTISM	0	2	0	2	4
SED	0	1	0	0	1
TBI	2	1	2	5	10
TA	0	8	3	0	11
MFP	1	1	0	0	2
PACE	0	0	0	0	0
MENTAL HEALTH	0	2	3	0	5
SUB USE DIS	0	0	0	0	0
NURSING FACILITY	2	3	1	6	12
Total	**30**	**46**	**35**	**41**	**152**

Waiver	Q3/14	Q4/14	Q1/15
PD	43	29	57
I/DD	42	36	35
FE	16	11	15
AUTISM	4	1	4
SED	5	4	1
TBI	19	10	10
TA	8	15	11
MFP	6	4	2
PACE	0	1	0
MENTAL HEALTH	4	10	5
SUB USE DIS	0	0	0
NURSING FACILITY	10	25	12
Total	**157**	**146**	**152**

Safety Net Care Pool Report

Demonstration Year 3 - QE March 2015

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

Paid 02/03/2015

Medicare #	Medicaid #	Provider Name	1st Qtr Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
263302	100080290A	Children's Mercy Hospital	1,868,275.50	810,271.08	1,058,004.42
170040	100099470A	University of Kansas Hospital	5,604,827.25	2,430,813.58*	3,174,013.67
		Total	**7,473,102.75**	**4,293,546.63**	**4,232,018.09**

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

2015 KanCare Evaluation Quarterly Report
Year 3, CY2015, Quarter 1, January - March
May 18, 2015

Background/Objectives

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

The KanCare Evaluation Design includes over 100 annual performance measures developed to measure the effectiveness and usefulness of the five-year KanCare demonstration managed care Medicaid program. Annual performance measures include baseline and cross-year comparisons; the first year of the KanCare demonstration, calendar year (CY) 2013 serves as a baseline year 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) CY2015 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 response to recommendations made in the previous KanCare Evaluation Quarterly Reports and in the KanCare Annual Evaluation Report, State staff have drafted or revised reporting templates, held interagency and interagency/MCO work group meetings, and have met with the Ombudsman (Kerrie Bacon) and staff from KDHE and KDADS. Follow-up on these recommendations has been a priority agenda item on 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 2 business days of inquiry receipt, 98% of all inquiries within 5 business days, and 100% of all inquiries within 15 business days.

Data Sources

The data sources for the Q1 CY2015 KanCare Quarterly Evaluation Report are monthly call center customer service reports that replace quarterly KanCare Key Management Activities Report (KKMAR) discontinued in Q4 2014.

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

In Table 1, the quarterly counts of member and provider customer service inquiries for Q1-Q4 of CY2013 were based on Pay for Performance (P4P) report data, and the quarterly counts for Q1 CY2014 were based on monthly data reported to KFMC by MCO program managers. Percentages reported in the KKMAR were then used to calculate the number of inquiries resolved and not resolved within two, five, and 15 business days. Beginning in Q2 CY2014, the monthly call center reports are now the primary data source for reporting customer service inquiries.

Current Quarter and Trend Over Time

In Q1 CY2015, 99.997% of the customer service inquiries received by the MCOs were resolved within two business days (see Table 1). The five 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%.

Table 1 - Timeliness of Resolution of Customer Service Inquiries									
	CY2013				CY2014				CY2015
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Number of Inquiries Received	261,286	181,427	157,547	146,374	141,964	133,570	143,028	121,857	**152,412**
Number of Inquiries Resolved Within 2 Business Days	260,859	180,903	157,185	146,299	141,907	133,539	142,705	121,839	**152,407**
Number of Inquiries Not Resolved Within 2 Business Days	298	524	362	75	57	27	323	18	**5**
Percent of Inquiries Resolved Within 2 Business Days	99.84%	99.71%	99.77%	99.95%	99.96%	99.98%	99.77%	99.99%	**99.997%**
Number of Inquiries Resolved Within 5 Business Days	261,286	181,427	157,458	146,349	141,951	133,570	143,001	121,844	**152,412**
Number of Inquiries Not Resolved Within 5 Business Days	0	0	89	25	13	0	27	13	**0**
Percent of Inquiries Resolved Within 5 Business Days	100%	100%	99.94%	99.98%	99.99%	100%	100%	99.99%	**100%**
Number of Inquiries Resolved Within 15 Business Days	261,286	181,427	157,547	146,374	141,964	133,570	143,028	121,850	**152,412**
Number of Inquiries Not Resolved Within 15 Business Days	0	0	0	0	0	0	0	7	**0**
Percent of Inquiries Resolved Within 15 Business Days	100%	100%	100%	100%	100%	100%	100%	99.99%	**100%**

The quarterly number of customer service inquiries to the three MCOs in Q1 CY2015 is the highest since Q3 CY2013. As shown in Table 1, up until this quarter, the aggregate number of customer service inquiries received by the MCOs has been decreasing over time. Of the 152,412 customer service inquiries in Q1 CY2015, 103,160 (67.7%) were from members (see Table 2) and 49,252 were from providers (see Table 3). Of the 103,160 member calls, 43.1% were received by Sunflower, 33.1% by UnitedHealthcare, and 23.8% by Amerigroup. Of the 49,262 provider inquiries, Amerigroup received 36.8%, Sunflower 29.4%, and UnitedHealthcare 33.8%.

Table 2 - Customer Service Inquiries by Member, Quarter 2, CY2014 to Quarter 1, CY2015								
	CY2014						CY2015	
	Q2		Q3		Q4		Q1	
Member Inquiries	#	%	#	%	#	%	#	%
1. Benefit Inquiry – regular or VAS	17,373	21.8%	18,025	20.1%	15,799	21.3%	**20,775**	**20.1%**
2. Concern with access to service or care; or concern with service or care disruption	1,729	2.2%	2,242	2.5%	1,617	2.2%	**2,059**	**2.0%**
3. Care management or health plan program	2,248	2.8%	2,363	2.6%	2,797	3.8%	**2,309**	**2.2%**
4. Claim or billing question	6,626	8.3%	6,193	6.9%	5,490	7.4%	**7,107**	**6.9%**
5. Coordination of benefits	1,494	1.9%	2,278	2.5%	2,252	3.0%	**3,437**	**3.3%**
6. Disenrollment request	448	0.6%	507	0.6%	484	0.7%	**632**	**0.6%**
7. Eligibility inquiry	8,336	10.5%	11,066	12.3%	9,462	12.8%	**13,330**	**12.9%**
8. Enrollment information	1,830	2.3%	2,417	2.7%	2,220	3.0%	**2,141**	**2.1%**
9. Find/change PCP	11,619	14.6%	12,509	13.9%	9,818	13.2%	**15,586**	**15.1%**
10. Find a specialist	3,037	3.8%	3,905	4.4%	2,634	3.6%	**4,070**	**3.9%**
11. Assistance with scheduling an appointment	89	0.1%	61	0.1%	43	0.1%	**46**	**0.0%**
12. Need transportation	1,798	2.3%	1,621	1.8%	1,571	2.1%	**1,812**	**1.8%**
13. Order ID card	6,406	8.0%	7,087	7.9%	5,372	7.2%	**7,653**	**7.4%**
14. Question about letter or outbound call	1,003	1.3%	675	0.8%	701	0.9%	**1,013**	**1.0%**
15. Request member materials	1,197	1.5%	1,059	1.2%	1,188	1.6%	**1,080**	**1.0%**
16. Update demographic information	9,526	12.0%	11,494	12.8%	7,481	10.1%	**13,404**	**13.0%**
17. Member emergent or crisis call	900	1.1%	1,293	1.4%	628	0.8%	**938**	**0.9%**
18. Other	3,923	4.9%	4,887	5.4%	4,562	6.2%	**5,768**	**5.6%**
Total	**79,582**		**89,682**		**74,119**		**103,160**	

Table 3 - Customer Service Inquiries by Provider, Quarter 2, CY2014 to Quarter 1, CY2015								
	CY2014						CY2015	
	Q2		Q3		Q4		Q1	
Provider Inquiries	#	%	#	%	#	%	#	%
1. Authorization – New	2,149	4.0%	1,968	3.7%	1,841	3.9%	**2,351**	**4.8%**
2. Authorization – Status	3,649	6.8%	2,961	5.6%	2,306	4.8%	**2,456**	**5.3%**
3. Benefits inquiry	5,071	9.4%	4,261	8.0%	4,256	8.9%	**4,594**	**9.9%**
4. Claim Denial Inquiry	4,843	9.0%	5,256	9.9%	4,760	10.0%	**5,182**	**11.2%**
5. Claim Status Inquiry	18,401	34.1%	18,822	35.3%	18,284	38.3%	**19,457**	**42.1%**
6. Claim Payment Question/Dispute	6,829	12.6%	7,093	13.3%	6,355	13.3%	**6,822**	**14.7%**
7. Billing Inquiry	365	0.7%	326	0.6%	552	1.2%	**851**	**1.8%**
8. Coordination of Benefit	1,012	1.9%	1,099	2.1%	1,095	2.3%	**1,167**	**2.5%**
9. Member Eligibility Inquiry	2,085	3.9%	1,986	3.7%	1,652	3.5%	**1,866**	**4.0%**
10. Recoupment or Negative Balance	140	0.3%	150	0.3%	162	0.3%	**353**	**0.8%**
11. Pharmacy/Prescription Inquiry	505	0.9%	542	1.0%	568	1.2%	**599**	**1.3%**
12. Request Provider Materials	41	0.1%	40	0.1%	28	0.1%	**31**	**0.1%**
13. Update Demographic Information	6,181	11.4%	6,764	12.7%	4,093	8.6%	**538**	**1.2%**
14. Verify/Change Participation Status	416	0.8%	284	0.5%	226	0.5%	**272**	**0.6%**
15. Web Support	508	0.9%	284	0.5%	183	0.4%	**197**	**0.4%**
16. Credentialing Issues	285	0.5%	177	0.3%	90	0.2%	**163**	**0.4%**
17. Other	1,508	2.8%	1,333	2.5%	1,287	2.7%	**2,353**	**4.8%**
Total	**53,988**		**53,346**		**47,738**		**49,252**	

The monthly call center report categorizes customer service inquiries by 18 member categories and by 17 provider categories.

