Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 09.30.16

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

KanCare
Section 1115 Quarterly Report
Demonstration Year: 4 (1/1/2016-12/31/2016)
Federal Fiscal Quarter: 4/2016 (07/16-09/16)

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I. Introduction

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

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

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

This five year demonstration will:

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

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

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

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

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

II. Enrollment Information

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

Demonstration Population	Enrollees at Close of Qtr. (06/30/2016)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	14,886	15,823	937
Population 2: ABD/SD Non Dual	28,495	29,014	519
Population 3: Adults	54,189	56,624	2,435
Population 4: Children	253,247	261,956	8,709
Population 5: DD Waiver	8,961	9,009	48
Population 6: LTC	20,746	21,612	866
Population 7: MN Dual	1,234	1,283	49
Population 8: MN Non Dual	1,209	1,263	54
Population 9: Waiver	4,510	4,594	84
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**387,477**	**401,178**	**13,701**

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 3rd quarter of 2016, Tribal Technical Advisory Group (TTAG) meetings with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations continued, on the following date with attendees in person and by phone: September 6, 2016 (11 attendees).

The state's KanCare Advisory Council did not meet during this quarter, and is scheduled to meet on December 1, 2016.

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

- Autism Advisory Council (quarterly)
- Money Follows the Person (quarterly)
- PACE Program (quarterly)
- HCBS Provider Forum teleconferences (monthly)
- Long-term Care Roundtable with Department of Children & Families (quarterly)
- Big Tent Coalition meetings to discuss KanCare and stakeholder issues (monthly)
- Interhab (CDDO and I/DD Provider Association) board meetings (monthly)
- KACIL (centers for independent living) board meetings (monthly)
- Presentations, attendance, and information is available as requested by small groups, consumers, stakeholders, providers and associations across Kansas
- Community Mental Health Centers meetings to address billing and other concerns (monthly and quarterly)
- Series of workgroup meetings and committee meetings with the Managed Care Organizations and Community Mental Health Centers
- Regular meetings with the Kansas Hospital Association KanCare implementation technical assistance group
- Series of meetings with behavioral health institutions, private psychiatric hospitals, and Psychiatric Treatment Residential Facilities (PRTFs) to address care coordination and improved integration
- State Mental Health Hospital mental health reform meetings (quarterly)
- Multi-Functional Eligibility Instrument (FE, PD & TBI) Advisory Workgroup
- I/DD Functional Eligibility Instrument Advisory Workgroup
- Systems Collaboration with Aging & Disability, Behavioral Health and Foster Care Agencies
- PRTF Stakeholder meeting (quarterly)
- Mental Health Coalition meeting (bi-weekly)
- Kansas Association of Addiction Professionals (monthly)
- Crisis Response & Triage meetings with stakeholders including MCOs to improve timely, effective crisis services for members and improved care coordination post crises (bi-weekly)
- Lunch and Learn biweekly series on a variety of behavioral health topics including prevention and the prevention framework initiative; SUD 101; trauma informed systems of care; recovery and peer support; housing and homeless initiatives; community crisis center development

- Bi-monthly Governor's Behavioral Health Services Planning Council meetings; and monthly meetings with the 9 subcommittees such as Suicide Prevention, Justice Involved Youth and Adult, and Rural and Frontier
- Mental Health Excellence and grant project meetings
- Monthly Nursing Facility Stakeholder Meetings

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

KanCare Credentialing Uniformity Workgroup

The KanCare Credentialing Uniformity Workgroup membership consists of the State, the three MCOs, the Fiscal Agent, and healthcare providers from the Kansas Hospital Association and Kansas Medical Society. The agenda for this group is to analyze current enrollment and credentialing practices in order to ease burdens for the providers, while still enabling the MCOs to meet their corporate credentialing needs. The workgroup is currently working with the Fiscal Agent to expand and upgrade the Provider Enrollment Portal. This will be a centralized portal where providers can submit required documents one time rather than having to complete the same forms up to four different times. Version one of the portal is complete and assessment is underway. The design has been demonstrated to providers and MCO partners. Once this assessment is complete, the workgroup will be working with the Fiscal Agent to integrate the desired changes into the expanded Provider Enrollment Portal, while also including any necessary items from the new Managed Care Rules.

KanCare Consumer and Specialized Issues (CSI) Workgroup

The CSI Workgroup met on September 29, 2016, at the Self Advocacy Coalition of Kansas' office in Lawrence, Kansas. The topics discussed were Nursing Hours on the HCBS TA waiver; some consideration as to whether some parts of the state have a shortage of nurses available to provide these services; and agreement to have this issue on a future agenda for the MCOs and KDADS to review and provide follow up. The workgroup received an update on the KanCare application processing at the KanCare Clearinghouse; and an update from KDADS on the Autism Waiver renewal. KDADS also spoke on the topic of provider surveys and how it affects Medicaid rates. The workgroup's next meeting is scheduled for December 15, 2016, in Topeka, Kansas.

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 130 events for the third quarter of 2016. This included partner development, sponsorships, member outreach and advocacy. The Community Relations Representatives' primary focus continues to be member education of services and how to get the most out of the KanCare program. Below is a sampling of marketing activities Amerigroup supported in the third quarter:

• Boys and Girls Club focus group
• Families Together Collateral Review
• NEK-CAP Conference exhibit
• Kansas Public Health Association Conference
• KAMU Conference Wichita exhibit

Outreach Activities: Amerigroup's Outreach Care Specialists continued their telephonic outreach efforts and mailings to new members to welcome them and to ensure they have completed their initial health risk assessment. They continue with ongoing targeted outreach to improve member knowledge about the services available to them. They also reached out to members who appeared to be due for an annual checkup or who need other medical services, to help schedule their appointment with their provider to help improve their overall health. The Community Relations Representatives participated in a variety of community events reaching almost 22,100 Kansans in the third quarter. These activities provide the opportunity to obtain valuable feedback and to cover current topics that are relevant to the members, such as: KAN Be Healthy, access to care, diabetes, well child visits, employment, high blood pressure, your PCP and you, and more. Amerigroup also met with members who participate in their adult, teen and foster care advisory groups to help assess their effectiveness and to improve various health related strategies, programs and systems of care. Below is a sampling of some of their outreach efforts this past quarter:
• Welcome Baby Jubilee
• USD Youth Health Days Exhibit
• Central Ave Parade Exhibit
• YMCA Back to School
• Wyandotte Back to School Exhibit
• Bethel Life Church Convoy of Hope

Advocacy Activities: Amerigroup's advocacy efforts for the third quarter continued to be broad based to support the needs of the general population, pregnant women, children, people with disabilities and the elderly. Their staff participated in coalitions, committees, and boards across the state, which help staff learn the needs of the communities they serve and how to better serve them. 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 the advocacy activities this past quarter:
• Poverty Conference Exhibit
• Latino Health For All Coalition Meeting
• KanCare HCBS Training
• Montgomery County Coalition/Early Childhood Coalition
• Community Baby Shower meeting

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

Marketing Activities: During the 3rd quarter of 2016, Sunflower Health Plan's marketing activities focused on increasing awareness of preventive services and healthcare benefits through member postcard mailings and community event sponsorships. Sunflower Health Plan ramped up its farmer's market program during this quarter, serving an average of 100 people at each event. The farmer's market program has introduced Sunflower members to community access points for locally grown produce, including the Supplemental Nutrition Assistance Program, and has raised awareness of other health benefits and social services. Through health fairs, farmers markets, school assemblies and other community events, Sunflower Health Plan worked to improve health literacy and distributed copies of its health education books and health plan benefits booklets. Additionally, Sunflower sponsored local and statewide member and provider events as well as fundraisers for charitable organizations such as the American Stroke Foundation. Sunflower also promoted KanCare services and benefits by exhibiting at provider conferences. Some notable events and programs include:

- La Placita Community/Neighborhood Event and Parade with the Latino Health for All Coalition
- "Member Day" at seven farmers markets during Q3
- Kansas School Nurse Conference
- Women's Wellness Expo
- Annual Conference for Behavioral Health
- Dodge City Community Health Fair
- Senior Fair in Salina
- Wyandotte County Back-to-School Fair
- Convoy of Hope Back-to-School Event
- Atchison Community Health Carnival
- Mid-West Ability Summit

Outreach Activities: During the 3rd quarter, Sunflower Health Plan's outreach centered on back-to-school events, particularly immunization clinics, and the plan's farmer's market voucher program to promote healthful eating. Sunflower Health Plan's MemberConnections representatives made approximately 374 successful home visits during 3rd Quarter 2016 (separate from the home visits made by case managers at the health plan). MemberConnections Home Visits are part of Sunflower's outreach program to increase health literacy and link members with community resources. The MemberConnections team also held Community Baby Showers and delivered presentations to youth during assemblies as part of Sunflower's Adopt-a-school program. Sunflower's farmer's market program grew during this reporting period, serving a total of 957 members during the 3rd quarter. The program provides vouchers for free produce at the local market where Sunflower representatives are present with information for members about age-appropriate health screenings and health plan benefits. The farmer's market program supports nutrition education and healthful eating as well as community supported agriculture. Sunflower co-coordinated immunization clinics to help close care gaps for childhood and adolescent vaccinations. These events involved coordination with local health systems and the other two managed care organizations.

Highlights from member outreach activities this quarter include:
- Held seven Farmers Market member events in the 3rd quarter, plus volunteered at the Community WIC Garden in Olathe to harvest produce for WIC clients.
- Held a Sunflower Member baby shower and participated in other community events to promote prenatal care.
- Participated in 33 community health events, including the La Placita Latino health events in Kansas City, KS, and the Native Voices Health Fair at the Mid-America All-Indian Center in Wichita.
- Held Sunflower Health Plan's quarterly Member and Community Advisory Committee meeting on August 31, 2016, in Topeka. The main agenda topics for member feedback were HCBS Settings Final Rule, Foster Care and the latest communication tools for health plan members.
- Wyandotte County Back-to-school Fair
- Convoy of Hope Back-to-school Event
- Healthcore Clinic Vaccination Day
- EC Tyree Health Clinic and Dental Clinic Community Day.

Advocacy Activities: Sunflower continued its efforts to bring stakeholders together for the benefit of people with disabilities, and people and their families who are impacted by mental illness. Much of the focus is on employment opportunities and integration of long-term services and supports. Sunflower completed its third quarter as the statewide coordinator for Project SEARCH, a one-year, school-to-work program for young adults with intellectual and developmental disabilities, and already the program has grown. (Marion County Special Education Cooperative has secured local community grant funding for start-up funds to begin implementing Project SEARCH.) Sunflower Health Plan participated in a study of the Long-Term Quality Alliance (LTQA), which aims to improve outcomes and quality of life for persons and their families who are managing functional limitations due to chronic health conditions. Sunflower staff also contributed to community workgroups and coalitions advocating for health literacy, persons with disabilities and other topics addressing population health in Kansas. The 3rd quarter community meetings and workgroups included Kansas Youth Advisory Council summer meeting, Anti-Bullying Event at the Boys & Girls Club, Health Alliance ICT, Health Literacy Kansas, Health & Wellness Coalition of Wichita, Mother & Child Health Coalition's anti-poverty session, the Fetal and Infant Mortality Review Community Action Teams, and the Project SEARCH quarterly meeting.

Information related to UnitedHealthcare Community Plan marketing, outreach and advocacy activities:
Marketing Activities: UnitedHealthcare Community Plan of Kansas' (UHC) primary focus during this reporting period was continued emphasis on member, provider, and community education regarding benefits and health services. UHC focused on completing new member welcome calls, and Health Risk Assessments. UHC also engaged in other outreach calls to invite members to Community Baby Showers and Clinic Days. UHC mails members a HealthTalk newsletter each quarter with tips on living a healthier life. UHC also delivered the quarterly Practice Matters Newsletter to Providers. Throughout the quarter, UHC hosted a number of meetings and presentation with key providers, hospitals and FQHCs throughout the state that involved discussions around exploring innovative and collaborative opportunities. Additional work was done to learn more about the challenges of Rural Health. In

addition, two providers with ACO (Accountable Care Organization) agreements with UHC received shared savings payments for successful care management. UHC also focused on creating and developing new member education about the WORK program, and tips for members on obtaining employment. UHC also launched a Foster Care Pilot in Wichita partnering with Young People in Recovery and hosting community events.

Outreach Activities: UHC leveraged Bilingual Community Outreach Specialists who focused on member oriented activities targeted within their assigned geographical areas across Kansas. UHC staff also educated Members and Providers on UHC's Value Added Benefits, along with the features and benefits of KanCare. Several key UHC outreach initiatives this quarter included member education "Lobby sits," in provider offices, "Food for Thought Programs" health food programs hosted on-site at provider offices, and several health fairs and clinic days held throughout the state. The Outreach team supported numerous FQHC events and put some special focus on the National Health Center Week to celebrate the FQHCs and the work they do in our communities.

In the third quarter of 2016, UHC hosted three Community Baby Showers, in Garden City, Hays and Parsons. These Community Events have been well received and provide pregnant and new moms with information about healthy pregnancies and deliveries, as well as child safe sleeping and car seat installation. In addition, UHC participated in two baby showers hosted by community based organizations. UHC's Member Advisory Meeting was held in Q3 2016 in Garden City, and focused on, among other agenda items, topics related to rural health and wellness. UHC also hosted a Provider/Community Organization Advisory meeting in Hays to get the provider perspective on rural health gaps.