- Member customer service inquiries
  - There were 29,041 more customer service inquiries from members in Q1 CY2015 than in the previous quarter, an increase of 39.2%.
  - The category with the highest increases (compared to the previous quarter) was "Update Demographic Information" – increased by 5,923. (10,801 of the 13,404 inquiries were reported by Sunflower.)
  - Other categories with high increases may be due to Q1 being an open enrollment period. These included:
    - "Find/Change PCP" increased by 5,768;
    - "Benefit Inquiry" increased by 4,976;
    - "Eligibility Inquiry" increased by 3,868; and
    - "Order an ID Card" increased by 2,281.
  - For members, benefit inquiries were again the highest percentage (20.1%) of the 103,160 calls received in Q1, an increase of 4,976 compared with the previous quarter. The lowest percentage of calls (0.04%) was from members requesting assistance with scheduling an appointment.
- Provider customer service inquiries
  - Provider inquiries increased in Q1 CY2015, but only by 1,514.

- The categories with the highest increases were "Claim Status Inquiry" (increased by 1,173) and "Other" (increased by 1,056).
- The "Update Demographic Information" decreased by 3,555, with Sunflower counts for this category now comparable to those reported by Amerigroup and UnitedHealthcare.
- For providers, claim status inquiries were again the highest percentage (39.5%) of the 49,262 provider calls, and the lowest was from providers requesting provider materials (0.06%).

While the distribution by category has been fairly consistent by quarter, the categorization of the inquiries differs greatly by MCO. There were several categories where 75% or more of the inquiries were reported by one MCO, including:

- Member Customer Service Inquiries:
  - "Member emergent or crisis call" – 99.7% of 938 inquiries - Sunflower;
  - "Update demographic information" – 80.6% of 13,404 inquiries - Sunflower;
  - "Enrollment information" – 76.6% of 2,141 inquiries - Amerigroup; and
  - "Need transportation" – 75.8% of 1,812 inquiries - Amerigroup;
- Provider Customer Service Inquiries:
  - "Authorization – New" – 99.1% of 2,351 inquiries – Amerigroup;
  - "Update demographic information" – 95.5% of 538 inquiries – Sunflower;
  - "Recoupment or negative balance" – 94.3% of 353 inquiries – UnitedHealthcare;
  - "Coordination of benefits" – 90.7% of 1,167 inquiries – UnitedHealthcare; and
  - "Billing inquiry" – 76.4% of 851 inquiries – Sunflower.

Conclusions

- In Q1 CY2015, 99.997% of the customer service inquiries received by the MCOs were resolved within two business days. The customer service inquiry reports show that the MCOs have consistently met contractual standards for resolving inquiries within two, five, and 15 business days in each quarter of CY2013, CY2014, and CY2015 to date.
- Of the 5 inquiries not resolved within two business days, all were resolved within five business days.
- The number of inquiries in Q1 CY2015 is the highest number received by the three MCOs since Q3 CY2013. The number of member inquiries increased by 39.3% compared with the previous quarter. The increase may, as indicated by the categories where increases occurred, be due to Q1 being an open enrollment period.
- Of the 103,160 customer inquiries by members, Sunflower received 43.1% of the calls, UnitedHealthcare 33.1%, and Amerigroup 23.8%. Of the 49,252 provider inquiries, Amerigroup received 36.8%, UnitedHealthcare 33.8%, and Sunflower 29.4%.
- For members, benefit inquiries were again the highest percentage (20.1%) of the calls received in Q1, an increase of 4,976 compared with the previous quarter. For providers, claim status inquiries were again the highest percentage (39.5%) of calls.
- Based on the wide range of reported number of calls in some of the categories, criteria used by the MCOs to categorize member and provider inquiries appear to vary greatly by MCO.

Recommendations

- The State should work with the MCOs to develop consistent criteria for classifying the member and provider inquiries.
- As there were more inquiries in the "Other" category (2,353) than in eight of the 17 categories, additional explanation should be provided to better describe to the State the types of inquiries included in the "Other" category to determine whether additional categories may be beneficial.

Timeliness of Claims Processing

Data Sources

Timeliness of Claims Processing is based on MCO data reported in a monthly Claims Overview Report implemented in October 2014, and reporting claims data beginning in January 2014. To more clearly track timeliness of claims processing in CY2014, and as recommended in previous quarterly evaluation reports, the State developed, with interagency input, the Claims Overview Report template to provide clearer and more detailed tracking of the timeliness of claims processing.

In this revised Claims report, MCOs show the number of claims received each month and whether or not these claims were processed in a timely manner, as defined by the type of claim and State-specified timelines. Prior to October 2014, claims reports focused on the claims processed in a particular month, and reported the number and percentage of the claims that had been processed within the contractually required timeline. The current template reports the number of claims received by each MCO during each month, and reports the number and percent of claims received that month that were processed within the contractually required timelines. While it was anticipated that the revised reporting implemented in October 2014 would result in few revisions in the data reported in the "Timeliness of Claims Processing" table for previous quarters, data were updated in the Q4 CY2014 report (that included claims received/processed in Q1-Q3) due to a vendor delay in reporting data to Amerigroup. In this this quarterly report data were updated to correct the number of Sunflower clean claims for pharmacy, which had originally included only claims paid rather than all pharmacy clean claims processed within 30 days.

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."

Due to the 30 to 90 day processing timelines, depending on type of claim, MCOs have submitted monthly reports for clean claims received in through February 2015, for non-clean claims received through January 2015, and for all claims received through December 2014. To best assess trends, timeliness of claims processing is reported and compared by quarter in this report. In the Q1 2015 report, data are reported for Q1 through Q4, CY2014, quarters where data are available for each month of the quarter for all claim types.

In the Q1 CY2015 report, average TATs for processing clean claims are based on data reported in Claims Overview reports for claims processed during January through March 2015. (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 two previous quarters. Turnaround time (TAT) data for Q2 and Q3 CY2014 were reported in monthly Adjusted Claims and Claims Processing Turnaround Time (TAT) reports.

While reviewing the TAT data for this report, KFMC found that each of the MCOs was using a different method to calculate the average TAT for Total Services. In this quarter's report (Table 5), KFMC recalculated the Total Services Average TAT for each MCO for Q1 CY2014 through Q1 CY2015 using a weighted average, but excluding the pharmacy claims, as all pharmacy claims for each of the MCOs are processed "same day."

Timeliness of Processing Clean Claims, Non-Clean Claims, and All Claims

As indicated in Table 4:

- 99.89% of 4,293,012"clean claims" received in Q4 CY2014 were processed within 30 days;
- 99.96% of 173,754 "non-clean claims" received in Q4 were processed within 60 days; and
- 99.997% of 4,466,766 "all claims" received in Q4 were processed within 90 days.

For claims received by MCOs in CY2014 (Q1 through Q4):

- 99.94% of 16,500,508 clean claims were processed within 30 days;
- 99.94% of 629,724 non-clean claims were processed within 60 days; and
- 99.997% of all claims (17,130,232) were processed within 90 days.

The MCOs received and processed a higher number of claims in all categories in Q4 compared to Q1 to Q3.

Table 4 - Timeliness of Claims Processing, CY2014					
Clean Claims	**Q1**	**Q2**	**Q3**	**Q4**	**Q1-Q4**
Number of Claims Received	3,916,708	4,172,590	4,118,292	4,293,014	16,500,604
Number of Claims Excluded	29	47	18	2	96
Number of Claims Not Excluded	3,916,679	4,172,543	4,118,274	4,293,012	16,500,508
Number of Claims received within month processed within **30 days**	3,914,870	4,170,436	4,116,668	4,288,088	16,490,062
Number of Claims **not** processed within **30 days**	1,809	2,107	1,606	4,924	10,446
Percent of claims processed within **30 days**	99.95%	99.95%	99.96%	99.89%	99.94%
Non-Clean Claims	**Q1**	**Q2**	**Q3**	**Q4**	**Q1-Q4**
Number of Claims Received	137,570	178,534	140,895	174,130	631,129
Number of Claims Excluded	375	337	317	376	1,405
Number of Claims Not Excluded	137,195	178,197	140,578	173,754	629,724
Number of Claims received within month processed within **60 days**	137,089	178,062	140,502	173,678	629,331
Number of Claims **not** processed within **60 days**	106	135	76	76	393
Percent of claims processed within **60 days**	99.92%	99.92%	99.95%	99.96%	99.94%
All Claims	**Q1**	**Q2**	**Q3**	**Q4**	**Q1-Q4**
Number of Claims Received	4,054,278	4,351,124	4,259,187	4,467,144	17,131,733
Number of Claims Excluded	404	384	335	378	1,501
Number of Claims Not Excluded	4,053,874	4,350,740	4,258,852	4,466,766	17,130,232
Number of Claims received within month processed within **90 days**	4,053,746	4,350,651	4,258,729	4,466,651	17,129,777
Number of Claims **not** processed within **90 days**	128	89	123	115	455
Percent of claims processed within **90 days**	99.997%	99.998%	99.997%	99.997%	99.997%

The number and percentage of clean claims not processed within 30 days more than doubled in Q4 (4,924) compared to Q3 CY2014 (1,606). The number of non-clean claims not processed was the same in Q4 and Q3 (76). The number of "all claims" not processed within 90 days decreased slightly in Q4.

- Of the 4,924 clean claims not processed within 30 days in Q4, 77.0% (3,793) were Sunflower claims; 22.7% (1,116) were UnitedHealthcare claims; and only 0.3% (15) were Amerigroup claims.
- In CY2014, of 10,446 clean claims not processed within 30 days, 86.3% (9,010) were Sunflower claims; 11.6% (1,213) were UnitedHealthcare claims; and 2.1% (223) were Amerigroup claims.
- In CY2014, of 393 non-clean claims not processed within 60 days, 39.7% (156) were Amerigroup claims; 32.6% (128) were Sunflower claims; and 27.7% (109) were UnitedHealthcare claims.
- Of the 455 "all claims" not processed within 90 days, 64.8% (295) were Sunflower claims; 18.0% (82) were UnitedHealthcare claims; and 17.1% (78) were Amerigroup claims.

Current Quarter and Trend over Time for Average Turnaround Time for Processing Clean Claims

As indicated in Table 5, the MCOs processed 4,526,451 clean claims in Q1 CY2015 (includes claims received prior to Q1), an increase of 59,519 compared to Q4 CY 2014. The number of clean claims processed has increased during each quarter of CY2014 through Q1 CY2015. In Q1CY2014, 3,630,971 clean claims were processed, a difference of 743,263 compared to Q1 CY2015.

Table 5 - Number of All Claims Processed by Quarter by Service Category and Average Monthly Turnaround Time (TAT) Ranges for Clean Claims Processed, Quarter 1, CY2014 - Quarter 1, CY2015

	CY2014								CY2015	
	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Quarter 1	
	Claims Processed	Average TAT Monthly Ranges for Processing Clean Claims	Claims Processed	Average TAT Monthly Ranges for Processing Clean Claims	Claims Processed	Average TAT Monthly Ranges for Processing Clean Claims	Claims Processed	Average TAT Monthly Ranges for Processing Clean Claims	Claims Processed	Average TAT Monthly Ranges for Processing Clean Claims
Hospital Inpatient	23,726	**5.5 to 18.6**	23,376	**5 to 19.2**	25,989	**7 to 17.4**	27,375	**6.6 to 12.8**	27,110	**6.4 to 15.9**
Hospital Outpatient	215,985	**3.6 to 12.8**	222,420	**3.6 to 11.8**	235,670	**4.1 to 11.2**	252,041	**4.2 to 9.6**	240,486	**3.5 to 10.8**
Pharmacy	1,575,423	**same day**	1,597,223	**same day**	1,586,476	**same day**	1,604,130	**same day**	1,740,255	**same day**
Dental	98,870	**2 to 21**	111,113	**3 to 13**	99,349	**3 to 13**	105,340	**12 to 13.3**	105,373	**4 to 13.1**
Vision	54,930	**7 to 12.3**	61,826	**8 to 12.1**	76,827	**8 to 12**	58,246	**8 to 12**	57,234	**10 to 12.1**
Non-Emergency Transportation	96,758	**10.9 to 18**	112,633	**11.1 to 17**	126,908	**11 to 14**	133,337	**11 to 13.6**	107,432	**10.7 to 15**
Medical (Physical health not otherwise specified)	1,095,920	**3.6 to 10.6**	1,254,776	**3.3 to 9.8**	1,361,812	**3.6 to 10.1**	1,514,103	**3.2 to 10**	1,475,673	**3.4 to 10.5**
Nursing Facilities	77,055	**4.3 to 11.2**	78,473	**4.6 to 11.5**	79,614	**5.7 to 9.6**	108,011	**4 to 10.8**	90,576	**4.2 to 9.7**
HCBS	159,227	**3.7 to 15.6**	224,777	**3.2 to 14.2**	254,082	**3.3 to 14.2**	299,835	**4 to 10.1**	263,182	**4.1 to 8.7**
Behavioral Health	385,294	**3.4 to 9.4**	404,386	**3.5 to 8.2**	367,138	**3.8 to 8.5**	364,514	**2.8 to 8.3**	419,130	**2.7 to 9.4**
Total Services Average TAT	**3,783,188**	**4.7 to 11.5**	**4,091,003**	**4.5 to 10.8**	**4,213,865**	**4.5 to 10.9**	**4,466,932**	**4.3 to 10.2**	**4,526,451**	**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 not changed greatly in the last four quarters or based on the number of claims processed. As shown in Table 5, the average TAT for Total Services was 4.3 to 10.3 days in Q1 CY2015.

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

- Clean pharmacy claims, had the shortest turnaround times and were consistently processed on a same day basis by each of the three MCOs. (Due to the high volume of pharmacy claims, and the consistent processing of these claims “same day,” TATs for pharmacy claims were excluded when calculating the quarterly weighted averages of TATs for all services.)
- Clean claims for non-emergency transportation had longer TATs, with quarterly average TATs ranging from 10.7 to 15 days in Q1 CY2015.
- Vision claims also had longer TATs, with quarterly average TATs ranging from 10 to 12.1 days in Q1 CY2015.

- Dental claims also have longer TATs; in Q1 Dental TATs averaged 12 to 13 days for the two MCOs (Amerigroup and UnitedHealthcare); Sunflower had average monthly TATs ranging from 4.0 to 13.1 days.
- In Q1 CY2015, UnitedHealthcare had higher average monthly TATs for all services except Non-Emergency Transportation. Amerigroup had lower average monthly TATs for Hospital Inpatient, Hospital Outpatient, Medical, Nursing Facilities, HCBS, Behavioral Health, and for the average total for all services.

It should be noted that the average TAT monthly ranges reported in Table 5 only include clean claims processed by the MCOs in Q1 through Q4, and do not include clean claims received but not yet processed.

Beginning in CY2015, the TAT for Nursing Facility claims and HCBS claims are pay-for-performance measures, added an incentive for the MCOs to reduce the TATs for processing claims for these services.

Conclusions

- In Q4 CY2014, MCOs processed 99.89% of clean claims within 30 days; 99.96% of non-clean claims within 60 days; and 99.997% of all claims within 90 days.
- The number and percentage of clean claims not processed within 30 days increased in Q4 compared to the three previous quarters.
- Of the 4,924 clean claims not processed within 30 days in Q4, 77.0% were Sunflower claims, 22.7% were UnitedHealthcare claims, and 0.3% of claims were Amerigroup claims. Of the 10,446 clean claims in CY2014 not processed within 30 days, 86.3% were Sunflower claims; 11.6% UnitedHealthcare, and 2.1% Amerigroup.
- The MCOs processed 4,526,451 clean claims in Q1 CY2014 (includes claims received prior to Q4), an increase of 59,519 compared to Q4 CY 2014. The number of clean claims processed has increased during each quarter of CY2014 through Q1 CY2015.
- 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 not changed greatly in the last four quarters or based on the number of claims processed. In Q1 CY2015, the average TAT for Total Services was 4.3 to 10.3 days.
- The average TAT for processing clean claims for individual service types again varied by service type and by MCO.
- Beginning in CY2015, TAT for clean claims for Nursing Facilities and HCBS claims are pay-for-performance measures, providing an incentive for MCOs to reduce the TATs for processing claims for these services.

Recommendations

- Sunflower and UnitedHealthcare should make concerted efforts to improve processes to increase the percentage of clean claims processed within 30 days.
- 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 or where the average number of days varies by five to seven days month to month.

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) reports track 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 the grievances, including narratives of grievance description and resolution, date received, Medicaid ID, number of business days to resolve, etc. Categories of the grievances received during the quarter are further summarized by count in a Reason Summary Chart in the report.

The STC and GAR reports each have lists of specific grievance categories that have only a few categories with similar category names. The STC report includes 11 grievance categories, and the GAR Reason Summary Table has 20 categories (see Table 6). Only three of the categories overlap clearly (Claims/Billing Issues, Quality of Care or Service, and Other).

The GAR report includes detailed descriptions of the grievances resolved within the quarter. In reviewing these detailed grievances, KFMC found many of the grievances did not appear to be based on specific or consistent criteria by the MCOs, and some grievances appeared to be misclassified. Clearer definitions of grievance categories would assist the MCOs in categorizing grievances and improving consistency throughout the KanCare program.

Transportation-related grievances are a good example of differences in categorization by each of the MCOs. Of the 229 transportation-related grievances resolved in Q1, 36.7% were categorized as “Timeliness”; 28.4% were categorized as “Availability”; 24.5% were categorized as “Attitude/Service of Staff”; 4.4% were “Billing and Financial Issues”; 2.2% “Quality of Care or Service”; 0.9% “Lack of Information from Provider”; 0.9% “Prior or Post Authorization”; and 2.2% “Other” (see Table 7). MCOs again varied in their categorization rates:

- Amerigroup categorized 50.0% of 44 transportation-related grievances as “Availability”; 11.4% as “Timeliness”; 15.9% as “Billing and Financial Issues”; 15.9% as “Attitude/Service of Staff”; 2.3% as “Quality of Care or Service”; 2.3% as “Lack of Information from Provider”; and 2.3% as “Other.”
- Sunflower categorized 39.4% of 109 transportation-related grievances as “Availability”; 34.9% as “Timeliness”; 17.4% as “Attitude/Service of Staff”; 2.8% as “Billing and Financial

Issues"; 1.8% as "Prior or Post Authorization"; 1.8% as "Quality of Care or Service"; 0.9% as "Lack of Information from Provider"; and 0.9% as "Other."

- UnitedHealthcare categorized 53.9% of 76 transportation-related grievances as "Timeliness"; 39.5% as "Attitude/Service of Staff"; 2.6% as "Quality of Care or Service"; and 3.9% as "Other."