Summary of key outreach activities reflecting UHC staff meeting personally with members/providers:
- Met with approximately 5,640 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.
- Met with approximately 613 individuals from community based organizations which work directly with UHC members.
- Met with more than 1,302 individuals from provider offices located throughout the State .

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

Throughout this quarter, many members and disability advocates learned more about how to access and navigate their benefits with UHC, including how care coordination is provided to those on Home and Community Based Waiver programs and where to go when they have questions. At events, it is not uncommon for UHC staff to meet individuals with a newly acquired disability, and their families and caregivers, who are in need of education on available resources, programs and services.

In support of consumers with Developmental Disabilities, UHC's outreach specialist attended the Supported Decision Making conference, hosted by the Kansas Council on Developmental Disabilities. This event supports consumers, families and providers who are seeking the greatest level of independence possible for consumers with intellectual or developmental disabilities. This outreach specialist also attended the Wyandotte County CDDO picnic in August, an opportunity to interact with and offer support to over 100 consumers.

IV. Operational Developments/Issues

a. Systems and reporting issues, approval and contracting with new plans: No new plans have been contracted with for the KanCare program. Through a variety of accessible forums and input avenues, the State is kept advised of any systems or reporting issues on an ongoing basis and such issues are managed either internally, with our MMIS Fiscal Agent, with the operating state agency and/or with the MCOs and other contractors to address and resolve the issues.

KanCare contract Amendment 22 approved by CMS on August 31, 2016. Amendment 23 was sent to CMS on July 27, 2016. This Amendment instituted a 4% rate reduction to certain provider types. CMS requested additional information from the State on August 1, 2016 and September 26, 2016.

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

b. Benefits: All pre-KanCare benefits continue, and the program includes value added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value added service utilization, per each of the KanCare MCOs, by top three value added services and total for January-September, 2016, follows:

MCO	Value Added Service	Units YTD	Value YTD
Amerigroup	Adult Dental Care	3,103	$373,303
	Member Incentive Program	10,856	$229,765
	Mail Order OTC	8,612	$151,461
	Total of all Amerigroup VAS Jan-Sept 2016	***28,058***	***$892,531***
Sunflower	CentAccount Debit Card	63,475	$1,269,500
	Dental Visits for Adults	7,394	$243,499
	Smoking Cessation Program	299	$71,760
	Total of all Sunflower VAS Jan-Sept 2016	***97,586***	***$1,742,837***
United	Baby Blocks Program and Rewards	860	$103,200
	Adult Dental Services	1,779	$88,740
	Rewards for Preventive Visits & Health Actions	12,068	$84,311
	Total of all United VAS Jan-Sept 2016	***21,043***	***$539,674***

c. Enrollment issues: For the third quarter of calendar year 2016 there were 11 Native Americans who chose to not enroll in KanCare and who are still eligible for KanCare.

The table below represents the enrollment reason categories for the third quarter of calendar year 2016. All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Newborn Assignment	8
KDHE - Administrative Change	64
WEB - Change Assignment	22
KanCare Default - Case Continuity	147
KanCare Default – Morbidity	284
KanCare Default - 90 Day Retro-reattach	131
KanCare Default - Previous Assignment	273
KanCare Default - Continuity of Plan	709
AOE – Choice	330
Choice - Enrollment in KanCare MCO via Medicaid Application	868
Change - Enrollment Form	365
Change - Choice	479
Change - Access to Care – Good Cause Reason	9
Change - Case Continuity – Good Cause Reason	1
Change – Due to Treatment Not Available in Network – Good Cause Reason	1
Assignment Adjustment Due to Eligibility	17
Total	**3708**

d. Grievances, appeals and state hearing information

MCOs' Grievance Database
Members – CY16 3rd quarter report

MCO	QOC (non HCBS, non Trans)	Customer Service	Member Rights Dignity	Access to Svc or Care	Pharm	QOC (HCBS)	Trans (incl Reim.)	Trans (No Show)	Trans (Late)	Trans (Safety)	VAS	Billing/Fin Issues (non Trans)	Other
AMG	7	31	1	9	1	2	21	18	8	2	2	16	0
SUN	5	18	10	67	14	4	21	17	3	2	7	6	12
UHC	34	0	1	1	9	2	20	24	16	3	0	30	2
Total	46	49	12	77	24	8	62	59	27	7	9	52	14

MCOs' Appeals Database

Members – CY16 3rd quarter report

Member Appeal Reasons AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	SFH requested
MEDICAL NECESSITY DENIAL					
Criteria Not Met - DME	12 6	 1	9 2	3 3	 2
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	 17	 14		 3	1
Criteria Not Met - Medical Procedure (NOS)	1 6		 4	1 2	 1
Criteria Not Met - Radiology	2 6		1 4	1 2	
Criteria Not Met - Pharmacy	14 64 47	1 1 2	13 33 21	 30 24	 3
Criteria Not Met - PT/OT/ST	1 20		 9	1 11	
Criteria Not Met - Dental	2 1 2	 1	1 1	1 1 	
Criteria Not Met or Level of Care - Home Health	10 1		1	9 1	1 1
Criteria Not Met - Hospice					
Criteria Not Met - Out of network provider, specialist or specific provider request					
Criteria Not Met – Inpatient Behavioral Health	1 18 3	 2	 6 	1 12 1	 1
Criteria Not Met – Behavioral Health Outpatient Services and Testing	21		6	15	
Level of Care - LTSS/HCBS	7 1	1	3 1	3	1 3 1
Level of Care - WORK					
Level of Care - LTC NF					
Level of Care - Mental Health					1
Ambulance (include Air and Ground)					
Other- Medical Necessity	6	1	2	3	1
NONCOVERED SERVICE DENIAL					
Service not covered - Dental					
Service not covered - Home Health	1		1		

Service not covered - Pharmacy	1 1		1	1	
Service not covered - Out of Network providers					
Service not covered - OT/PT/Speech	1			1	
Service not covered - DME	1 1		1 1		1
Service not covered - Behavioral Health					
Other - Noncovered service	1 3 2		2 1	1 1 1	
Lock In					
Billing and Financial Issues	1	1			1
PRIOR AUTHORIZATION DENIAL					
Late notification	1		1		
No authorization submitted					
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	**31** **166** **86**	**3** **1** **21**	**18** **78** **29**	**10** **87** **36**	**1** **8** **10**

MCOs' Appeals Database

Providers - CY16 3rd quarter report (appeals resolved)

PROVIDER Appeal Reasons **AMG – Red** **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**	**SFH requested**
MEDICAL NECESSITY DENIAL					
Criteria Not Met - DME	2		2		2
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	16 28 74	1	2 18 38	14 10 35	4 6
Criteria Not Met - Medical Procedure (NOS)	1 4		0 2	1 2	2
Criteria Not Met - Radiology	7		4	3	1
Criteria Not Met - Pharmacy	18 3	2	13	3 3	1
Criteria Not Met - PT/OT/ST					
Criteria Not Met - Dental	2		2		
Criteria Not Met - Vision	63		14	49	

Criteria Not Met or Level of Care - Home Health	1			1	
Criteria Not Met - Hospice					
Criteria Not Met - Out of network provider, specialist or specific provider request					
Criteria Not Met – Inpatient Behavioral Health	2 8		1 1	1 7	
Criteria Not Met – Behavioral Health Outpatient Services and Testing	3 3 2		 1 1	3 2 1	1
Level of Care - LTSS/HCBS					
Level of Care - WORK					
Level of Care - LTC NF					
Level of Care - Mental Health					
Ambulance (include Air and Ground)	2			2	
Other-medical necessity	32 3 1		18 3 1	14	
NONCOVERED SERVICE DENIAL					
Service not covered - Dental	1 7 1		1 3 1	4	
Service not covered - Vision					
Service not covered - Home Health	9		2	7	
Service not covered - Pharmacy	1		1		
Service not covered - Out of Network providers					
Service not covered - OT/PT/Speech					
Service not covered - DME	1 3	 1	1 2		
Service not covered - Behavioral Health	1			1	
Other- not covered service	1 2 80	 2	1 26	 2 52	 1
BILLING AND FINANCIAL ISSUES					

Claim Denied- contained errors	3632 16 14	 1	1175 7 8	2123 9 5	38 27 5
Claim Denied- by MCO in Error	7071 1		3617 1	2474	42 8
PRIOR AUTHORIZATION DENIAL					
Late notification	19 33		1 9	18 24	 1 1
No authorization submitted	1 14 21	 1	 9 11	1 5 9	 1 1
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	**10807** **191** **206**	**2** **0** **6**	**4836** **71** **90**	**4655** **120** **110**	**81** **46** **15**

MCO's Appeals Database

Provider Appeal Summary – CY16 2nd quarter report

AMG – Red **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**	**Proceeded to SFH**
Resolved at 1st Appeal Level	10091 0 206	2 0 6	4608 0 90	4262 0 110	76 - 15
Resolved at 2nd Appeal Level	716 191 0	0 0 0	228 71 0	393 120 0	0 22 -

State of Kansas Office of Administrative Fair Hearings

Members – CY16 3rd quarter report

AMG-Red **SUN-Green** **UHC-Purple**	**Withdrawn**	**Dismissed -Moot MCO Reversed decision**	**Dismissed No Internal Appeal**	**Dismissed-No Adverse Action**	**Default Dismissal-Appellant did not respond/ appear**	**Dismissed-Untimely**	**OAH upheld MCO decision**	**OAH reversed MCO decision**
Dental Denied/ Not Covered					1			
CT/MRI/X-Ray Denied	1							
DME Denied	 1	 1		1			1 1	
Home Health hours Denied					1 1	1		1
Comm Psych Supt/ BH Svcs Denied	1	1		1	2			

LTSS/HCBS/Work PCA Hrs Denied		1		1			5 1	1
Pharm/Lab/Genetic Testing Denied		2 2					1	
Inpt/Outpt/Observ Med Procedure Denied	1	1						
Specialist Ofc Visit/ Ambulance Denied								
TOTAL AMG – Red SUN – Green UHC – Purple	2 2	1 4 3		2 1	4 1	1	6 3	1 1

State of Kansas Office of Administrative Fair Hearings
Providers – CY16 3rd quarter report

AMG-Red SUN-Green UHC-Purple	Withdrawn	Dismissed-Moot MCO Reversed decision	Dismissed – No Internal Appeal	Dismissed-No Adverse Action	Default Dismissal-Appellant did not respond/ appear	Dismissed-Untimely	OAH upheld MCO decision	OAH reversed MCO decision
Claim Denied (Contained Errors)								
Claim Denied by MCO in Error								
Recoupment								
DME Denied	2	9 3	1		2			
Dental Denied	1							
Radiology Denied			4			1		
Home Health/Hospice/ LTC Denied	4	8	1					
Air/Ambulance Charges								
Inpt/Outpt/Observation Med Procedure Denied – Facility Charges	5 4 5	8 3 2	2 2	3 1				
Inpt/Outpt/Observation Med Procedure Denied – Physician charges	3 1	8 1	4					
Mental Health HCBS/TCM Hrs Denied	1	5 4 1						
Pharm/Lab/Genetic Testing Denied		3 1	10					
TOTALs -- AMG – Red SUN – Green UHC - Purple	13 7 6	41 9 6	17 5 2	3 1	2	1		

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

f. Changes in provider qualifications/standards: None.

g. Access: As noted in previous reports, members who are not in their open enrollment period are unable to change plans without a good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs. In Q3 of 2016, there were a total of 171 requests, which is similar to the 174 requests in second quarter of 2016. However, the Q3 numbers show a sharp drop from the numbers as the quarter progressed, from July (83) to September (27), indicating that issues are being resolved.