Table 6 - Comparison of Grievance Report Categories, Quarters 1-4, CY2014, through Quarter 1, CY2015

	Reports		STC Report										GAR Report									
			CY2014								CY2015		CY2014								CY2015	
			Q1		Q2		Q3		Q4		Q1		Q1		Q2		Q3		Q4		Q1	
	STC	GAR	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Transportation	√		226	45.4%	206	40.9%	291	43.3%	213	35.0%	251	39.6%										
Claims/Billing Issues	√	√	106	21.3%	123	24.4%	151	22.5%	213	35.0%	197	31.1%	125	25.1%	128	25.6%	144	23.4%	229	36.3%	227	35.7%
Quality of Care or Service	√	√	44	8.8%	64	12.7%	88	13.1%	70	11.5%	39	6.2%	48	9.6%	48	9.6%	58	9.4%	40	6.3%	40	6.3%
Customer Service	√		38	7.6%	29	5.8%	42	6.3%	21	3.4%	43	6.8%										
Benefit Denial or LImitation	√		13	2.6%	15	3.0%	30	4.5%	8	1.3%	23	3.6%										
Access to Service or Care	√		24	4.8%	21	4.2%	26	3.9%	34	5.6%	34	5.4%										
Health Plan Administration	√		20	4.0%	15	3.0%	20	3.0%	23	3.8%	11	1.7%										
Member Rights/Dignity	√		1	0.2%	8	1.6%	14	2.1%	17	2.8%	23	3.6%										
Service or Care Disruption	√		6	1.2%	16	3.2%	5	0.7%	2	0.3%	6	0.9%										
Clinical/Utilization Management	√		0	0.0%	4	0.8%	5	0.7%	1	0.2%	3	0.5%										
Other	√	√	20	4.0%	3	0.6%	0	0.0%	7	1.1%	4	0.6%	26	5.2%	21	4.2%	34	5.5%	33	5.2%	25	3.9%
Availability		√											80	16.1%	91	18.2%	124	20.2%	86	13.6%	83	13.1%
Timeliness		√											85	17.1%	95	19.0%	103	16.7%	97	15.4%	86	13.5%
Attitude/Service of Staff		√											106	21.3%	70	14.0%	101	16.4%	113	17.9%	116	18.3%
Lack of Information from Provider		√											4	0.8%	2	0.4%	9	1.5%	4	0.6%	3	0.5%
Level of Care Dispute		√											2	0.4%	2	0.4%	9	1.5%	5	0.8%	5	0.8%
Prior or Post Authorization		√											3	0.6%	6	1.2%	8	1.3%	4	0.6%	5	0.8%
Accessibility of Office		√											3	0.6%	9	1.8%	8	1.3%	5	0.8%	3	0.5%
Pharmacy		√											6	1.2%	13	2.6%	5	0.8%	8	1.3%	9	1.4%
Criteria Not Met - Medical Procedure		√											4	0.8%	4	0.8%	2	0.3%	1	0.2%	6	0.9%
Criteria Not Met - Durable Medical Equipment		√											3	0.6%	4	0.8%	5	0.8%			2	0.3%
Criteria Not Met - Inpatient Admissions		√																			2	0.3%
Sleep Studies		√													1	0.2%	2	0.3%				
HCBS		√											2	0.4%	3	0.6%	1	0.2%	5	0.8%	12	1.9%
Quality of Office, Building		√											1	0.2%	3	0.6%	1	0.2%				
Sterilization		√															1	0.2%				
Overpayments		√																	1	0.2%		
"AOR" (Appointment of Representation)																					10	1.6%
No category listed		√																			1	
Total			498		504		672		609		634		498		500		615		631		635	

Another example is the different categorizations used for grievances related to the CentAccount (Sunflower) and Healthy Rewards (Amerigroup) incentive programs. Of 14 grievances related to CentAccount – 8 were categorized as "Billing and Financial Issues," 2 were categorized as "Availability," 1 was categorized as "Prior or Post Authorizations," and 3 were categorized as "Other." Of six grievances related to Healthy Rewards - 1 was categorized as "Billing and Financial Issues," 1 was categorized as "Attitude/Service of Staff," 2 were categorized as "HCBS," and 2 were categorized as "Other."

It would also seem realistic to categorize any grievances referred for "QOC Investigation" as "QOC" rather than "Attitude/Service of Staff," "Availability," or "Other."

Table 7 - Transportation-Related Grievances by Category, Quarter 1, CY2015								
	Amerigroup		Sunflower		UnitedHealthcare		Total	
	#	%	#	%	#	%	#	%
Timeliness	5	11.4%	38	34.9%	41	53.9%	84	36.7%
Availability	22	50.0%	43	39.4%			65	28.4%
Attitude/Service of Staff	7	15.9%	19	17.4%	30	39.5%	56	24.5%
Billing and Financial Issues	7	15.9%	3	2.8%			10	4.4%
Prior or Post Authorization			2	1.8%			2	0.9%
Quality of Care or Service	1	2.3%	2	1.8%	2	2.6%	5	2.2%
Lack of Information from Provider	1	2.3%	1	0.9%			2	0.9%
Other	1	2.3%	1	0.9%	3	3.9%	5	2.2%
Transportation-Related Total	44		109		76		229	

It should also be noted that some grievance "resolutions," particularly those related to billing issues and transportation, involve repeated contacts to providers and vendors. As this is the end of the third year of the KanCare program, it would seem that the number of providers who are balance billing members should be decreasing. In the last four quarters the number of grievances categorized by UnitedHealthcare as "Billing and Financial Issues" included: Q2 CY2014 - 100 (48.5%) of 206 grievances; Q3 CY2014 - 114 (39.7%) of 287 grievances"; Q4 CY2014 - 183 (54.8%) of 334 grievances; and in Q1 CY2015 - 174 (60.8%) of 286. Most of these "Billing and Financial Issues grievances were specifically indicated as "balance billing." (Amerigroup had 33 billing-related grievances in Q1 CY2015, and Sunflower had 21.) The Q1 CY 2015 UnitedHealthcare GAR report lists 147 different providers for these 174 grievances. One of the medical centers, listed in 11 grievances in Q4 2014, was listed for 10 grievances in Q1 2015. In the STC report, UnitedHealthcare indicated they send a letter to "each provider who erroneously billed members advising him or her to cease billing," and that the "Provider Relations Team is informed of repeat offenders in order to educate those providers about the claims submission process and the regulations that prohibit billing a Medicaid member." As several providers continue to balance bill members, and with the continued high number of providers each quarter balance billing, it would seem beneficial to educate providers proactively rather than reactively about balance billing regulations. Of particular concern is that, while UnitedHealthcare received 174 billing-related grievances this quarter, it is possible that many more members received balance bills from providers but did not contact UnitedHealthcare.

Resolution details provided also raise some potential concerns. Some examples include:

- Several grievances are listed as resolved due to the fact they are now in the Appeal process.
- A complaint about a provider not taking time to address some health concerns (that resulted in an ER visit later in the day) was resolved by "explained provider's tight schedules. Most are very busy."
- Several grievances were indicated as resolved because of being unable to contact the provider.

Conclusions

- Grievance categories in the GAR and STC reports continue to be interpreted differently by each MCO. Transportation-related grievances, in particular, continue to be categorized differently by each MCO for similarly described situations.
- The grievance categories with the highest number of grievances were those related to transportation and billing. Most of the billing-related grievances (76.7%) were UnitedHealthcare grievances for billing of members by 147 different providers.
- The GAR reports continue to have inconsistencies by MCOs in their reporting of grievances.

Recommendations

- MCOs, particularly UnitedHealthcare, should make efforts to educate all providers (and not just those reported by members) about balance billing regulations and policies to reduce the number of billing-related grievances.
- Grievance categories within the GAR and STC reports should be more clearly defined by the State. Wherever possible, grievance categories in different reports should be consistently named and defined.
- Data in the GAR and STC grievance reports should be reviewed and compared to ensure consistent reporting of data within reports and between reports where applicable.

Track Timely Resolution of Grievances

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

Data Source

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

Current Quarter Compared to Previous Quarters

As shown in Table 8, 98.3% (625) of the 636 grievances closed in Q1 CY2015 were resolved within 30 business days; and 99.1% (630) were resolved within 60 business days. The six grievances were not resolved within the State-required 60 business days were grievances received by Sunflower. (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.)

Table 8 - Timeliness of Resolution of Grievances									
	CY2013				CY2014				CY2015
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Number of Grievances Received in Quarter	445	496	422	423	498	501	679	609	**683**
Number of Grievances Closed in Quarter*	422	462	412	427	501	507	684	615	**636**
Number of Grievances Closed in Quarter Resolved Within 30 Business Days*	422	462	412	427	499	490	680	614	**625**
Percent of Grievances closed in Quarter Resolved Within 30 Business Days	100%	100%	100%	100%	99.6%	96.6%	99.4%	99.8%	**98.3%**
Number of Grievances Closed in Quarter Resolved Within 60 Business Days*	422	462	412	427	501	500	683	615	**630**
Percent of Grievances Closed in Quarter Resolved Within 60 Business Days	100%	100%	100%	100%	100%	98.6%	99.9%	100.0%	**99.1%**
Number of Grievances Closed in Quarter Not Resolved Within 60 Business Days*	0	0	0	0	0	7	1	**0**	**6**

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

In the nine quarters of KanCare to date, the number of grievances received and the number of grievances closed, as reported in the GAR report, increased slightly each quarter. In Q3 CY2014, the number of grievances received (679) and the number of grievances closed (684) were a sharper increase than the previous quarters. In Q4, the number of grievances received decreased by 70 (609), still over 100 to150 higher than CY2013 and the first half of CY2014. The number of grievances received in Q1 CY2015 increased to 683, the highest number received to date.