The majority of good cause requests (GCRs) during the Q3 of 2016 continue to be due to members mistakenly believing that they can file good cause requests because they prefer a provider outside of their assigned MCO's network. KDHE is continuing to explore educational materials or information, including what could be added to member enrollment packets, to further explain what would be considered "good cause." Unfortunately, GCRs still occur due to providers advising patients to file GCRs to switch plans. Most of the GCRs in all three quarters of 2016 are due to two clinics advising their patients to file GCRs when their clinics were terminated from MCO networks. And as in previous quarters, GCRs filed after the choice period are denied as not reflective of good cause if the request is based solely on the member's preference, when other participating providers are available within access standards. In these cases, the MCOs are tasked with offering to assist the member in scheduling an appointment with one of their participating providers. The remaining requests show varied reasons and causes for changing plans. The GCR requests showed an overall downward trend from the requests at the beginning of 2015 through December 2015, but did increase in the first and second quarters of 2016.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the third quarter of 2016, there were 5 state fair hearings filed for a denied GCR. One was filed too late, two dismissed and two upheld. A summary of GCR actions this quarter is as follows:

Status	July	August	September
Total GCRs filed	83	61	27
Approved	2	6	1
Denied	49	38	15
Withdrawn (resolved, no need to change)	19	6	8
Dismissed (due to inability to contact the member)	13	11	3
Pending	0	0	0

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

but the network reports generated still require updates. Numbers of contracting providers are as follows (for this table, providers were de-duplicated by NPI):

KanCare MCO	# of Unique Providers as of 12/31/15	# of Unique Providers as of 3/31/16	# of Unique Providers as of 6/30/16	# of Unique Providers as of 9/30/16
Amerigroup	13,652	15,802	16,410	16,623
Sunflower	19,914	20,389	20,647	20,734
UHC	20,190	21,290	22,133	24,321

h. MLTSS implementation and operation: In the third quarter, Kansas continued to offer services to individuals on the HCBS-PD Program waiting list, as well as individuals on the HCBS-I/DD Program waiting list. During the month of August, all people on the waiting list for HCBS-PD waiver services were sent an offer to begin receiving services. Additional details are included in section XIII below.

i. Updates on the safety net care pool including DSRIP activities: Currently there are two hospitals participating in the DSRIP activities. They are Children's Mercy Hospital (CMH) and Kansas University Medical Center (KU). CMH has chosen to do the following projects: Complex Care for Children, and Patient Centered Medical Homes. KU will be completing STOP Sepsis, and Self-Management and Care Resiliency for their projects. Kansas Foundation for Medical Care (KFMC) is working with the State on improving healthcare quality in KanCare. The hospitals continued identifying community partners, creating training for community partners, and working toward reaching the project milestones for the DY4. A DSRIP Learning Collaborative was held on September 21, 2016, at the University of Kansas Hospital, with Children's Mercy Hospital, KFMC, and the State of Kansas in attendance.

j. Information on any issues regarding the concurrent 1915(c) waivers and on any upcoming 1915(c) waiver changes (amendments, expirations, renewals):
   - The Serious Emotional Disturbance (SED) waiver is operating off an extension approved through December 23, 2016. Previously the State had withdrawn the submitted renewal request, to address concerns CMS expressed regarding mitigation of conflict of interest. The State is working closely with CMS to mitigate the conflict of interest concerns. The State has had technical assistance calls with CMS and continues to work on the concerns. The state believes CMS is close to granting approval of our conflict of interest mitigation strategy.
   - The Autism waiver is currently operating off an extension through December 25, 2016. CMS has required the state to remove three autism wavier services and provide them under the state plan as EPSDT services. At the direction of CMS, the state has been unable to submit the autism waiver until the SPAs for the autism services are submitted.

k. *Legislative activity:* The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight, a statutory joint legislative committee, met on August 4 and 5, 2016, to review the current state of KanCare and HCBS services.
    - The committee received KanCare program updates from KDHE, including eligibility determinations, MCO financial status, KanCare opportunities and waiver integration project, and provider pharmacy issues.
    - The committee received information from KDADS about state hospital issues, HCBS waiver and waiting list updates, and activities related to the HCBS Settings Rule.
    - The committee also received presentations from each of the KanCare MCOs, received information from the KanCare Ombudsman, and took comments from stakeholders (with related responses from agency and MCO staff).

V. Policy Developments/Issues

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

VI. Financial/Budget Neutrality Development/Issues

Budget neutrality: KDHE issues retroactive monthly capitated payments; therefore, the budget neutrality document cannot be reconciled on a quarterly basis to the CMS 64 expenditure report because the CMS 64 reflects only those payments made during the quarter. Based on this, the State is not using the CMS-64 as the source document, but rather is using a monthly financial summary report provided by HP, the State's fiscal agent. The budget neutrality monitoring spreadsheet for QE 09.30.16 is attached. Utilizing the HP-provided monthly financial summary, the data is filtered by MEG excluding CHIP and Refugee, and retro payments in the demonstration year are included.

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

VII. Member Month Reporting

Sum of Member Unduplicated Count	Member Month			Totals
MEG	*2016-07*	*2016-08*	*2016-09*	*Grand Total*
Population 1: ABD/SD Dual	14,992	14,969	14,898	44,859
Population 2: ABD/SD Non Dual	28,402	28,655	28,508	85,565
Population 3: Adults	53,379	53,942	54,189	161,510
Population 4: Children	252,624	254,003	253,249	759,876
Population 5: DD Waiver	8,882	8,935	8,968	26,785
Population 6: LTC	20,638	20,669	20,917	52,224
Population 7: MN Dual	1,273	1,281	1,241	3,795
Population 8: MN Non Dual	1,237	1,238	1,210	3,685
Population 9: Waiver	4,485	4,481	4,511	13,477
Grand Total	**385,912**	**388,173**	**387,691**	**1,161,776**

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

VIII. Consumer Issues

Summary of consumer issues during the second quarter of 2016:

Issue	Resolution	Action Taken to Prevent Further Occurrences
Member spenddown issues – spenddown incorrectly applied by plans, causing unpaid claims and inflated patient out of pocket amounts.	MCOs work with the State to monitor and adjust incorrect spenddown amounts. Weekly spreadsheets are sent to the State, showing the MCO remediation efforts.	All affected plans have system correction projects and reprocessing projects continuing in progress. This information is posted on each plan's Issue logs, and the KanCare Claims Resolution Log for providers and the State to review and monitor. MCOs must report spenddown files to the State that track the spenddown files.
Member authorization denials for variety of reasons. This caused some consumers to have a delay in service.	Most of the denials were due to incomplete authorization requests, which were subsequently denied. Also denials due to Customer Service representatives providing incorrect information.	A few authorization and documentation requirements were relaxed, but there are lingering issues due to the process being largely a manual review process. Customer Service representatives have had new scripts and re-training regarding what requires an authorization.
Client obligation assessed on incorrect claims/patients.	MCOs occasionally assess (or fail to assess) client obligation on the correct member and/or claims.	This happens sporadically, and there are multiple causes.

Members sometimes find it difficult to find providers with open panels.	MCOs are working to correct provider network directory database issues. Also educating providers to reach out to MCOs when their directory information changes or if they add/subtract providers to the practice.	The State is working with the MCOs by reviewing the network reports and making suggestions for improvement. This discussion is part of the State on site reviews.
Retroactively eligible members are denied authorizations or claims denied for timely filing.	Members are denied authorization, services and care coordination due to retroactive eligibility.	The new eligibility system KEES is available but has some lingering system issues. Also there was a departmental shift in the processing of eligibility requests which has caused some delays in establishing eligibility. Some of the processes require manual intervention, which still may lead to errors.

Continued consumer support was conducted by KDHE's out-stationed eligibility workers (OEW). OEW staff assisted in determining eligibility for 4,001 consumers. OEW also assisted in resolving 2,170 issues involving such matters as urgent medical needs, obtaining correct information on applications and addressing gaps or errors in pending applications/reviews with the KanCare Clearinghouse.

During this quarter, OEW staff also participated in 5 community events providing KanCare program outreach, education and information.

IX. Quality Assurance/Monitoring Activity

Kansas has created a broad-based structure to ensure comprehensive, collaborative and integrated oversight and monitoring of the KanCare Medicaid managed care program. KDHE and KDADS have established the Medicaid Enterprise Leadership (MEL) team for comprehensive oversight and monitoring. The MEL team is a review, feedback and policy direction body partly focusing on the monitoring and implementation of the State's KanCare Quality Improvement Strategy (QIS). The MEL team makes sure that KanCare activity is consistent with the managed care contract and approved terms and conditions of the KanCare 1115(a) Medicaid demonstration waiver. The MEL team directs the policy initiatives of the KanCare Steering Committee, which includes both executive and operational leadership from both KDHE and KDADS.

The following sources of information guide the ongoing review of and updates to the KanCare QIS: Results of KanCare managed care organization (MCO) and state reporting, quality monitoring/onsite reviews and other KanCare contract monitoring results; external quality review findings and reports; feedback from governmental agencies, the KanCare MCOs, Medicaid providers, Medicaid members/consumers, and public health advocates; and the MEL team's review of and feedback regarding the overall KanCare quality plan. This combined information assists the MEL team and the MCOs to identify and recommend quality initiatives and metrics of importance to the Kansas Medicaid population.

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

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

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

- Quarterly business meetings between KDHE's MCO Management team and cross-function/leadership MCO staff to continue to further develop operational details regarding the KanCare State Quality Strategy. Specific attention was paid to development of the performance measures, pay-for-performance measures and performance improvement projects in the KanCare program.
- Ongoing interagency and cross-agency collaboration, and coordination with MCOs, to develop and communicate both specific templates to be used for reporting key components of performance for the KanCare program, as well as the protocols, processes and timelines to be used for the ongoing receipt, distribution, review and feedback regarding submitted reports. The process of report management, review and feedback is now automated to ensure efficient access to reported information and maximum utilization/feedback related to the data.
- Implementation and monitoring of the External Quality Review Organization (EQRO) work plan for 2016, with the associated deliverables detail. The ongoing quarterly business meetings mentioned in first bullet also are used to discuss and plan EQRO activities, the MCO requirements related to those activities, and the associated EQRO timeline/action items.
- Work continued during the third quarter on the planning for the comprehensive annual compliance reviews of the MCOs – which are done in partnership between Kansas' EQRO and the two state agencies (KDHE and KDADS) managing the KanCare program, to maximize leverage and efficiency. The 2016 review is the full Balanced Budget Act review, and planning started in the 4th quarter 2015 for this audit. It will assess identified compliance issues as well as findings from previous audits. The State will also monitor for compliance with the state contract. As of September 30, 2016, the second BBA on site audit has occurred, with the final review scheduled for October.

- MFCU monthly meetings to address fraud, waste, and abuse cases, referrals to MCOs and State, and collaborate on solutions to identify and prevent fraud, waste and abuse.
- Continued state staff participation in cross-agency long-term care meetings to report quality assurance and programmatic activities to KDHE for oversight and collaboration.
- Continued participation in weekly calls with each MCO to discuss ongoing provider and member issues, and to troubleshoot operational problems. Progress is monitored through these calls and through issue logs. Additionally, top management staff from KDADS, KDHE and the three MCOs meet monthly face-to-face to discuss issues and improvements to KanCare.
- Monitor large, global system issues through a weekly log issued to all MCOs and the State's fiscal agent. The resulting log is posted out on the KanCare website for providers and other interested parties to view. Continue monthly meetings to discuss trends and progress.
- Complex Case staffing of HCBS and Behavioral Health issues. Each MCO brings complex cases for State consideration, and the State provides technical assistance about program policies and alternatives to address identified needs. These are held biweekly and integrated the State's behavioral health and long-term supports and services teams.
- For the programs administered by KDADS: The Quality Assurance (QA) process is designed to give continuous feedback to KDADS, KDHE and stakeholders regarding the quality of services being provided to KanCare members. KDADS quality assurance staff are integrated in the Survey, Certification and Credentialing Commission (SCCC) to align staff resources for efficient and timely performance measurement. QA staff review random samples of individual case files to monitor and report compliance with performance measures designated in Attachment J of the Special Terms and Conditions.
- Also for the programs administered by KDADS: These measures are monitored and reviewed in collaboration with program staff in the Community Services and Programs Commission and reported through the Financial and Information Services Commission at KDADS. This oversight is enhanced through collaboration with the Department of Children and Families and the Department of Health and Environment. During this quarter, HCBS performance measures were reported to CMS via the 372 reporting process. A quality assurance procedure manual is in the draft stages, and once finalized it will be utilized to document this process. In the manual, protocols and interpretive guidelines have been established with the goal of ensuring consistency in the reviews.
- During this quarter, the Quality Assurance team within KDADS reviewed the 2014 quality outcomes and remediation process with each MCO. MCOs were provided with draft protocols from the draft quality assurance procedure manual. 2015 data was uploaded by each MCO in July. The QA team began their reviews with an expected completion date of 11/30/2016.
- MCOs were given their sample for Q1 and Q2 on 6/30/16 with upload to be completed by 8/31/16. Quality Review will be completed for Q1 and Q2 by 12/1/16.
- Timelines for the quarterly reviews were established and began in the third quarter of 2016.
- The draft Quality Review Policy by KDADS was introduced through the KDHE KanCare policy process to be reviewed for comment by the MCOs. Revisions to the policy are in process to ensure alignment with CMS regulations.

X. Managed Care Reporting Requirements

a. A description of network adequacy reporting including GeoAccess mapping: Each MCO submits a quarterly network adequacy report. The State uses this report to monitor the quality of network data and changes to the networks, drill down into provider types and specialties, and extract data to respond to requests received from various stakeholders. In addition, each MCO submits quarterly network reports that serve as a tool for KanCare managers to monitor accessibility to certain provider types. Each MCO also submits a separate report on HCBS service provider participation. Based on these network reports, two reports are published to the KanCare website monthly for public viewing:

1. Summary and Comparison of Physical and Behavioral Health Network is posted at http://www.kancare.ks.gov/download/KanCare_MCO_Network_Access.pdf. This report pulls together a summary table from each MCO and provides a side-by-side comparison of the access maps for each plan by specialty.
2. HCBS Service Providers by County: http://www.kancare.ks.gov/download/HCBS_Report_Update.pdf, includes a network status table of waiver services for each MCO.

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

KanCare Customer Service Report - Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:24	2.29%	138,409
Sunflower	0:18	1.89%	128,699
United	0:09	0.48%	120,944
HP – Fiscal Agent	0.00	0.10%	20,688

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:24	2.54%	62,937
Sunflower	0:10	0.73%	71,917
United	0:06	0.48%	53,589
HP – Fiscal Agent	0.00	0.10%	6,138

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

MCOs' Grievance Trends
Members – CY16 3rd Quarter

Amerigroup 3rd Quarter Grievance Trends		
Total # of Resolved Grievances	118	
Top 3 Trends		
Trend 1: Customer Service	31	26%
Trend 2: Transportation (including reimbursement)	21	18%
Trend 3: Transportation (No Show)	18	15%

Sunflower 3rd Quarter Grievance Trends		
Total # of Resolved Grievances	186	
Top 3 Trends		
Trend 1: Access to Service or Care	67	36%
Trend 2: Transportation (including reimbursement)	21	11%
Trend 3: Customer Services	18	10%

United 3rd Quarter Grievance Trends		
Total # of Resolved Grievances	142	
Top 3 Trends		
Trend 1: Quality of Care (non HCBS)	34	24%
Trend 2: Billing/Financial Issues	30	21%
Trend 3: Trans (No Show)	24	17%

MCOs' Appeals Trends
Member/Provider – CY16 3rd Quarter

Amerigroup 3rd Quarter Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	31		Total # of Resolved Provider Appeals	10807	
Top 3 Trends			Top 3 Trends		
Trend 1: Criteria Not Met - Pharmacy	14	45%	Trend 1: Claim Denied by MCO in Error	7071	65%
Trend 2: Level of Care - LTSS/HCBS	7	23%	Trend 2: Claim Denied - Contained Errors	3632	34%
Trend 3: Criteria Not Met - Dental & Radiology*	2	6%	Trend 3: Other - Medical Necessity	32	0%

Sunflower 3rd Quarter Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	166		Total # of Resolved Provider Appeals	191	
Top 3 Trends			Top 3 Trends		
Trend 1: Criteria Not Met - Pharmacy	64	39%	Trend 1: Criteria Not Met - Vision	63	33%
Trend 2: Criteria Not Met - BH Outpt Svcs & Testing	21	13%	Trend 2: Late Notification	33	17%
Trend 3: Criteria Not Met - PT/OT/ST	20	12%	Trend 3: Criteria Not Met - Inpt Adm (non BH)	28	15%

United 3rd Quarter Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	86		Total # of Resolved Provider Appeals	206	
Top 3 Trends			Top 3 Trends		
Trend 1: Criteria Not Met - Pharmacy	47	55%	Trend 1: Other - Not Covered Service	80	39%
Trend 2: Criteria Not Met - Inpt Adm (non BH)	17	20%	Trend 2: Criteria Not Met - Inpt Adm (non BH)	74	36%
Trend 3: Criteria Not Met - DME & Other-Med Necessity**	6	7%	Trend 3: No authorization submitted	21	10%

Notes: *For Member Appeals, Amerigroup reported 2 for Criteria Not Met - Dental & for Criteria Not Met - Radiology so reported both as Trend #3.

**For Member Appeals, United reported 6 for Criteria Not Met - DME & Other - Medical Necessity so reported both as Trend #3

MCOs' SFH Reversed Decisions
Member/Provider – CY16 3rd Quarter

Amerigroup 3rd Quarter					
Total # of Member SFH	8		Total # of Provider SFH	76	
OAH reversed MCO decision	1	13%	OAH reversed MCO decision	0	0%

Sunflower 3rd Quarter					
Total # of Member SFH	14		Total # of Provider SFH	22	
OAH reversed MCO decision	1	7%	OAH reversed MCO decision	0	0%

United 3rd Quarter					
Total # of Member SFH	10		Total # of Provider SFH	15	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%

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

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

f. Summary of MCO critical incident report: Shifting focus to opportunities for process and system improvement, the Cross-Agency Adverse Incident Management Team drafted a Critical Incident Form for MCOs to track MCO-specific critical incidents and document provider and MCO correspondence, collaboration and responses to each incident. The team made several suggestions to revise the types of critical incidents and current definitions of critical incidents collected in the Adverse Incident Reporting (AIR) database. Role and responsibility clarification for all parties will be prioritized and suggestions were made for reducing report duplication across the critical incident management system. The team began reassessing progress related to the applicable KanCare Special Terms and Conditions and documenting advancements by subject area and by agency.

Following updates to critical incident definitions and major updates and revisions to the AIR database, the testing phase is complete and provider training is underway. AIR reporting access will expand from a provider reporting tool to a public reporting tool. Previous confidentiality concerns have been remedied through limits on historical information and a worklist assignment process to ensure MCOs are only able to access reports for their members.

AIR is not intended to replace the State reporting system for abuse, neglect and exploitation (ANE) of individuals who are served on the behavioral health and HCBS programs. ANE substantiations are reported separately to KDADS from the Department of Children and Families (DCF) and monitored by the KDADS program integrity team. The program integrity team ensures individuals with reported ANE are receiving adequate supports and protections available through KDADS programs, KanCare, and other community resources. A summary of the 2016 AIRS reports through the quarter ending September 30, 2016, follows:

Critical Incidents	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	**TOTALS**
Reviewed	**263**	**394**	**585**		**1242**
Pending Resolution	**1**	**3**	**24**		**28**
Total Received	**264**	**397**	**609**		**1270**
APS Substantiations*	**69**	**65**	**72**		**206**

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

XI. Safety Net Care Pool

The Safety Net Care Pool (SNCP) is divided into two pools: the Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool. The State has requested a sixty day extension to submit Attachment J to determine the impact on the Rural Healthcare Initiative. The HCAIP first and second quarter payments were made on August 12. The State is waiting on the Attachment J approval to make the third quarter payment. The LPTH/BCCH Pool third quarter payments will be processed in November 2016. The attached Safety Net Care Pool Report identifies pool payments to participating hospitals, including funding sources, applicable to the first and second quarters.

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

XII. Demonstration Evaluation

The entity selected by KDHE to conduct KanCare Evaluation reviews and reports is the Kansas Foundation for Medical Care (KFMC). The draft KanCare evaluation design was submitted by Kansas to

CMS on April 26, 2013. CMS conducted review and provided feedback to Kansas on June 25, 2013. Kansas addressed that feedback, and the final design was completed and submitted by Kansas to CMS on August 23, 2013. On September 11, 2013, Kansas was informed that the Evaluation Design had been approved by CMS with no changes. KFMC developed and submitted quarterly evaluation reports, annual evaluation reports for 2013, 2014 and 2015, as well as a revised evaluation design in March 2015.

For the third quarter of 2016, KFMC's quarterly report is attached. As with the previous evaluation design reports, the State will review the Quarterly Report, with specific attention to the related recommendations, and will continue to take responsive action designed to accomplish enhancements to the state's oversight and monitoring of the KanCare program, and to improve outcomes for members utilizing KanCare services.

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

a. Claims Adjudication Statistics

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

b. Waiting List Management

PD Waiting List Management

For the quarter ending September 30, 2016:

- Current number of individuals on the PD Waiting List: 350
- Number of individuals added to the waiting list: 286
- Number of individuals removed from the waiting list: 499
    - 224 started receiving HCBS-PD waiver services
    - 4 were deceased
    - 271 were removed for other reasons (refused services, voluntary removal, etc.)

I/DD Waiting List Management

For the quarter ending September 30, 2016:

- Current number of individuals on the I/DD Waiting List: 3528
- Number of individuals added to the waiting list: 538
- Number of individuals removed from the waiting list: 178
    - 125 started receiving HCBS-I/DD waiver services
    - 53 were removed for other reasons (refused services, voluntary removal, etc.)

The current point-in-time limit for HCBS-I/DD is 8,900. KDADS is currently serving 8,976 individuals.

XIV. Enclosures/Attachments

Section of Report Where Attachment Noted	Description of Attachment
VI	KanCare Budget Neutrality Monitoring Spreadsheet for QE 09.30.16
X(e)	Summary of KanCare Ombudsman Activities for QE 09.30.16
XI	KanCare Safety Net Care Pool Report for QE 09.30.16
XII	KFMC KanCare Evaluation Report for QE 09.30.16
XIII(a)	KDHE Summary of Claims Adjudication Statistics for QE 09.30.16

XV. State Contacts

Dr. Susan Mosier, Secretary
Michael Randol, Division Director and Medicaid Director
Kansas Department of Health and Environment
Division of Health Care Finance
Landon State Office Building – 9th Floor
900 SW Jackson Street
Topeka, Kansas 66612
(785) 296-3512 (phone)
(785) 296-4813 (fax)
Susan.Mosier@ks.gov
Michael.Randol@ks.gov

XVI. Date Submitted to CMS

November 29, 2016

KanCare Budget Neutrality
Demonstration Year 4

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

	Assistance Total Expenditures	Total Member Months	Administration Total Expenditures
DY4Q1	$722,397,762	1,059,350	$39,348,196
DY4Q2	$745,224,600	1,111,408	$50,186,294
DY4Q3	$739,628,299	1,142,579	$43,147,074
DY4Q4	$0	0	$0
DY4 Total	$2,207,250,661	3,313,337	$132,681,564

UNIQUE ENROLLEES (Updated Annually)			
Pop 1: ABD/SD Dual	0	Pop 6: LTC	0
Pop 2: ABD/SD Non Dual	0	Pop 7: MN Dual	0
Pop 3: Adults	0	Pop 8: MN Non Dual	0
Pop 4: Children	0	Pop 9: Waiver	0
Pop 5: DD Waiver	0		
		Total:	0

OVERALL UNDUPLICATED BENEFICIARIES:	0

	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
DY4Q1									
Expenditures	$7,439,738	$107,512,256	$78,279,534	$161,583,226	$119,553,089	$205,407,845	$2,133,234	$6,045,736	$34,443,104
Member-Months	31,540	100,707	142,001	677,132	26,337	62,328	3,647	3,574	12,084
DY4Q2									
Expenditures	$4,733,238	$110,349,070	$83,876,874	$168,801,043	$123,121,459	$207,786,424	$2,408,376	$6,460,922	$37,687,193
Member-Months	21,447	108,593	157,915	712,343	26,856	62,899	4,254	3,807	13,294
DY4Q3									
Expenditures	$4,192,628	$107,312,629	$87,065,293	$163,999,531	$121,275,101	$209,838,361	$1,930,875	$6,160,236	$37,853,644
Member-Months	21,537	111,794	166,989	728,206	27,235	65,025	4,020	4,017	13,756
DY4Q4									
Expenditures	$0	$0	$0	$0	$0	$0	$0	$0	$0
Member-Months	0	0	0	0	0	0	0	0	0
DY4 Total									
Expenditures	$16,365,603	$325,173,956	$249,221,701	$494,383,800	$363,949,650	$623,032,630	$6,472,485	$18,666,893	$109,983,942
Member-Months	74,524	321,094	466,905	2,117,681	80,428	190,252	11,921	11,398	39,134
DY 4 PMPM	$220	$1,013	$534	$233	$4,525	$3,275	$543	$1,638	$2,810

Note:

1. For DY4 Member-Months are CAP + RETRO combined.
3. Unique Enrollees: this table is populated at the end of DY4.
4. DY4Q2: Expenditures and Member-Months for Dual populations decreased due to shift of Dual population to NonDuals. This resulted in an increase of expenditures and member months in the NonDual populations.
5. DY4Q3: Continue to see decrease in Expenditures and Member-Months for Duals due to Dual population shifting to NonDuals.
6. DY4Q3: Mid-Year Rate Adjustments updated in July 2016. This resulted in increases/decreases of expenditures across all MEGS.

KanCare Ombudsman KDHE Quarterly Report

Kerrie J. Bacon, KanCare Ombudsman
3rd Quarter, 2016 Report

Accessibility by Ombudsman's Office

The KanCare Ombudsman was available to members and potential members of KanCare (Medicaid) through the phone, email, letters and in person during the third quarter of 2016. In 2014 and 2015 there were approximately 2000 contacts through these various means. In the first three quarters of 2016, there were 2663 contacts. It is evident from the chart below that the biggest increase in contacts was in 1st quarter and has continued to drop off but is still significantly above the average of the last two years' numbers (32% for 3rd qtr.).

Contacts	**Qtr. 1**	**Qtr. 2**	**Qtr. 3**	**Qtr. 4**	Comments
2013	615	456	436	341	this year does not include emails
2014	545	474	526	547	
2015	510	462	579	524	Avg. for 2014/2015 is 521
2016	1130	846	687		
% incr./dec.	117%	63%	32%		Increase over average of 2014/2015

MCO related	**Q1/15**	**Q2/15**	**Q3/15**	**Q4/15**	**Q1/16**	**Q2/16**	**Q3/16**
Amerigroup	53	69	63	45	92	46	45
Sunflower	96	92	72	62	92	57	59
UnitedHealthcare	75	47	52	32	66	47	37
Total	**224**	**208**	**187**	**139**	**250**	**150**	**141**

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

Outreach by Ombudsman's office

- Attended the Poverty Conference and shared information on the KanCare Ombudsman's Office, Topeka, KS, July 20-21, 2016
- Provided a report and testimony for the Robert Bethel Joint Committee on HCBS and KanCare Oversight, August 5, 2016.
- Attended and shared information on the KanCare Ombudsman's office at the Midwest Ability Summit, Overland Park, KS, August 27. 2016
- Shared information on the KanCare Ombudsman's office at the Northeast Kansas Head Start Conference, September 6, 2016.
- Shared information on the KanCare Ombudsman's office with the Western Kansas Long term Care Ombudsman's Regional team and local community providers; Salina, KS, September 19, 2016
- The Ombudsman's office sponsors the KanCare (I/DD) Friends and Family Advisory Council which met two times during the third quarter.
- Hosted the KanCare Member Lunch-and-Learn bi-weekly conference calls for all KanCare members, parents, guardians, consumers and other interested parties. Calls address topics of interest, resources in the community, emerging issues and includes a question and answer time. Managed care organizations continue to participate on the calls and answer questions as needed...