- Of the three MCOs, in Q1 UnitedHealthcare had the highest number of grievances received (305 reported in the STC report; 322 reported in the GAR report as received in Q1). Amerigroup received the fewest grievances in Q1 (158). Sunflower reported in both the STC and GAR reports receiving 203 grievances in Q1. However, based on the detailed descriptions of grievances provided in the GAR report, the 203 reported by Sunflower includes 13 grievances received in Q4 2014.
- In the Q1 STC report, UnitedHealthcare reported 257 of 305 grievances received in Q1 were resolved in Q1; Amerigroup reported 113 of 158 grievances received in Q1 were resolved in Q1. Sunflower reported that 203 of 203 grievances received in Q1 were resolved in Q1. (As noted above, 13 of the 203 were reported in the GAR as having been received in Q4 2014.)
- In the quarterly GAR reports, MCOs report the number and types of grievances in a "Reason Summary Chart." The categories in this chart match the categorization of grievances in the detailed summary of each grievance in another section of the GAR report.
  - The categories in the GAR report continue to differ from those reported in the STC report submitted quarterly to the State.
  - As noted in other sections of this quarterly report, the MCOs categorize grievances differently and appear to not have access to detailed category criteria for categorizing grievances consistently by all MCOs.
  - Reporting of grievances in the Reasons Summary Chart differs by MCO:
    - Amerigroup reported categorization of 158 grievances, which matches the number of grievances they reported as having been received in Q1. The detailed and categorized grievances in the GAR report, however, include details on 146

grievances resolved in Q1 – 113 received in Q1 plus 33 received in Q4 2014 and resolved in Q1. No detailed descriptions are included in the GAR report for the additional 12 grievances Amerigroup lists in the Reasons Summary Chart.
    - Sunflower reported 203 grievances in the Reasons Summary Chart and provided details and categorizations of 203 grievances – 190 of the grievances were received in Q1 and resolved in Q1; 12 were received in Q4 2014 and resolved in Q1; and one was received in 2013 that mistakenly had not been included in previous quarterly reports.
    - UnitedHealthcare reported categorization of 337 grievances in the Reasons Summary Chart. The 337 includes 51 grievances resolved in Q2 2015 (not Q1); 271 received in Q1 and resolved in Q1; and 15 received in Q4 2014 that were resolved in Q1.
    - In the detailed grievances, UnitedHealthcare categorized 13 grievances as "AOR" instead of one or more of the categories included in the Reasons Summary Chart. KFMC contacted UnitedHealthcare and was told that "AOR" refers to "Appointment of Representation." One grievance also had no categorization included. Using different categorizations (or no categorization) makes it difficult to assess the accuracy of reporting for the Reasons Summary Chart.
- Grievances are reported in detail in a separate tab of the GAR report. Sunflower and Amerigroup provide adequate detail of each grievance to allow review by the State (and EQRO) to assess whether the categorizations adequately apply to each specific grievance. The UnitedHealthcare details focus on providing instead the names, dates of service, addresses, etc., but not enough description of the grievance to assess whether the categorization was appropriate. Many of the UnitedHealthcare grievances appear to be potential duplicates, which may be inflating the number of grievances reported.

Conclusions

- The number of grievances received in Q1 CY2015 increased to 683, the highest number received to date.
- Of grievances closed in Q1 CY2015, 98.3% were resolved within 30 business days, and 99.1% were resolved within 60 business days. The six grievances not resolved within 60 business days were received by Sunflower.
- In the GAR reported grievances resolved in Q1, MCOs again appeared to differ in the criteria they used to categorize and report these grievances in the various reporting tools.

Recommendation

- The State should work with the MCOs to identify specific criteria for categorizing grievances to provide better consistency in reporting. Additional definitions should be provided by the State to the MCOs as to what counts of grievances should be reported in the Reasons Summary Chart, STC report, and other sections of the GAR report.

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

Table 9 summarizes the quarterly numbers and types of grievances to date for the aggregated MCO data. In Q1 CY2015, 634 grievances received were itemized, 25 more than in Q4 CY2015. (The total number of non-itemized grievances reported in the STC report as received in Q1 CY2015 was 666; in the GAR report, the MCOs report receiving 683 grievances in Q1 CY2015.)

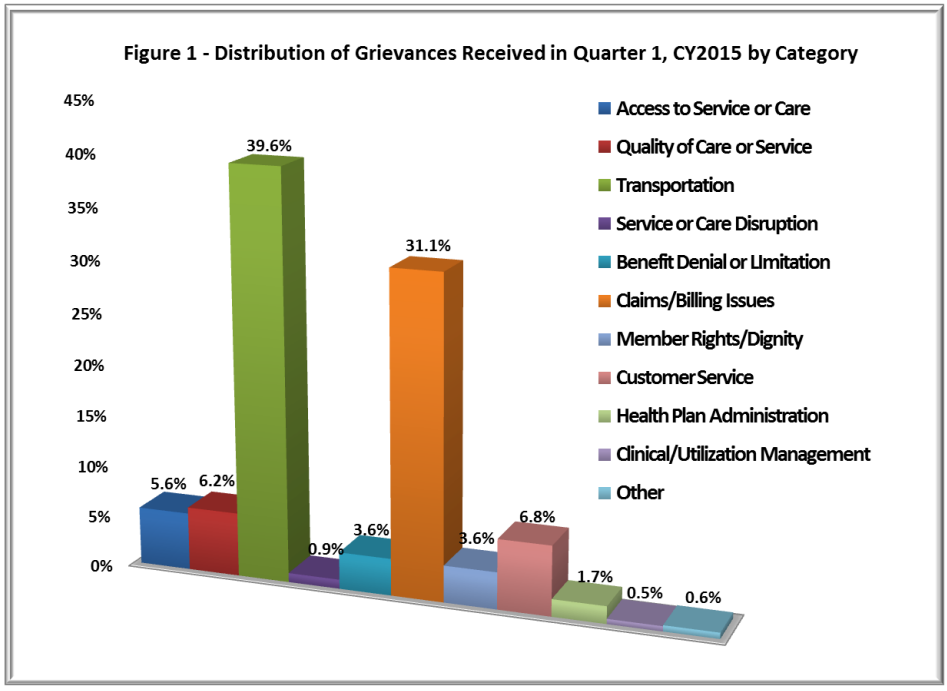
The grievance category (as reported in the STC report) that increased the most in Q1 (compared to Q4 2014) was Transportation (251 grievances in Q1 compared to 213 in Q4). The number of transportation-related grievances in Q1, however, was lower than three of the previous eight quarters. The number of grievances in Claims/Billing category decreased in Q1 compared to Q4 CY2014 (197 in Q1; 213 in Q4), but was higher than the number of grievances in seven of the eight previous quarter. In the past nine quarters, 66.3% of 4,697 grievances were related to Transportation (44.4%) and Claims/Billing (22.0%). As displayed in Table 10 and Figure 1, 39.6% of the grievances in Q1 were related to Transportation and 31.1% were related to Claims/Billing Issues. For comparison, Figure 2 shows the distribution of grievances in Q4 CY2014, and Figure 3 shows the distribution of grievances in Q1 CY2014.

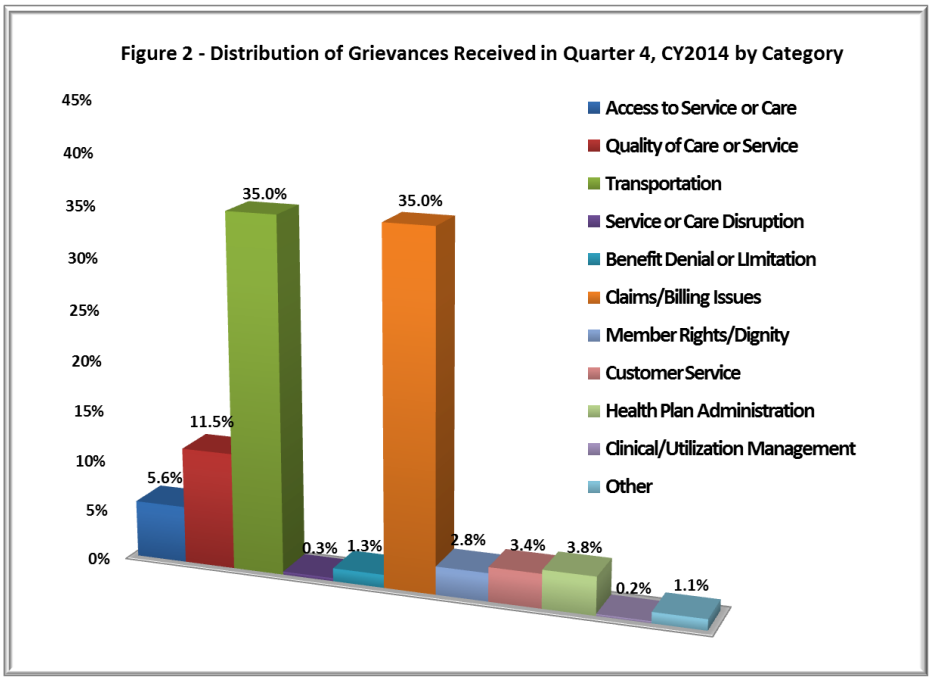
Table 9 - Number of Grievances Received each Quarter by Category

	CY2013				CY2014				CY2015
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Transportation	271	261	183	182	226	206	291	213	251
Claims/Billing Issues	35	87	48	72	106	123	151	213	197
Quality of Care or Service	19	34	30	56	44	64	88	70	39
Access to Service or Care	16	13	13	27	24	21	26	34	34
Health Plan Administration	17	31	26	27	20	15	20	23	11
Customer Service	52	52	34	25	38	29	42	21	43
Member Rights/Dignity	4	5	10	6	1	4	14	17	23
Benefit Denial or LImitation	16	4	7	10	13	15	30	8	23
Service or Care Disruption	3	11	16	7	6	16	5	2	6
Clinical/Utilization Management	4	10	14	5	0	8	5	1	3
Other	13	3	18	3	20	3	0	7	4
Total	450	511	399	420	498	504	672	609	634
Total Grievances Reported Received in Quarter	450	511	399	420	498	504	691	609	666
Total Grievances Resolved by the end of the quarter of those received in the quarter*†	407	453	344	385	474	474	672	560	573

*MCOs are contractually required to resolve 98% of member grievances within 30 day, and 100% of member grievances within 60 business days (via an extension request). Grievances received late in the quarter may not be resolved until the following quarter.
†Does not include Grievances resolved in the quarter that were received in the previous quarter