Outreach through the KanCare Ombudsman Volunteer Program Update.

- The ***KanCare Ombudsman Johnson County Satellite Office*** is in its second quarter of providing assistance to KanCare members.
  - It has assisted approximately 39 consumers for 3rd quarter.
  - We have four fully trained volunteers. We are now focusing our efforts for the next few months on getting the Wyandotte office moving forward.
- The ***KanCare Ombudsman Southern Kansas Satellite Office (Wichita)*** is in its fourth quarter of providing assistance to KanCare members.
  - It has assisted approximately 118 consumers for 3rd quarter.
  - There are four active volunteers at the end of third quarter and two new volunteers are being trained.
- Both Satellite offices have begun assisting consumers with filling out applications on the phone and by appointment in person.
- Volunteer Applications are available on the KanCare Ombudsman webpage. www.KanCare.ks.gov/ombudsman.htm.

Data by Ombudsman's Office

The Ombudsman On-Line tracker has been updated to include the main Ombudsman office and Ombudsman satellite offices covered by volunteers. Starting with the fourth quarter report, we will be able to provide the number of contacts made to the different Ombudsman's offices across Kansas.

Contact Method	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16
phone	415	378	462	438	862	644	507
email	94	82	112	83	265	191	174
letter	1	1	0	2	2	3	1
in person	0	1	5	1	0	8	3
online	0	0	0	0	1	0	2
Total	510	462	579	524	1130	846	687

Caller Type	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16
Provider	111	94	102	93	179	110	100
Consumer	366	343	426	385	866	601	544
MCO employee	3	3	5	3	7	4	10
Other	30	22	46	43	78	131	33
Total	510	462	579	524	1130	846	687

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

	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16
Avg. Days to Resolve Issue	7	7	11	6	7	5	6
% files resolved in one day or less	54%	38%	36%	45%	49.6%	56%	54%
% files closed	87%	88%	93%	83%	77%	88%	87%

The Ombudsman On-Line tracker has been updated to include the main Ombudsman office and Ombudsman satellite offices covered by volunteers. Starting with the fourth quarter report, we will be able to provide the number of contacts made to the different Ombudsman's offices across Kansas.

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

Waiver	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16
PD	57	48	33	28	48	22	13
I/DD	35	25	29	28	48	27	21
FE	15	12	16	18	23	19	10
Autism	4	3	4	5	1	2	2
SED	1	7	5	4	4	0	1
TBI	10	9	7	9	10	3	7
TA	11	13	11	13	10	9	4
MFP	2	2	3	1	8	5	3
PACE	0	0	1	1	0	0	0
Mental Health	5	9	7	11	8	6	3
Substance Use Disorder	0	0	0	2	0	0	0
Nursing Facility	12	28	33	29	47	27	16
Other	512	320	443	391	941	739	612
Total	664	476	592	540	1148	859	692

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

Issues	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16
Access to Providers	3	11	1	12	7	6	9
Appeals, Grievances	42	33	47	26	49	42	36
Billing	36	40	41	30	43	39	37
Care Coordinators	10	8	9	8	7	3	6
Change MCO	8	4	10	9	15	3	0
Dental	7	5	1	4	4	5	5
Durable Medical Equipment	25	12	7	8	7	7	2
Guardianship Issues	5	1	2	1	0	1	2
HCBS Eligibility issues	11	15	24	30	45	33	21
HCBS General Issues	60	36	54	34	69	32	16
HCBS Reduction in hours of service	10	8	13	16	12	4	3
HCBS Waiting List issues	11	8	9	11	18	2	2
Housing issues	1	6	4	3	8	2	2
Medicaid Eligibility Issues	139	108	206	182	512	244	173
Medicaid Service Issues	20	24	27	21	29	20	10
Nursing Facility Issues	15	34	34	29	40	25	22
Other	130	150	141	149	332	377	381
Pharmacy	25	33	14	20	24	13	11
Questions for Conf Calls/sessions	5	2	0	1	0	0	1
Thank you	14	15	11	12	72	85	114
Transportation	12	17	8	7	6	8	6
Unspecified	31	12	36	21	79	38	21
Total	620	582	699	634	1378	989	880

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

Resource Category	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16
Question/Issue Resolved	84	61	65	58	122	239	233
Used Issues/Resources Resolved	262	234	321	296	463	394	313
KDHE Resources	95	77	124	87	214	97	97
DCF Resources	20	13	25	37	6	2	1
MCO Resources	79	73	48	62	48	43	44
HCBS Team	32	43	36	29	28	21	12
CSP Mental Health Team	0	1	0	2	1	1	0
Other KDADS Resources	31	31	38	58	53	16	44
Provided Resources to Member	85	108	177	184	361	239	115
Referred to State/Community Agency	22	54	75	72	111	40	53
Referred to DRC and/or KLS	26	16	19	5	13	7	4
Closed	14	29	60	72	198	313	111
Total	750	740	988	962	1618	1412	1027

Managed Care Organization Issues: by Category, by Quarter

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

Issue Category - Amerigroup	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16
Access to Providers (usually Medical)	0	1	0	1	1	1	2
Appeals / Grievances	3	9	5	1	9	5	1
Billing	10	12	7	10	11	6	7
Care Coordinator Issues	1	3	3	3	4	1	3
Change MCO	2	1	4	2	1	1	0
Dental	2	0	0	11	0	0	1
Durable Medical Equipment	2	2	0	0	2	2	1
Guardianship	1	0	0	0	0	0	0
HCBS Eligibility issues	0	2	9	4	8	5	4
HCBS General Issues	14	12	12	3	13	3	3
HCBS Reduction in hours of service	0	0	5	6	6	1	1
HCBS Waiting List	2	2	3	2	0	0	0
Housing Issues	0	1	1	1	1	1	0
Medicaid Eligibility Issues	9	4	10	2	28	8	5
Medical Services	1	4	2	2	7	2	3
Nursing Facility Issues	2	1	5	5	2	1	0
Other	10	20	11	3	19	16	20
Pharmacy	1	4	2	1	3	1	0
Questions for Conference Calls/Sessions	0	0	0	4	0	0	0
Thank you.	0	0	1	1	6	4	9
Transportation	1	7	4	0	2	1	1
Unspecified	2	0	5	1	2	0	0
Total	63	85	89	63	125	59	61

Issue Category - Sunflower	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16
Access to Providers (usually Medical)	0	3	0	8	1	1	2
Appeals / Grievances	22	15	18	4	14	11	8
Billing	13	11	9	6	6	7	9
Care Coordinator Issues	2	3	3	2	2	1	1
Change MCO	3	1	3	6	3	1	0
Dental	1	3	0	1	1	2	0
Durable Medical Equipment	10	7	1	9	5	2	0
Guardianship	0	0	1	3	0	0	0
HCBS Eligibility issues	2	6	1	0	3	7	3
HCBS General Issues	22	9	10	0	15	9	1
HCBS Reduction in hours of service	4	4	4	7	0	3	1
HCBS Waiting List	0	0	2	1	1	0	0
Housing Issues	0	2	0	0	0	0	0
Medicaid Eligibility Issues	17	16	13	12	26	7	10
Medical Services	5	7	7	4	4	8	0
Nursing Facility Issues	3	3	3	0	3	3	2
Other	14	19	14	2	23	12	24
Pharmacy	7	16	5	2	4	1	4
Questions for Conference Calls/Sessions	1	0	0	0	0	0	0
Thank you.	4	3	5	1	7	6	8
Transportation	3	4	1	6	1	2	4
Unspecified	3	0	1	7	1	0	0
Total	136	132	101	81	120	83	77

Issue Category - UnitedHealthcare	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16
Access to Providers (usually Medical)	2	4	1	2	2	1	0
Appeals / Grievances	11	3	6	0	6	4	5
Billing	5	5	7	2	3	5	2
Care Coordinator Issues	5	2	2	9	0	0	2
Change MCO	2	1	1	0	3	0	0
Dental	2	1	0	1	1	3	2
Durable Medical Equipment	6	1	2	1	0	1	0
Guardianship	1	0	0	4	0	0	0
HCBS Eligibility issues	3	1	4	1	6	3	2
HCBS General Issues	11	6	7	3	11	5	2
HCBS Reduction in hours of service	4	2	2	1	2	0	0
HCBS Waiting List	3	0	1	0	2	1	1
Housing Issues	0	2	1	3	0	0	0
Medicaid Eligibility Issues	11	8	10	4	18	4	5
Medical Services	6	4	6	1	4	1	4
Nursing Facility Issues	4	4	4	0	2	1	2
Other	16	11	10	1	14	20	20
Pharmacy	8	6	2	0	7	2	4
Questions for Conference Calls/Sessions	1	0	0	1	0	0	0
Thank you.	2	1	0	1	5	8	6
Transportation	5	3	2	3	1	0	0
Unspecified	0	0	2	4	2	0	0
Total	108	65	70	42	89	59	57

Next Steps for Ombudsman's Office

KanCare Ombudsman Volunteer Program

- The Ombudsman Volunteer Program has begun a weekly education call for Volunteers for continuing education.
- The Ombudsman Volunteer Coordinator, Lisa Churchill, has put together a radio public service announcement to recruit volunteers for the Kansas City Metro and Wichita areas.

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 4- QE September 2016

Health Care Access Improvement Pool

Paid 8/4/2016

Hospital Name	HCAIP DY/QTR: 2016/3	Provider Access Fund 2443	Federal Medicaid Fund 3414
Bob Wilson Memorial Hospital	95,034.00	41,216.25	53,817.75
Children's Mercy Hospital South	503,260.00	218,263.86	284,996.14
Coffey County Hospital	38,898.00	16,870.06	22,027.94
Coffeyville Regional Medical Center, Inc.	128,696.00	55,815.46	72,880.54
Cushing Memorial Hospital	223,592.00	96,971.85	126,620.15
Doctors Hospital	2,854.00	1,237.78	1,616.22
Geary Community Hospital	215,788.00	93,587.26	122,200.74
Hays Medical Center, Inc.	488,352.00	211,798.26	276,553.74
Hutchinson Hospital Corporation	212,956.00	92,359.02	120,596.98
Kansas Heart Hospital LLC	55,944.00	24,262.91	31,681.09
Kansas Medical Center LLC	57,578.00	24,971.58	32,606.42
Kansas Rehabilitation Hospital	2,632.00	1,141.50	1,490.50
Labette County Medical Center	140,558.00	60,960.00	79,598.00
Lawrence Memorial Hospital	478,830.00	207,668.57	271,161.43
Meadowbrook Rehabilitation Hospital (CLC of Gardner)	64,246.00	27,863.49	36,382.51
Memorial Hospital, Inc.	66,210.00	28,715.28	37,494.72
Menorah Medical Center	369,986.00	160,462.93	209,523.07
Mercy Health Center - Ft. Scott	155,914.00	67,619.90	88,294.10
Mercy Hospital, Inc.	12,958.00	5,619.88	7,338.12
Mercy Reg Health Ctr	390,794.00	169,487.36	221,306.64
Miami County Medical Center	99,624.00	43,206.93	56,417.07
Mid-America Rehabilitation Hospital	4,366.00	1,893.53	2,472.47
Morton County Health System	14,370.00	6,232.27	8,137.73
Mt. Carmel Medical Center	384,058.00	166,565.95	217,492.05
Newton Medical Center	206,350.00	89,494.00	116,856.01
Olathe Medical Center	309,642.00	134,291.74	175,350.26
Overland Park Regional Medical Ctr.	1,230,748.00	533,775.41	696,972.59
Pratt Regional Medical Center	59,550.00	25,826.84	33,723.17
Providence Medical Center	883,584.00	383,210.38	500,373.62
Ransom Memorial Hospital	130,036.00	56,396.61	73,639.39
Saint Luke's South Hospital, Inc.	139,580.00	60,535.85	79,044.15
Salina Regional Health Center	378,502.00	164,156.32	214,345.68
Salina Surgical Hospital	7,564.00	3,280.51	4,283.49
Shawnee Mission Medical Center, Inc.	1,566,828.00	679,533.30	887,294.70
South Central KS Reg Medical Ctr	96,268.00	41,751.43	54,516.57
Southwest Medical Center	196,512.00	85,227.25	111,284.75
St. Catherine Hospital	437,738.00	189,846.97	247,891.03
St. Francis Health Center	848,902.00	368,168.80	480,733.20
St. John Hospital	146,644.00	63,599.50	83,044.50
Stormont Vail Regional Health Center	2,110,878.00	915,487.79	1,195,390.21
Sumner Regional Medical Center	67,816.00	29,411.80	38,404.20
Surgical & Diag. Ctr. of Great Bend	184,258.00	79,912.69	104,345.31
Susan B. Allen Memorial Hospital	227,582.00	98,702.31	128,879.69
Via Christi Hospital St Teresa	134,988.00	58,544.30	76,443.70
Via Christi Regional Medical Center	3,859,393.27	1,673,818.86	2,185,574.41
Via Christi Rehabilitation Center	61,844.00	26,821.74	35,022.26
Wesley Medical Center	2,749,706.00	1,192,547.49	1,557,158.51
Wesley Rehabilitation Hospital	4,918.00	2,132.94	2,785.06
Western Plains Medical Complex	248,224.00	107,654.75	140,569.25

Kansas Foundation for Medical Care, Inc

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

November 22, 2016

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

RE: 2016 KanCare Evaluation Quarterly Report
Year 4, Quarter 3, July - September

Dear Ms. Phelps:

Enclosed is the 3rd Quarter 2016 KanCare Evaluation quarterly report If you have questions regarding this information, please contact me, jpanichello@kfmc.org.