Table 10 - Percentage of Grievances by Category Received Each Quarter To Date									
	CY2013				CY2014				CY2015
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Total Grievances Received	450	511	399	420	498	504	691	609	634
	% of 450	% of 511	% of 399	% of 420	% of 498	% of 504	% of 691	% of 609	% of 634
Transportation	60.2%	51.1%	45.9%	43.3%	45.4%	40.9%	43.3%	35.0%	39.6%
Claims/Billing Issues	7.8%	17.0%	12.0%	17.1%	21.3%	24.4%	22.5%	35.0%	31.1%
Quality of Care or Service	4.2%	6.7%	7.5%	13.3%	8.8%	12.7%	13.1%	11.5%	6.2%
Access to Service or Care	3.6%	2.5%	3.3%	6.4%	4.8%	4.2%	3.9%	5.6%	5.4%
Health Plan Administration	3.8%	6.1%	6.5%	6.4%	4.0%	3.0%	3.0%	3.8%	1.7%
Customer Service	11.6%	10.2%	8.5%	6.0%	7.6%	5.8%	6.3%	3.4%	6.8%
Member Rights/Dignity	0.9%	1.0%	2.5%	1.4%	0.2%	1.6%	2.1%	2.8%	3.6%
Benefit Denial or LImitation	3.6%	0.8%	1.8%	2.4%	2.6%	3.0%	4.5%	1.3%	3.6%
Service or Care Disruption	0.7%	2.2%	4.0%	1.7%	1.2%	3.2%	0.7%	0.3%	0.9%
Clinical/Utilization Management	0.9%	2.0%	3.5%	1.2%	0.0%	0.8%	0.7%	0.2%	0.5%
Other	2.9%	0.6%	4.5%	0.7%	4.0%	0.6%	0.0%	1.1%	0.6%





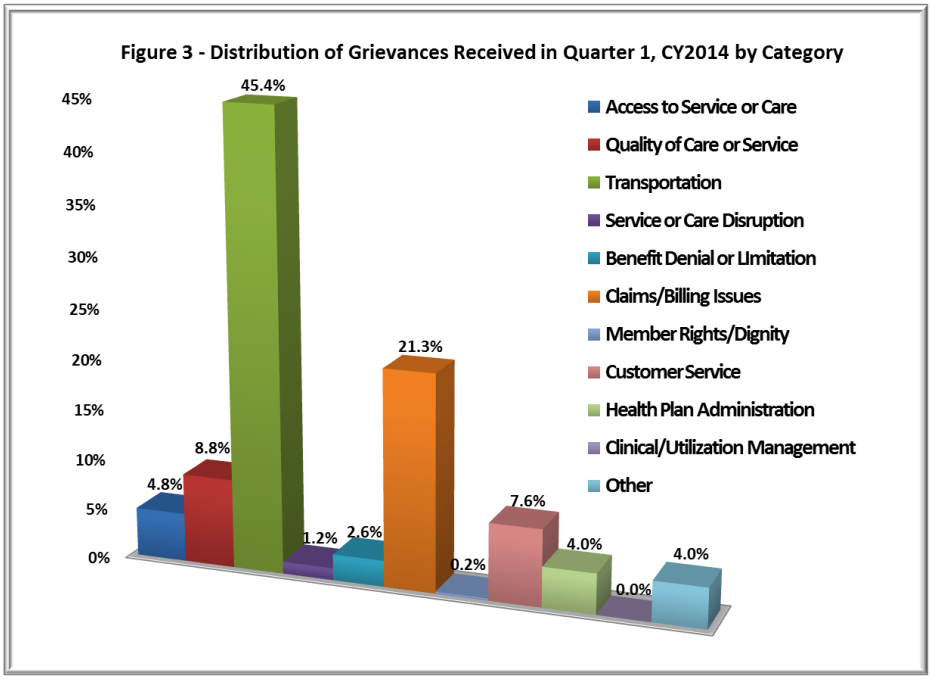


Table 11 reports the types of grievances resolved in Q1 CY2015 in total and by waiver.

Of 630 grievances resolved in Q1 CY2015 that were reported by 589 members, 170 (27%) were reported by 160 members receiving waiver services.

- Of the 170 grievances received from waiver members, 84 (49.4%) were transportation-related.

- Physical Disability (PD) waiver members had the most grievances, with 94 members reporting 98 grievances in Q1. This was an increase compared to the previous quarter where 68 PD waiver members reported 81 grievances. Of the 98 grievances in Q1, 59.2% were transportation-related.
- Frail Elderly (FE) waiver members had the second highest number of reported grievances, with 26 members reporting 31 grievances, 45.2% transportation-related. In the previous quarter, 31 members receiving FE waiver services reported 38 grievances, 39.5% transportation-related.
- Intellectual/Developmental Disability (I/DD) waiver members reported 17 grievances (from 17 members), with only four that were transportation-related. In Q4 CY2014, 10 I/DD members reported 14 grievances, four that were transportation-related.
- The number of Traumatic Brain Injury grievances dropped from 17 (16 members) in Q4 CY2014 to 11 (11 members), with half of the grievances transportation-related.
- Other waiver members reporting grievances were Serious Emotional Disturbance (SED) waiver (six grievances from six members), two transportation-related; Technology Assisted (TA) (six grievances from five members), one transportation-related; and one grievance from a member receiving Autism services (not transportation-related).

Table 11 - Comparison of Grievance Categories by Waiver for Grievances Resolved in Quarter 1, CY2015*

	Number of Grievances		Grievances by Waiver Type						
	All Members	Waiver Members Subtotal	FE	I/DD	PD	SED	TA	Autism	TBI
Billing and Financial Issues	227	44	12	4	20	2	3	1	2
Quality of Care or Service	40	9		1	6	2			
Attitude/Service of Staff	116	28	4	3	18	1			2
Timeliness	86	35	6	1	24	1			3
Availability	83	30	5	2	21		1		1
Pharmacy	9	1			1				
Accessibility of Office	3	1			1				
Lack of Information from Provider	3	1	1						
Level of Care Dispute	5	1							1
Prior or Post Authorization	5	1					1		
HCBS	12	7	1	2	3		1		
Criteria not met - Medical Procedure	6	2		1	1				
"AOR" (Appointment of Representation)	10	2		1					1
Other	25	8	2	2	3				1
Total Grievances Resolved Q4	630	170	31	17	98	6	6	1	11
Transportation-Related	218	84	14	4	58	2	1	0	5
# of Members with Grievances Resolved Q4	589	160	26	17	94	6	5	1	11

*Includes grievances received in Quarter 4, CY2014, that were resolved in Quarter 1, CY2015

Conclusions (All Grievances)

- The numbers of grievances received and the resolved within the quarter are inconsistently reported in the GAR and STC reports.
- Of 630 grievances received by MCOs in Q1 CY2015 that were reported by 589 members, 170 (27%) were reported by 160 members receiving waiver services.

- Grievances related to transportation and claims/billing continue to be the most frequently reported by members.

Recommendation

- MCOs should review the GAR and STC reports to ensure that the number of grievances received and the number resolved within the quarter are consistently reported.

Access-Related Grievances

Of the 634 grievances received in Q1 CY2015, 34 (5.4%) were categorized in the STC report as "Access to Service or Care." (See Tables 9 and 10.) Access-related grievances have consistently been one of the least frequent categories of reported grievances. The number of "Access to Service or Care" grievances has ranged from 13 reported in Q2 and Q3 of CY2013 to 34 reported in Q4 CY2014 and Q1 CY2015.

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

- Amerigroup described 3 access-related grievances received in Q1 CY2015 (compared to 10 in the previous quarter) as situations where members had difficulty or were unable to obtain services or supplies. They indicated they plan to continue to monitor grievances for repeat providers, and that "provider relations staff continue to monitor the network to identify service gaps and work with provider to contract with Amerigroup to perform key services."
- UnitedHealthcare reported 5 access-related grievances received in Q1. They indicated that grievances related to availability of network providers are considered during their geo access studies to identify potential network gaps. For grievances related to appointment availability, provider offices are contacted to review appointment availability standards.
- Sunflower reported 26 access-related grievances and that "12% are regarding member been placed in a Lock-in," and that no additional trends were identified.

No grievances were specifically categorized in the GAR as "Access to Care or Service."
Other categories in the GAR that could be related to "Access to Service or Care" include "Accessibility of Office" and "Availability."

The GAR report provides additional details on grievances resolved during Q1 CY2015. "Accessibility of Office" grievances included inability to get an appointment, concern about not receiving proper care from the member's PCP, and verbal and physical abuse from a member's provider (which would seem more appropriately categorized as a Quality of Care" grievance).

Quality-Related Grievances

Of 634 grievances received in Q1 CY2015, 39 (6.2%) were categorized in the STC report as being related to "Quality of Service or Care" (QOC). In the GAR report, 40 of the grievances resolved in Q1 (6.3%) were categorized as "Quality of Care" (QOC).

In CY2014, there were 266 grievances categorized in the STC report as being related to QOC. The number of QOC grievances increased during each quarter of CY2014 ranging from 44 in Q1 CY2014 to 70 in Q4; the number of QOC grievances reported by the MCOs dropped this quarter to 39.

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

- Amerigroup described the 17 QOC grievances received in Q1 as situations where "members felt they received inappropriate treatment from their treating provider." Nine of the 17 grievances were referred to the Quality Management for a Quality of Care investigation. Amerigroup indicated that concerns that were investigated and substantiated were elevated to the medical director who followed up with providers on corrective action.
- UnitedHealthcare indicated the 12 QOC grievances received in Q1 included a variety of issues ranging from unprofessional behavior to allegations of misdiagnosis, and that QOC grievances go the a confidential peer review process.
- Sunflower reported 10 QOC grievances received in Q1, and indicated "60% of the Quality of Service or Care issues are related to the members feeling mistreated at their providers offices."

Of the 40 QOC grievances reported in the GAR as resolved, 9 were from members receiving waiver services including: six members receiving PD waiver services; two member receiving SED waiver services; and one member receiving I/DD waiver services.

In reviewing the descriptions of resolved grievances in the three MCOs' GAR reports for Q1, KFMC found 32 grievances that could potentially be considered to be related to QOC, particularly where resolution was through the MCO Quality Management staff, that were categorized as "Attitude/Service of Staff" (20 grievances); "Level of Care Dispute" (one grievance); "Accessibility of Office" (two grievances); "AOR" (three grievances); "Criteria not met – Inpatient" (two grievances); "Other" (one grievance); "Pharmacy" (one grievance); and "Availability" (three grievances). Alternatively, a few grievances categorized as QOC could just as easily have been categorized as "Billing/Financial Issues" or "Sleep Study." Where grievances are reported as being referred for QOC investigations, it would seem more appropriate to categorize the grievance as "QOC."

Conclusions (Access and Quality of Care Grievances)

- The number of access-related grievances each quarter is a relatively small percentage of grievances reported, ranging from 13 in Q2 and in Q3 of CY2013 to 34 reported in Q4 CY2014 and Q1 CY2015 (5.4% of grievances received).
- The number of grievances categorized as QOC is also a relatively small percentage of grievances reported. In Q1 CY2015, only 39 (6.2%) of 634 grievances were categorized as QOC.
- Due to the wide range in types of grievances categorized as QOC, the number of grievances not categorized as QOC (but could just as easily be classified as such), and due to the many categories in the GAR report that included grievances that could be considered access-related, it is difficult to conclude whether access-related and QOC grievances are increasing

or decreasing. Developing standardized category criteria, and ensuring consistent use of categories and criteria in the GAR and STC reports, would improve the ability to assess the number of access-related and QOC-related grievances and to assess trends over time.
- Grievances referred for Quality of Care review and processing are often not categorized as "Quality of Care."

Recommendations

- Clearer definitions and criteria for categorizing "Access to Service or Care," "Quality of Care," and other grievance categories in the GAR and STC reports are needed. Use of comparable category types and clear criteria in both reports would improve the ability to assess trends over time in reporting of grievances related to quality of care and other grievance categories.
- Grievances referred to MCO Quality Management as Quality of Care grievances should be categorized as "Quality of Care," particularly if resolution of the grievances is through the Quality Management staff.
- The type and scope of access-related grievances would be more clearly defined by reporting transportation-related access grievances separately from grievances related to non-transportation-related access issues, particularly in the GAR report (as the STC report already tracks transportation-related grievances separately).

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 CY2015 is the KanCare Ombudsman Update report presented by Kerrie Bacon, the KanCare Ombudsman, on 1/23/2015, to the Robert G. (Bob) Bethell Joint Legislative Committee on Home and Community Based Services and KanCare Oversight.

Current Quarter and Trend Over Time

The Ombudsman's Office has a current staffing of three individuals – the Ombudsman, a part-time assistant, and a third full-time volunteer coordinator who began work in September 2014. 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. Ombudsman's Office staff are working with the Center for Community Support and Research at Wichita State University to develop a training program for volunteers. Training of volunteers is planned to begin by August 2015, first in Kansas City, followed by Wichita, and then expand statewide in 2016.

Contact with the Ombudsman's Office is primarily by phone and email, but also includes face-to-face contacts. A primary task for the Ombudsman's Office has been to provide information

to KanCare members and assist them in reaching MCO staff that can provide additional information and assistance in resolving questions and concerns.

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.

Table 12 summarizes the number and type of contacts received and caller types in Q1 CY2015. There were 224 MCO-related contacts this quarter, 43.9% of the 510contacts reported. Most of the contacts to the Ombudsman's Office in Q1 CY2015 were from consumers, 71.8% of 510 contacts and 82.1% of the 224 MCO-related contacts. Phone contacts comprised 81.4% of the contacts this quarter. The 94 email contacts reported this quarter did not include the many emails made in response to initial emails.

Table 12 - Ombudsman Contacts by Contact Method and Caller Type, Quarter 1, CY 2015

Contact Method			Caller Type		
	All contacts	MCO-related		All contacts	MCO-related
Phone	415	188	Consumer	366	184
Email	94*	36*	Provider	111	35
Letter	1	0	MCO employee	3	3
			Other	30	2
Total	510	224	Total	510	224

*Does not include additional emails responding to the initial emails.

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 13, 135 contacts were waiver-related in Q1 CY2015, compared to 110 in Q4 CY2014 and 143 in Q3 CY2014. The most frequent waiver-related issues were for/from KanCare members receiving waiver services for Physical Disability (PD) (57 contacts in Q1 CY2015, up from 29 in Q4 CY2014 and 43 in Q3 CY2014) and Intellectual/Developmental Disability (I/DD) (35 contacts in Q1 CY2015, down from 36 in Q4 CY2014 and 42 in Q3 CY2014).

Since some contacts include more than one issue, the Ombudsman's Office began tracking the number of issues in addition to the number of contacts. As reported in Table 14, there were 620 issues and inquiries tracked out of the 510 contacts in Q1 CY2015. The highest number of issues and inquiries were related to Medicaid Eligibility (139 issues compared to 194 in Q4 CY2014) and HCBS (92 issues compared to 75 in Q4 CY2014). Of the 620 issues and inquiries, 307 (49.5%) were MCO-related.

Of 442 files closed in Q1, (54%) were resolved in one day or less.
In Q4, the Ombudsman's Office began reporting the number of issues that involved responding to questions and the number of issues that involved use of other resources from various State agencies, MCOs, and other community resources.

Table 13 - Waiver-Related Inquiries to Ombudsman Office, Quarter 3, CY2014 to Quarter 1, CY2015

	Q3 CY2014		Q4 CY2014		Q1 CY2015	
Waiver	#	%	#	%	#	%
Intellectual/Developmental Disability (I/DD)	42	29.4%	36	32.7%	35	25.9%
Physical Disability (PD)	43	30.1%	29	26.4%	57	42.2%
Technology Assisted (TA)	8	5.6%	15	13.6%	11	8.1%
Frail Elderly (FE)	16	11.2%	11	10.0%	15	11.1%
Traumatic Brain Injury (TBI)	19	13.3%	10	9.1%	10	7.4%
Serious Emotional Disturbance (SED)	5	3.5%	4	3.6%	1	0.7%
Money Follows the Person (MFP)	6	4.2%	4	3.6%	2	1.5%
Autism	4	2.8%	1	0.9%	4	3.0%
Total	143		110		135	

Table 14 - Types of Issues and Inquiries Submitted to Ombudsman, Quarter 4, CY2014 and Quarter 1, CY2015

	Quarter 4 CY2014					Quarter 1 CY2015				
	All Issues		MCO-related Issues			All Issues		MCO-related Issues		
Issues	#	% of 704	#	% of 321	% of 704	#	% of 620	#	% of 307	% of 620
Medicaid Eligibility Issues	194	27.6%	39	12.1%	5.5%	139	22.4%	37	12.1%	6.0%
Appeals, Grievances	46	6.5%	41	12.8%	5.8%	42	6.8%	36	11.7%	5.8%
Medical Service Issues	70	9.9%	39	12.1%	5.5%	20	3.2%	12	3.9%	1.9%
Billing	42	6.0%	26	8.1%	3.7%	36	5.8%	28	9.1%	4.5%
Durable Medical Equipment	8	1.1%	8	2.5%	1.1%	25	4.0%	18	5.9%	2.9%
Pharmacy	19	2.7%	11	3.4%	1.6%	25	4.0%	16	5.2%	2.6%
HCBS										
HCBS General Issues	49	7.0%	32	10.0%	4.5%	60	9.7%	47	15.3%	7.6%
HCBS Eligibility Issues	11	1.6%	10	3.1%	1.4%	11	1.8%	5	1.6%	0.8%
HCBS Reduction in Hours of Service	8	1.1%	6	1.9%	0.9%	10	1.6%	8	2.6%	1.3%
HCBS Waiting List	7	1.0%	2	0.6%	0.3%	11	1.8%	5	1.6%	0.8%
Care Coordinator Issues	14	2.0%	14	4.4%	2.0%	10	1.6%	8	2.6%	1.3%
Transportation	13	1.8%	9	2.8%	1.3%	12	1.9%	9	2.9%	1.5%
Nursing Facility Issues	24	3.4%	8	2.5%	1.1%	15	2.4%	9	2.9%	1.5%
Housing Issues	10	1.4%	8	2.5%	1.1%	1	0.2%	0	0.0%	0.0%
Change MCO	9	1.3%	8	2.5%	1.1%	8	1.3%	7	2.3%	1.1%
Dental	9	1.3%	6	1.9%	0.9%	7	1.1%	5	1.6%	0.8%
Access to Providers	15	2.1%	13	4.0%	1.8%	3	0.5%	2	0.7%	0.3%
Guardianship Issues	2	0.3%	1	0.3%	0.1%	5	0.8%	2	0.7%	0.3%
I/DD Conference Call Questions	2	0.3%	1	0.3%	0.1%	5	0.8%	2	0.7%	0.3%
Other	112	15.9%	33	10.3%	4.7%	130	21.0%	40	13.0%	6.5%
Unspecified or Thank you	43	6.1%	6	1.9%	0.9%	45	7.3%	11	3.6%	1.8%
Total	704		321		45.6%	620		307		49.5%

Conclusions

- In Q1 CY2015, the Ombudsman's Office has continued to expand and improve their tracking and reporting of issues and inquiries they receive.
- In 510 contacts and calls, 620 issues and inquiries were tracked this quarter. Of these 620 issues, 307 (49.5%) were MCO-related. The highest number of issues and inquiries were related to Medicaid Eligibility (139 issues) and HCBS (92 issues).
- Of 442 files closed in Q1, 54% were resolved in one day or less.
- Training of volunteers is planned to begin in August 2015, first in Kansas City and Wichita, and expand statewide in 2016.

Recommendation

- While the Ombudsman's Office is tracking MCO-related contacts and issues, tracking of issues referred to MCOs in the MCO GAR report is recommended to assist in identifying resolution of grievances referred to the MCOs by the Ombudsman's Office. Addition of a tracking field on the grievance detail report to identify grievances forwarded to the MCOs by the Ombudsman for resolution could assist in tracking resolution of grievances.