Sincerely,

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

Enclosure

2016 KanCare Evaluation

Quarterly Report

Year 4, Quarter 3, July - September

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

Prepared for:

KanCare

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Year 4, Quarter 3, July - September

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Year 4, Quarter 3, July – September
November 22, 2016

Background/Objectives

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

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

A subset of the annual performance measures was selected to be assessed and reported quarterly. The quarterly measures for the third quarter (Q3) CY2016 report include the following:

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

KanCare healthcare services are coordinated by three managed care organizations (MCOs): Amerigroup of Kansas, Inc. (Amerigroup or AGP), Sunflower State Health Plan (Sunflower or SSHP), and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare or UHC). For the KanCare Quarterly and Annual Evaluations, data from the three MCOs are combined wherever possible to better assess the overall impact of the KanCare program.

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

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

Timely Resolution of Customer Service Inquiries

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

Data Sources

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

Current Quarter and Trend over Time

In Q3 CY2016, 99.61% of the 97,059 member customer service inquiries received by the MCOs and 99.97% of the 43,809 provider customer service inquiries were resolved within two business days (see Table 1). During each quarter to date the two-day resolution rate exceeded 99.6%.

Table 1. Timeliness of Resolution of Member and Provider Customer Service Inquiries,

	Member Inquiries		Provider Inquiries	
	Q3 CY2015	Q3 CY2016	Q3 CY2015	Q3 CY2016
Number of Inquiries Received	99,007	**97,059**	45,365	**43,809**
Number of Inquiries Resolved Within 2 Business Days	99,002	**96,683**	45,365	**43,796**
Number of Inquiries Not Resolved Within 2 Business Days	5	**376**	0	**13**
Percent of Inquiries Resolved Within 2 Business Days	99.995%	**99.61%**	100%	**99.97%**
Number of Inquiries Resolved Within 5 Business Days	99,007	**96,876**	45,365	**43,796**
Number of Inquiries Not Resolved Within 5 Business Days	0	**183**	0	**13**
Percent of Inquiries Resolved Within 5 Business Days	100%	**99.81%**	100%	**99.97%**
Number of Inquiries Resolved Within 15 Business Days	99,007	**97,046**	45,365	**43,809**
Number of Inquiries Not Resolved Within 15 Business Days	0	**13**	0	**0**
Percent of Inquiries Resolved Within 15 Business Days	100%	**99.99%**	100%	**100%**

In Q3 CY2016, all three MCOs met contractual requirements for resolving at least 98% of customer service inquiries within five business days. Two of the three MCOs (AGP and SSHP) met the contractual requirements to resolve 100% of inquiries within 15 business days; AGP and SSHP each reported 100% of their member and provider inquiries were resolved within five business days. UHC reported 13 member customer inquiries in Q3 not resolved within 15 business days. In Q2 CY2016 (and in Q3 CY2015), all member and provider customer service inquiries were resolved within five business days; compared to 183 member inquiries and 13 provider inquiries unresolved within five days in Q3 CY2016.

Member Customer Service Inquiries

The MCOs categorize member customer service inquiries in their monthly call center reports by 18 service inquiry categories (see Table 2). Sunflower added a category for Health Homes; the 35 grievances reported in Q3 CY2016 as related to "Health Homes" were added to the "Other" category for consistency in reporting aggregated counts and percentages for the three MCOs.

Table 2. Customer Service Inquiries from Members, Q1 CY2015 to Q3 CY2016

	CY2015				CY2016		
Member Inquiries	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
1. Benefit Inquiry – regular or VAS	20,775	19,702	18,611	18,031	21,924	22,319	**21,652**
2. Concern with access to service or care; or concern with service or care disruption	2,059	1,754	1,691	1,597	1,934	1,716	**1,681**
3. Care management or health plan program	2,309	2,976	3,008	2,882	1,597	1,584	**1,363**
4. Claim or billing question	7,107	6,983	7,383	6,396	6,416	6,381	**5,557**
5. Coordination of benefits	3,437	3,079	3,030	2,898	3,280	2,964	**3,467**
6. Disenrollment request	632	561	634	544	606	600	**635**
7. Eligibility inquiry	13,330	12,750	15,214	14,423	18,002	13,478	**12,555**
8. Enrollment information	2,141	2,210	2,838	2,371	3,203	2,396	**2,558**
9. Find/change PCP	15,586	13,407	12,823	11,765	12,893	12,488	**12,906**
10. Find a specialist	4,070	3,875	3,835	3,469	3,512	3,375	**3,320**
11. Assistance with scheduling an appointment	46	36	26	40	30	47	**74**
12. Need transportation	1,812	1,789	1,402	1,220	1,326	1,200	**1,214**
13. Order ID card	7,653	6,348	6,240	5,797	6,958	6,453	**7,263**
14. Question about letter or outbound call	1,013	898	1,175	1,319	1,322	1,961	**1,338**
15. Request member materials	1,080	1,112	1,511	1,056	1,083	1,119	**976**
16. Update demographic information	13,404	12,639	13,481	11,967	12,944	13,343	**14,985**
17. Member emergent or crisis call	938	834	717	661	699	687	**597**
18. Other	5,768	6,641	5,388	4,801	5,018	4,491	**4,918**
Total	**103,160**	**97,594**	**99,007**	**91,237**	**102,742**	**96,632**	**97,059**

- Of the 97,059 member customer service inquiries in Q3 CY2016, 42.9% were received by Sunflower, 38.9% by UnitedHealthcare, and 18.2% by Amerigroup.
- Benefit inquiries continue in Q3 to be the highest percentage (22.3%) of member inquiries.
- In Q3 CY2016, the number of inquiries in five of the 18 categories was the lower than in the previous six quarters ("Care management or health plan program," "Claim or billing question," "Eligibility inquiry," "Find a specialist," and "Request member materials." The number of inquiries was higher in Q3 (than in the previous six quarters) for inquiries related to "Coordination of benefits" and "Update demographic information."
- As in previous quarters, there are categories where two thirds or more of the inquiries in the quarter were reported by one MCO; two of the five with over 70% of the inquiries reported by one MCO for the past eight quarters. This seems likely to be due to differing interpretations of the

criteria for several of the categories in the reporting template. The categories where over two thirds of the reported inquiries were from one MCO include:

- "Member emergent or crisis call" – 99.2% of 597 inquiries in Q3 CY2016 were reported by Sunflower. (CY2016: Q2 – 99.6%; Q1 99.7%; CY2015: Q4 – 99.4%; Q3 – 99.4%; Q2 - 99.8%; Q1 – 99.7%; CY2014: Q4 – 99.7%)
- "Update demographic information" – 79.2% of 14,985 inquiries in Q3 CY2016 were reported by Sunflower. (CY2016: Q2 – 78.9%; Q1 – 78.1%; CY2015: Q4 – 81.4%; Q3 – 82.1%; Q2 - 82.3%; Q1 – 82.1%; CY2014: Q4 – 71.0%)
- "Enrollment information" – 69.3% of 2,558 inquiries were reported in Q3 CY2016 by Amerigroup. (CY2016: Q1 – 75.8%; Q1 – 85.4%; CY2015: Q4 – 80.5%; Q3 – 76.8%; Q2 - 76.4%; Q1 CY2015 - 76.6%; CY2014: Q4 – 80.5%)
- "Care management or health plan program" – 86.4% of 1,363 inquiries in Q3 CY2016 were reported by Amerigroup. (Q2 – 82.1%)
- "Concern with access to service or care; or concern with service or care disruption" – 75.1% of 1,681 inquiries were reported in Q3 CY2016 by Sunflower. (Q2 – 69.7%)

The member customer service inquiry category "Concern with access to service or care; or concern with service or care disruption" seems to potentially describe contacts tracked as "grievances" or "appeals" in the State's STC and GAR reports. In Q3 CY2016, the MCOs received 1,681 contacts in this category that were in addition to the grievances and appeals reported by members. The State should provide clear criteria to the MCOs for this category to ensure grievance and appeals contacts are not misclassified as customer service inquiries.

Provider Customer Service Inquiries

The MCOs categorize provider customer service inquiries in their monthly call center reports by 17 provider service inquiry categories (see Table 3). Sunflower added a category for provider inquiries related to Health Homes; the three grievances reported in Q3 CY2016 as related "Health Homes" were added to the "Other" category for consistency in reporting aggregated counts and percentages for the three MCOs.

- Of the 43,809 provider inquiries received by MCOs in Q3 CY2016, Amerigroup received 36.5%, Sunflower 42.8%, and UnitedHealthcare 20.7%.
- For providers, claim status inquiries were again the highest percentage (47.2%) of the 43,809 provider inquiries.

As noted in previous quarterly reports, there are a number of categories where aggregated data primarily reflect one MCO rather than all three over time. Categories where two thirds or more of the provider inquiries in Q3 were reported by one MCO included:

- "Authorization – New" – 98.3% of 1,870 inquiries in Q3 CY2016 were reported by Amerigroup. (CY2016: Q2 – 99.0%; Q1 – 99.0%; CY2015: Q4 – 98.6%, Q3– 98.0%; Q2– 99.1%; Q1– 99.1%; CY2014: Q4 – 98.1%)
- "Update demographic information" – 95.3% of 549 inquiries were reported in Q3 CY2016 by Sunflower. (CY2016: Q2 – 95.4%; Q1 – 95.3%; CY2015: Q4 – 93.7%, Q3 – 96.2%; Q2 - 91.4%; Q1 - 95.5%; CY2014: Q4 - 99.5%)
- "Coordination of benefits" – 79.5% of 429 inquiries were reported in Q3 CY2016 by UnitedHealthcare. (CY2016: Q2 – 77.5%; Q1 – 73.7%; CY2015: Q4 – 87.9%, Q3– 85.5%; Q2 - 76.8%; Q1 - 90.7%; CY2014: Q4 - 91.0%)
- "Claim denial inquiry" – 68.6% of 5,540 inquiries in Q3 CY2016 were reported by UnitedHealthcare.

- "Other" – 71.5% of 1,784 inquiries in Q3 CY2016 were reported by Sunflower. (CY2016: Q2 – 64.7%; Q1 – 74.7%)

Table 3. Customer Service Inquiries from Providers, Q1 CY2015 to Q3 CY2016

	CY2015				CY2016		
Provider Inquiries	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
1. Authorization – New	2,351	2,369	1,880	1,759	1,942	1,812	**1,870**
2. Authorization – Status	2,456	2,417	2,323	2,594	2,773	2,373	**2,599**
3. Benefits inquiry	4,594	4,144	4,043	3,806	3,259	3,121	**3,273**
4. Claim denial inquiry	5,182	3,990	5,498	4,411	5,605	4,423	**5,540**
5. Claim status inquiry	19,457	21,314	19,898	22,399	23,613	21,685	**20,682**
6. Claim payment question/dispute	6,822	6,005	5,315	4,833	4,575	4,142	**3,725**
7. Billing inquiry	851	436	363	308	596	389	**407**
8. Coordination of benefits	1,167	939	792	777	373	396	**429**
9. Member eligibility inquiry	1,866	1,804	1,935	1,564	2,030	1,646	**1,754**
10. Recoupment or negative balance	353	243	165	91	66	85	**75**
11. Pharmacy/prescription inquiry	599	599	438	477	598	529	**583**
12. Request provider materials	31	62	62	34	71	40	**34**
13. Update demographic information	538	418	764	495	744	710	**549**
14. Verify/change participation status	272	282	441	273	345	258	**249**
15. Web support	197	209	252	194	182	103	**99**
16. Credentialing issues	163	239	208	195	231	162	**157**
17. Other	2,353	1,270	988	1,068	1,918	1,441	**1,784**
Total	**49,252**	**46,742**	45,365	45,278	**48,921**	**43,315**	**43,809**

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

Table 4. Maximum and Minimum Numbers of Claims-Related Provider Inquiries by MCO

	CY2015								CY2016					
	Q1		Q2		Q3		Q4		Q1		Q2		Q3	
	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min
Authorization - New	2,330	0	2,347	1	1,842	3	1,735	3	1,923	3	1,793	3	1,839	7
Authorization - Status	1,739	335	1,718	298	1,565	176	1,814	141	1,932	66	1,604	91	1,661	126
Benefits Inquiry	2,621	318	2,163	265	2,017	489	1,865	477	1,648	755	1,542	514	1,519	582
Claim Denial Inquiry	3,169	0	2,098	0	1,905	0	2,644	0	3,593	0	2,574	0	3,798	0
Claim Status Inquiry	7,090	5,941	8,399	6,273	8,209	5,174	10,466	5,720	14,458	2,473	12,825	2,751	11,845	2,911
Claim Payment Question/Dispute	4,142	990	3,303	785	2,772	669	2,404	570	2,276	293	1,955	311	1,745	346
Billing Inquiry	650	19	223	4	195	6	184	2	426	0	194	1	247	2

Amerigroup
Sunflower
UnitedHealthcare
Amerigroup & Sunflower

Table 5. Combined Totals of the Seven Claims-Related Provider Inquiry Categories by MCO							
	CY2015				CY2016		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Amerigroup	16,035	16,441	15,433	14,974	16,373	14,967	14,479
Sunflower	11,454	12,614	12,249	14,191	18,706	16,182	15,255
UnitedHealthcare	14,224	11,622	11,638	10,945	7,284	6,796	8,362
Total	**41,713**	**40,677**	**39,320**	**40,110**	**42,363**	**37,945**	**38,096**

Based on the combined totals for the seven claims-related categories, MCOs more clearly differed over time in the number of claims-related inquiries. Comparing Q3 CY2016 with the previous six quarters:

- UnitedHealthcare had the fewest claim-related provider inquiries in Q2 CY2015 through Q3 CY2016.
- Sunflower had the highest number of claim-related provider inquiries in Q1 through Q3 CY2016 compared to AGP and UHC; the quarterly number of claims-related inquiries was higher in CY 2016 than the quarterly numbers reported in CY2015.
- Amerigroup's claims-related provider inquiries in Q2 and Q3 CY2016 were lower than the previous five quarters.