CONCLUSIONS SUMMARY

Timely Resolution of Customer Service Inquiries

- In Q1 CY2015, 99.997% of the customer service inquiries received by the MCOs were resolved within two business days. The customer service inquiry reports show that the MCOs have consistently met contractual standards for resolving inquiries within two, five, and 15 business days in each quarter of CY2013, CY2014, and CY2015 to date.
- Of the 5 inquiries not resolved within two business days, all were resolved within five business days.
- The number of inquiries in Q1 CY2015 is the highest number received by the three MCOs since Q3 CY2013. The number of member inquiries increased by 39.3% compared with the previous quarter. The increase may, as indicated by the categories where increases occurred, be due to Q1 being an open enrollment period.
- Of the 103,160 customer inquiries by members, Sunflower received 43.1% of the calls, UnitedHealthcare 33.1%, and Amerigroup 23.8%. Of the 49,252 provider inquiries, Amerigroup received 36.8%, UnitedHealthcare 33.8%, and Sunflower 29.4%.
- For members, benefit inquiries were again the highest percentage (20.1%) of the calls received in Q1, an increase of 4,976 compared with the previous quarter. For providers, claim status inquiries were again the highest percentage (39.5%) of calls.
- Based on the wide range of reported number of calls in some of the categories, criteria used by the MCOs to categorize member and provider inquiries appear to vary greatly by MCO.

Timeliness of Claims Processing

- In Q4 CY2014, MCOs processed 99.89% of clean claims within 30 days; 99.96% of non-clean claims within 60 days; and 99.997% of all claims within 90 days.

- The number and percentage of clean claims not processed within 30 days increased in Q4 compared to the three previous quarters.
- Of the 4,924 clean claims not processed within 30 days in Q4, 77.0% were Sunflower claims, 22.7% were UnitedHealthcare claims, and 0.3% were Amerigroup claims. Of the 10,446 clean claims in CY2014 not processed within 30 days, 86.3% were Sunflower claims; 11.6% UnitedHealthcare, and 2.1% Amerigroup.
- The MCOs processed 4,526,451 clean claims in Q1 CY2014 (includes claims received prior to Q4), an increase of 59,519 compared to Q4 CY 2014. The number of clean claims processed has increased during each quarter of CY2014 through Q1 CY2015.
- 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 not changed greatly in the last four quarters or based on the number of claims processed. In Q1 CY2015, the average TAT for Total Services was 4.3 to 10.3 days.
- The average TAT for processing clean claims for individual service types again varied by service type and by MCO.
- Beginning in CY2015, TAT for clean claims for Nursing Facilities and HCBS claims are pay-for-performance measures, providing an incentive for MCOs to reduce the TATs for processing claims for these services.

Grievances

- The number of grievances received in Q1 CY2015, as reported in the GAR report, increased to 683, the highest number received to date. (In the STC report, the number of grievances reported for Q1 was 666, which was less than the 691 reported received in Q3 CY2014 in the STC report.)
- Of grievances closed in Q1 CY2015, 98.3% were resolved within 30 business days, and 99.1% were resolved within 60 business days. The six grievances not resolved within 60 business days were received by Sunflower.
- In the GAR reported grievances resolved in Q1, MCOs again appeared to differ in the criteria they used to categorize and report these grievances in the various reporting tools.
- Grievance categories in the GAR and STC reports continue to be interpreted differently by each MCO. Transportation-related grievances, in particular, continue to be categorized differently by each MCO for similarly described situations.
- The grievance categories with the highest number of grievances were those related to transportation and billing. Most of the billing-related grievances (76.7%) were UnitedHealthcare grievances for billing of members by 147 different providers.
- Of 630 grievances received by MCOs in Q1 CY2015 reported by 589 members, 170 (27%) were reported by 160 members receiving waiver services.
- Grievances related to transportation and claims/billing continue to be the most frequently reported by members.
- The number of access-related grievances each quarter is a relatively small percentage of grievances reported, ranging from 13 in Q2 and in Q3 of CY2013 to 34 reported in Q4 CY2014 and Q1 CY2015 (5.4% of grievances received).

- The number of grievances categorized as QOC is also a relatively small percentage of grievances reported. In Q1 CY2015, only 39 (6.2%) of 634 grievances were categorized as QOC.
- Due to the wide range in types of grievances categorized as QOC, the number of grievances not categorized as QOC (but could just as easily be classified as such), and due to the many categories in the GAR report that included grievances that could be considered access-related, it is difficult to conclude whether access-related and QOC grievances are increasing or decreasing. Developing standardized category criteria, and ensuring consistent use of categories and criteria in the GAR and STC reports, would improve the ability to assess the number of access-related and QOC-related grievances and to assess trends over time.
- Grievances referred for Quality of Care review and processing are often not categorized as "Quality of Care."

Ombudsman's Office

- In Q1 CY2015, the Ombudsman's Office has continued to expand and improve their tracking and reporting of issues and inquiries they receive.
- In 510 contacts and calls, 620 issues and inquiries were tracked this quarter. Of these 620 issues, 307 (49.5%) were MCO-related. The highest number of issues and inquiries were related to Medicaid Eligibility (139 issues) and HCBS (92 issues).
- Of 442 files closed in Q1, 54% were resolved in one day or less.
- Training of volunteers is planned to begin in August 2015, first in Kansas City and Wichita, and expand statewide in 2016.

Recommendations Summary

Timely Resolution of Customer Service Inquiries

- The State should work with the MCOs to develop consistent criteria for classifying the member and provider inquiries.
- As there were more inquiries in the "Other" category (2,353) than in eight of the 17 categories, additional explanation should be provided to better describe to the State the types of inquiries included in the "Other" category to determine whether additional categories may be beneficial.

Timeliness of Claims Processing

- Sunflower and UnitedHealthcare should make concerted efforts to improve processes to increase the percentage of clean claims processed within 30 days.
- 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 or where the average number of days varies by five to seven days month to month.

Grievances

- MCOs, particularly UnitedHealthcare, should make efforts to educate all providers (and not just those reported by members) about balance billing regulations and policies to reduce the number of billing-related grievances.
- Data in the GAR and STC grievance reports should be reviewed and compared for quality and completeness to ensure consistent and accurate reporting of data within reports and between reports where applicable.
- Grievance categories within the GAR and STC reports should be more clearly defined by the State. Wherever possible, grievance categories in different reports should be consistently named and defined. Specific criteria should be provided for categorizing grievances to provide better consistency in reporting. Additional definitions should be provided by the State to the MCOs as to what counts of grievances should be reported in the Reasons Summary Chart, STC report, and other sections of the GAR report.
- MCOs should review the GAR and STC reports to ensure that the number of grievances received and the number resolved within the quarter are consistently reported.
- Clearer definitions and criteria for categorizing "Access to Service or Care," "Quality of Care," and other grievance categories in the GAR and STC reports are needed. Use of comparable category types and clear criteria in both reports would improve the ability to assess trends over time in reporting of grievances related to quality of care and other grievance categories.
- Grievances referred to MCO Quality Management as Quality of Care grievances should be categorized as "Quality of Care," particularly if resolution of the grievances is through the Quality Management staff.
- The type and scope of access-related grievances would be more clearly defined by reporting transportation-related access grievances separately from grievances related to non-transportation-related access issues, particularly in the GAR report (as the STC report already tracks transportation-related grievances separately).

Ombudsman's Office

- While the Ombudsman's Office is tracking MCO-related contacts and issues, tracking of issues referred to MCOs in the MCO GAR report is recommended to assist in identifying resolution of grievances referred to the MCOs by the Ombudsman's Office. Addition of a tracking field on the grievance detail report to identify grievances forwarded to the MCOs by the Ombudsman for resolution could assist in tracking resolution of grievances.

End of report.

KDHE Summary of Claims Adjudication Data ~ *QE 3.31.15*

Amerigroup				January-March, 2015	
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	10,875	$384,135,371.59	1,882	$91,772,102.18	17.31%
Hospital Outpatient	81,673	$196,957,943.50	10,191	$25,034,367.08	12.48%
Pharmacy	484,339	$31,301,813.90	111,182	Not Applicable	22.96%
Dental	32,028	$8,862,191.76	2,871	$740,760.42	8.96%
Vision	18,857	$5,221,107.26	2,567	$900,328.38	13.61%
NEMT	27,058	$1,260,497.28	425	$14,881.12	1.57%
Medical (physical health not otherwise specified)	506,711	$253,686,254.29	61,474	$37,447,257.82	12.13%
Nursing Facilities-Total	32,124	$70,272,665.29	3,323	$5,470,105.92	10.34%
HCBS	50,124	$26,059,743.01	3,594	$1,666,581.28	7.17%
Behavioral Health	167,775	$21,612,771.69	14,854	$1,971,904.55	8.85%
Total All Services	1,411,564	$999,370,359.57	212,363	$165,018,288.75	15.04%

Sunflower				January-March, 2015	
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	9,065	307,960,411	1,835	65,625,107	20.24%
Hospital Outpatient	83,491	161,377,262	10,071	14,239,846	12.06%
Pharmacy	780,425	76,023,465	204,019	36,676,100	26.14%
Dental	40,951	10,592,716	3,329	838,245	8.13%
Vision	22,374	5,325,579	2,617	697,888	11.70%
NEMT	34,637	1,011,607	112	3,116	0.32%
Medical (physical health not otherwise specified)	479,078	193,051,022	60,803	39,822,405	12.69%
Nursing Facilities-Total	33,561	70,694,596	3,069	9,601,602	9.14%
HCBS	129,118	57,571,195	11,865	4,388,903	9.19%
Behavioral Health	187,060	25,567,610	14,447	2,076,336	7.72%
Total All Services	1,799,760	909,175,463	312,167	173,969,547	17.34%

United				January-March, 2015	
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	9,743	$313,345,766	2,241	$81,274,616	23.00%
Hospital Outpatient	102,570	$254,256,124	15,945	$71,127,984	15.54%
Pharmacy	605,772	$74,075,556	153,121	$32,920,657	25.28%
Dental	43,144	$12,318,038	2,569	$728,391	5.95%
Vision	23,011	$4,810,575	2,049	$468,813	8.90%
NEMT	48,619	$1,336,532	203	$3,836	0.42%
Medical (physical health not otherwise specified)	662,854	$263,135,366	97,439	$62,600,055	14.69%
Nursing Facilities-Total	32,386	$75,689,885	3,640	$9,943,152	11.24%
HCBS	113,387	$26,500,756	6,915	$2,149,675	6.09%
Behavioral Health	88,278	$24,805,081	6,298	$3,743,731	7.13%
Total All Services	1,729,764	$1,050,273,684	290,420	$264,960,915	16.79%