Recommendations

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

- The State should provide clear criteria to the MCOs for the member customer service category "*Concern with access to service or care; or concern with service or care disruption*" to ensure grievance and appeals contacts are not misclassified as customer service inquiries.
- Clear criteria for the seven claims-related provider customer service inquiry categories should be provided to allow better comparisons by MCO.

Timeliness of Claims Processing

Clean claims, including those of MCO vendors, are to be processed within 30 days, non-clean claims within 60 days, and all claims within 90 days. Clean claims received in the middle or end of a month may be processed in that month or the following month. Since a non-clean claim may take up to 60 days to process, a claim received in mid-March, for example, may be processed in March or may not be processed until early May and still meet contractual requirements.

A "clean claim" is a claim that can be paid or denied with no additional intervention required and does not include: adjusted or corrected claims; claims that require documentation (i.e., consent forms, medical records) for processing; claims from out-of-network providers that require research and setup of that provider in the system; and claims from providers where the updated rates, benefits, or policy changes were not provided by the State 30 days or more before the effective date. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Claims that are excluded from the measures include "claims submitted by providers placed on prepayment review or any other type of payment suspension or delay for potential enforcement issues" and "any claim which cannot be processed due to outstanding questions submitted to KDHE." In Table 6,

the numbers of excluded claims in CY2015 are listed by quarter for each of the claim categories – clean claims, non-clean claims, and all claims.

To allow for claims lag, the KanCare Evaluation Report for Q3 CY2016 assesses timeliness of processing clean, non-clean, and all claims reports received through Q2 CY2016.

Data Sources

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

The report also includes average turnaround time (TAT) for processing clean claims. Due to claims lag, claims processed in one month may be from that month or from a month or two prior to that month.

Timeliness of Claims Processing by Claim Type and Date Received

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

For claims received in Q2 CY2016:

- Clean claims: 99.966% of 4,247,972 clean claims received in Q2 CY2016 were reported by the MCOs as processed within 30 days.
  - In Q2 CY2016, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days.
  - In Q2 CY2016, the number of clean claims not processed within 30 days (1,465) decreased compared to the four previous quarters.
  - Of the 1,465 clean claims not processed within 30 days – 1,336 (91.2%) were claims received by Sunflower; 66 (4.5%) were claims received by Amerigroup, and 63 (4.3%) were claims received by UnitedHealthcare.
- Non-clean claims: 99.892% of 155,776 non-clean claims received in Q2 CY2016 were reported by the MCOs as processed within 60 days.
  - In Q2 CY2016, all of the MCOs met the contractual requirement of processing at least 99% of the non-clean claims within 60 days.
  - In Q2 CY2016, the numbers and percentages of non-clean claims not processed within 60 days (168) was lower than the previous three quarters (ranging from 203 to 881) but higher than in Q1 (29) and Q2 (60) CY2015.
  - Of the 168 “non-clean claims” not processed within 60 days - 91 (54.2%) were claims received by Amerigroup, 76 (45.2%) were claims received by Sunflower; and 1 (0.6%) was a claim received by UnitedHealthcare.
  - As indicated in Table 6, the number of “non-clean claims” excluded from the measure has increased in the last four quarters, ranging from 29 (0.2% of non-clean claims) in Q1 CY2015 to 2,974 (1.5% of non-clean claims) in Q1 CY2016. In Q2 CY2016, 73.6% of the 1,434 excluded non-clean claims were claims reported by Sunflower. In November 2016, KFMC questioned Sunflower staff as to why their excluded claims counts have been so much higher than the MCOs. Sunflower staff reported that the excluded non-clean claims were primarily newborn claims that, under State criteria, may pend for 45 days. Sunflower staff agreed that these claims should actually not be excluded, as these claims should, with few exceptions, be processed within 60 days. Sunflower plans to revise future reports to correct this error.

- All claims: 99.997% of 4,403,748 "all claims" received in Q2 CY2016 were reported by the MCOs as processed within 90 days.
  - In Q2 CY2016, none of the MCOs met the requirement of processing 100% of claims within 90 days. Of the 118 claims not processed within 90 days – 66 (55.9%) were claims received by Amerigroup; 43 (36.4%) were claims received by Sunflower; and 9 (7.6%) were claims received by UnitedHealthcare.
  - In Q2 CY2016, the number of "all claims" not processed within 90 days (118) was lower than in three of the four previous quarters.

Table 6. Timeliness of Claims Processing Q1 CY2015 to Q2 CY2016

	CY2015				CY2016	
	Q1	Q2	Q3	Q4	Q1	Q2
Clean Claims						
Number of clean claims received in quarter	4,286,318	4,289,698	4,293,070	4,265,406	4,380,378	**4,248,060**
Number of claims excluded	0	149	332	2,269	263	**88**
Number of clean claims not excluded	4,286,318	4,289,549	4,292,738	4,263,137	4,380,115	**4,247,972**
Number of clean claims received within quarter processed within 30 days	4,285,468	4,286,617	4,289,231	4,261,301	4,378,159	**4,246,507**
Number of clean claims received within quarter **not** processed within 30 days	850	2,932	3,507	1,836	1,956	**1,465**
Percent of clean claims processed within 30 days	**99.980%**	**99.932%**	**99.918%**	**99.957%**	**99.955%**	**99.966%**
Non-Clean Claims						
Number of non-clean claims received in quarter	180,925	164,617	150,266	176,809	198,558	**157,210**
Number of claims excluded	352	306	1,310	1,849	2,974	**1,434**
Number of non-claims not excluded	180,573	164,311	148,956	174,960	195,584	**155,776**
Number of non-clean claims received within quarter processed within 60 days	180,544	164,251	148,753	174,079	195,335	**155,608**
Number of non-clean claims received within quarter **not** processed within 60 days	29	60	203	881	249	**168**
Percent of non-clean claims processed within 60 days	**99.984%**	**99.963%**	**99.864%**	**99.496%**	**99.873%**	**99.892%**
All Claims						
Number of claims received in quarter	4,467,243	4,454,315	4,443,336	4,442,215	4,578,936	**4,405,270**
Number of claims excluded	352	455	1,642	4,118	3,237	**1,522**
Number of claims not excluded	4,466,891	4,453,860	4,441,694	4,438,097	4,575,699	**4,403,748**
Number of claims received within quarter processed within 90 days	4,466,812	4,453,606	4,441,634	4,437,802	4,575,552	**4,403,630**
Number of claims received within quarter **not** processed within 90 days	79	254	60	307	147	**118**
Percent of claims processed within 90 days	**99.998%**	**99.994%**	**99.999%**	**99.993%**	**99.997%**	**99.997%**

Average Turnaround Time for Processing Clean Claims

As indicated in Table 7, the MCOs reported 4,469,354 clean claims processed in Q3 CY2016 (includes claims received prior to Q3). Excluding pharmacy claims (which are processed same day) there were 3,045,520 clean claims processed.

The average TAT for Total Services (excluding pharmacy claims processed same day) was 5.8 to 10.6 days in Q3 CY2016, compared with 5.2 to 9.1 days in Q2 CY2016.

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

	CY2016			Monthly Ranges by Year (CY2014 & CY2015)	
Service Category	**Q1**	**Q2**	**Q3**	**CY2014**	**CY2015**
Hospital Inpatient	8.1 to 15.1	7.1 to 12.4	**8.3 to 18.2**	5.0 to 19.2	6.4 to 15.9
Hospital Outpatient	4.8 to 10.5	4.3 to 9.5	**4.4 to 12.9**	3.6 to 12.8	3.5 to 10.8
Pharmacy	same day	same day	**same day**	same day	same day
Dental	7.0 to 13.0	7.0 to 13.0	**6.0 to 13.0**	2.0 to 21.0	4.0 to 13.1
Vision	9.0 to 12.7	7.0 to 12.0	**7.0 to 11.9**	7.0 to 12.5	9.0 to 12.5
Non-Emergency Transportation	9.0 to 14.0	9.5 to 14.4	**9.7 to 13.5**	10.9 to 18	10.4 to 16
Medical (Physical health not otherwise specified)	4.4 to 9.9	4.4 to 8.9	**4.9 to 10.7**	3.3 to 10.6	3.4 to 10.5
Nursing Facilities	5.6 to 9.0	4.7 to 9.0	**4.8 to 9.7**	4.3 to 11.5	4.1 to 9.7
HCBS	5.8 to 9.7	6.0 to 8.7	**7.8 to 10.8**	3.2 to 15.6	4.1 to 10.2
Behavioral Health	4.2 to 10.3	4.2 to 9.3	**4.5 to 11.7**	3.4 to 8.6	2.7 to 10.5
Total Claims (Including Pharmacy)	4,409,846	4,315,854	**4,469,354**	16,763,501	17,820,402
Total Claims (Excluding Pharmacy)	2,646,703	2,622,624	**3,045,520**	10,370,998	10,999,807
Average TAT (Excluding Pharmacy)	**5.3 to 10.0**	**5.2 to 9.1**	**5.8 to 10.6**	**4.3 to 11.5**	**4.3 to 10.3**

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

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

- Pharmacy - Clean pharmacy claims had the shortest turnaround times and were consistently processed on a same day basis by each of the three MCOs.
- Hospital Inpatient – Hospital Inpatient claims had TATs in Q3 CY2016 ranging from 8.3 to 18.2 days, an increase compared to Q2 CY2016 (7.1 to 12.4) and Q1 CY2016 (8.1 to 15.1). Amerigroup had the shortest TATs in Q3 (8.3 to 10.0 days), an increase, however, compared to previous quarters. UnitedHealthcare had the highest TATs in Q3 (12.3 to 18.2 days), an increase compared to previous quarters. Sunflower's Q3 TAT (12.2 to 12.6) were higher than Q2 (11.6 to 12.4), but lower than in Q1 CY2016 (13.4 to 15.1).
- Dental - Dental claims TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 6.0 to 13.0 days in Q3 CY2016. Sunflower had the shortest TATs each month (6.0 to 7.0 days); Amerigroup and UnitedHealthcare had TATs of 13.0 days in Q3 CY2016 and the previous three quarters.
- Nursing Facilities – Nursing Facility claims had TATs ranging from 4.8 to 9.7 days in Q3, an increase compared to Q2 CY2016 (4.7 to 9.0 days). Amerigroup had the shortest TATs (4.8 to 5.7 days). Sunflower had the longest (8.8 to 9.7 days) in Q3, an increase compared to Q2 (8.6 to 9.0 days) and Q1 (7.5 to 9.0 days). UnitedHealthcare's TATs also increased in Q3 (7.6 to 8.8 days) compared to the previous two quarters.

- HCBS – HCBS claims had monthly TATs in Q3 ranging from 7.8 to 10.8 days, an increase compared to Q2 (6.0 to 8.7 days). Amerigroup had the shortest TATs (7.8 to 8.3 days), compared to Sunflower (9.1 to 9.3 days) and UnitedHealthcare (8.1 to 10.8 days).
- Behavioral Health (BH) – BH claims TATs ranged from 4.5 to 11.7 days in Q3 CY2016, an increase compared to Q2 (4.2 to 9.3 days) and Q1 (4.2 to 10.3 days). Amerigroup had the shortest TATs (4.5 to 5.4 days), compared to Sunflower (9.8 to 11.7 days) and UnitedHealthcare (8.3 to 10.0 days).
- Non-emergency transportation (NEMT) - Clean claims for NEMT had monthly average TATs ranging from 9.7 to 13.5 days in Q3, compared to 9.5 to 14.4 days in Q2 CY2016. Amerigroup had the longest TATs in Q3, ranging from 11.5 to 13.5 days, compared to 9.7 to 10.0 for Sunflower and 9.8 to 9.9 for UnitedHealthcare.
- Vision – The average TATs were consistently a week or longer in Q3 and previous quarters for all of the MCOs. In Q3 CY2016, the average monthly TATs ranged from 7.0 to 11.9 days, comparable to 7.0 to 12.0 in Q2.

Recommendation

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

Grievances

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

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

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

Data Sources

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

Beginning in Q2 CY2016, grievances and appeals are to be reported using updated categories. KDHE staff provided training to MCO staff to clarify criteria for each category and provided more detailed grievance and appeal criteria definitions and examples in the reporting template to promote more accurate and consistent reporting. A number of categories (including “Criteria Not Met – DME,” “Criteria Not Met –

Medical Procedure," and "Level of Care Dispute") are now to be tracked as "appeals" instead of "grievances."

Track Timely Resolution of Grievances

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

The number of grievances reported as resolved in a quarter includes some grievances from the previous quarter. As a result, the number of grievances reported as "received" each quarter does not equal the number of grievances "resolved" during the quarter.

Current Quarter Compared to Previous Quarters

As shown in Table 8, 86.8% (387) of the 446 grievances reported by the MCOs as closed in Q3 CY2016 were reported as resolved within 30 business days.

- Amerigroup and UnitedHealthcare reported that 100% of the grievances resolved in Q3 CY2016 (AGP – 118; UHC – 142) were resolved within 30 days.
- Sunflower reported 127 (68.4%) of 186 grievances closed in Q3 were resolved within 30 business days. The 59 grievances not resolved within 30 business days were resolved within 60 business days.

Table 8. Timeliness of Resolution of Grievances, Q1 to Q3 CY2016

	CY2016		
	Q1	Q2	Q3
Number of Grievances Received in Quarter	456	453	452
Number of Grievances Closed in Quarter*	437	465	446
Number of Grievances Closed in Quarter Resolved Within 30 Business Days*	433	452	387
Percent of Grievances closed in Quarter Resolved Within 30 Business Days	99.1%	97.2%	86.8%
Number of Grievances in Quarter Not Resolved within 30 Business Days	4	13	59
Number of Grievances Closed in Quarter Resolved Within 60 Business Days*	436	465	446
Percent of Grievances Closed in Quarter Resolved Within 60 Business Days	99.8%	100.0%	100.0%
Number of Grievances Closed in Quarter Not Resolved Within 60 Business Days*	1	0	0

*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 Q3 CY2016, the number of grievances received (452) was comparable to the number received in the previous two quarters.

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

All Grievances

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

Table 9. Grievance Categories - STC and GAR Reports	
STC Categories	**GAR Report Categories**
Claims/Billing Issues	Billing and Financial Issues
Access to Service or Care	Access to Service or Care
Quality of Care or Service	Quality of Care (non-HCBS) Quality of Care - HCBS
Customer Service	Customer Service
Transportation	Transportation Issue Transportation Safety Transportation No Show Transportation Late
Other	Other
Member Rights/Dignity	Member's Rights/Dignity
	Pharmacy Issues
	Value-Added Benefit
Benefit Denial or LImitation	
Clinical/Utilization Management	
Health Plan Administration	
Service or Care Disruption	

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

Using the same categories in both reports and/or providing guidance, criteria, and examples for the STC report categories would promote consistency and allow more complete assessment of grievances received and resolved over time. The STC categories should also be reviewed to assess whether any of the categories (such as "Benefit Denial or Limitation" or "Service or Care Disruption") may be appeals rather than grievances.

In the STC and GAR reports, MCOs reported they received 452 grievances in Q3 CY2016. In the STC report, the MCOs reported that 391 of the 452 were resolved within the quarter. The total number of grievances categorized in the STC Q3 report (see Table 10) adds up to 408 (instead of 452) due to errors in Amerigroup's STC report; Amerigroup reported receiving 118 grievances, but subcategories added up to 107.

Table 10. Number of Grievances in STC Reports by Category, Q1 CY2015 to Q3 CY2016*							
	CY2015				CY2016		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Total Grievances Received in Quarter	667	480	427	404	442	420	**452**
Grievances Resolved of those Received in the Quarter	573	420	366	379	407	357	**391**
Transportation	251	245	192	182	176	125	**172**
Claims/Billing Issues	217	56	44	62	90	86	**48**
Quality of Care or Service	53	40	57	22	36	34	**28**
Access to Service or Care	34	33	35	42	44	34	**41**
Health Plan Administration	13	19	11	9	16	10	**20**
Customer Service	49	67	36	42	27	30	**48**
Member Rights/Dignity	14	15	17	13	12	17	**16**
Benefit Denial or LImitation	24	10	12	8	10	8	**10**
Service or Care Disruption	6	4	3	6	14	7	**2**
Clinical/Utilization Management	4	2	0	2	5	1	**2**
Other	2	27	20	16	12	23	**21**
Total Grievances	**667**	**480**	**427**	**404**	**442**	**375**	**408**

*As reported by MCOs in STC reports.

Table 11 summarizes the numbers and categories of grievances resolved in Q3 CY2016 as reported in the GAR reports and illustrates the revisions in grievance categories beginning in Q2 CY2016.

Whereas prior to Q2 CY016, transportation-related grievances were categorized as “Timeliness,” “Availability,” “Attitude/Service of Staff,” Quality of Care or Service,” “Other,” “Lack of Information from Provider,” “Accessibility of Office,” and “Level of Care,” the revised GAR template now has specifically defined transportation categories: “Transportation – No Show,” “Transportation – Safety,” “Transportation – Late,” and “Transportation Issues” (defined as transportation issues not related to the other specific transportation categories). Adding these transportation categories to the GAR report will allow better comparisons with STC reports and promote better consistency in MCO reporting. The revised categories also allow better tracking of progress is addressing specific transportation-related grievances, such as transportation safety and “no shows.”

Despite the revised categories and the addition by KDHE of criteria descriptions and examples by category, KFMC found over 80 grievances that, as described by the MCOs in the Q3 GAR report, and in comparison to the grievance category definitions, appear to be misclassified. Over 75% of the potentially misclassified grievances identified were reported by Sunflower, including 27 transportation-related grievances categorized as “Access to service or care,” and 44 additional grievances in six other categories. In addition, the descriptions UnitedHealthcare provided for most grievances were, as in previous GAR reports, very limited, generally just repeating the grievance subcategory and limiting resolutions to documentation that a letter was sent to the member, making it difficult or impossible to determine whether the grievances were categorized appropriately.

Table 11. Comparison of Grievances Resolved, Q1 CY2015 to Q3 CY2016*							
	CY2015				CY2016		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Billing and Financial Issues						108	52
Claims/Billing Issues	227	86	63	77	97		
Quality of Care - non-HCBS/non-transportation						42	46
Quality of Care - HCBS						11	8
Quality of Care or Service	40	56	96	71	65		
Attitude/Service of Staff	116	144	138	120	108		
Customer Service						41	49
Member's Rights/Dignity						14	12
Access to Service or Care						50	77
Pharmacy Issues	9	10	3	11	9	20	24
Other	23	33	35	33	17	9	14
Value-added Benefit						6	9
Transportation - Late						22	27
Transportation - No Show						39	59
Transportation - Safety						14	7
Transportation - Other Issues						47	62
Availability	83	99	82	83	79		
Timeliness	86	83	24	26	31		
Lack of Information from Provider	3	5	5	2	2		
Level of Care Dispute	5	4	2	8	4		
Prior or Post Authorization	5	3	7	6	1		
Accessibility of Office	3	1	1	2	4		
Criteria Not Met - Medical Procedure	6	6	2	1	2		
Criteria Not Met - Durable Medical Equipment	2	2	1	-	2		
Criteria Not Met - Inpatient Hospitalization	2	-	1	-	-		
HCBS	12	-	7	3	-		
Sleep Studies	-	-	1	-	-		
Sterilization	-	1	1	1	-		
Overpayments	-	-	-	-	1		
Quality of Office, Building	-	-	-	1	-		
"AOR"	13	9	7	12	10		
Total	635	542	542	457	432	423	446

* As reported in quarterly grievance (GAR) reports.

Other potential errors in categorization, based on available descriptions, included:

- 17 Quality of Care (QOC) grievances categorized as “Access to Service or Care,” “Customer service,” “Member rights/dignity,” and “Other”;
- 11 “Access to service or care” grievances categorized as “Customer service,” “Member rights/dignity,” or “Other’;

- 16 "Customer service" grievances categorized as "Access to service or care," "Member rights/dignity," QOC, and "Other";
- Three "Billing and financial issues" grievances categorized as "Access to service or care," "Pharmacy," and "Other";
- Two "Value added benefit" grievances categorized as QOC and "Other"; and
- Nine "grievances" in seven categories that may be more appropriately categorized as appeal-related.

Table 12 reports the types of grievances resolved in Q3 CY2016 in total and by waiver, the number of members reporting grievances, and the number of transportation-related grievances.

Table 12. Comparison by Waiver for Grievances Resolved in Q3 CY2016*

	All members			Waiver members		Number of Grievances by Waiver Type^					
	# grievances	# members	Transportation-related	# grievances	# members	FE	I/DD	PD	SED	Autism	TBI
Billing and Financial Issues	52	46	-	12	7	4	1	6	1		
Access to Service or Care	77	71	27	19	15	3	3	6	1	1	5
Quality of Care (non-HCBS)	46	43	1	5	5	1	1	3			
Quality of Care - HCBS	8	8	-	8	8		3	4			1
Customer Service	49	46	1	16	15		4	8	2		2
Pharmacy Issues	24	23	-	5	5		1	3			1
Member's Rights/Dignity	12	10	1	7	6	1	1	3			2
Value-Added Benefit	9	9	-	3	3	1		2			
Transportation Issue	62	57	62	17	17	3	2	11			1
Transportation Safety	7	7	7	2	2	1		1			
Transportation No Show	59	55	59	23	21	6		13		1	3
Transportation Late	27	25	27	11	10	3	1	5	2		
Other	14	12	-	4	3			1	1		2
Total	446	412	185	132	117	23	17	66	7	2	17

*Includes grievances received in Quarter 2 CY2016 resolved in Quarter 3 CY2016.
^No grievances were categorized in Quarter 3 for Technology Assisted (TA) Waiver members.

Transportation-related grievances continued to be the most frequently reported grievances; MCOs reported resolution of 155 transportation-related grievances received from 144 members. Based on grievance details, however, an additional 30 grievances (27 SSHP, two UHC, and one AGP) were found to be transportation-related (see Table 12). Of the 185 transportation-related grievances, 70 (37.8%) were reported by Sunflower, 65 (35.1%) were reported by UnitedHealthcare, and 50 (27.0%) were reported by Amerigroup. Billing-related grievances continued to be the second most frequently reported grievances, with 46 members reporting 52 grievances, less than half the number (108) reported in Q2 CY2016.

As shown in Table 13, the percentage of transportation-related grievances was higher among waiver members (47.0%) compared to the total population (41.5%). Of the 446 grievances, 132 (29.6%) were from members receiving waiver services.

Table 13. Waiver-Related Grievances Resolved in Q3 CY2016				
	# Grievances	# Members Reporting Grievances	# Transportation-Related	% Transportation-Related
Physical Disability (PD)	65	54	33	50.8%
Frail Elderly (FE)	23	21	16	69.6%
Intellectual/Developmental Disability (I/DD)	17	17	4	23.5%
Traumatic Brain Injury (TBI)	18	7	5	27.8%
Serious Emotional Disturbance (SED)	7	7	2	28.6%
Technology Assisted (TA)	0	0	0	0.0%
Autism	2	2	2	100.0%
Waiver Members Total	132	108	62	47.0%
All Members Total	446	412	185	41.5%

The number and percentage of transportation-related grievances received from waiver members was higher in Q3 CY2016 than the three previous quarters. Of the 132 grievances received from 108 waiver members in Q3, 61 (47.0%) were transportation-related, compared to 46 (26.4%) in Q2 and 37 (34.6%) in Q1 CY2016. In CY2015, 47.6% of 538 waiver-related grievances were transportation related.

- Physical Disability (PD) waiver members had the most grievances in Q3, with 54 members reporting 65 grievances, 33 (50.8%) transportation-related. In Q2 CY2016, 66 PD waiver members reported 71 grievances, 26 (36.6%) transportation-related.
- Frail Elderly (FE) waiver members reported 23 grievances (21 members) in Q3, 16 (69.6%) transportation-related. In Q2 CY2016, 52 grievances were reported by 24 members, 12 (23.1%) transportation-related.
- Intellectual/Developmental Disability (I/DD) waiver members in Q3 reported 17 grievances (17 members), four (23.5%) transportation-related. In Q2 CY2016, 11 members reported 1 grievances, one (9.1%) transportation-related.
- Traumatic Brain Injury (TBI) waiver members reported 18 grievances (seven members), five (27.8%) transportation-related. In Q2 CY2016, 18 members reported 33 grievances, five (15.2%) transportation-related.
- Serious Emotional Disturbance (SED) waiver members reported seven grievances (seven members) in Q3, two (28.6%) transportation-related. In Q2 CY2016, six members reported six grievances, two (33.3%) transportation-related.
- Autism waiver members reported two grievances (two members) in Q3, both transportation related. In the six previous quarters, no grievances were reported as received from members on the Autism waiver.
- In Q3 CY2016, the MCOs did not report receiving grievances from Technical Assistance (TA) waiver members. In Q2 CY2016, one grievance was reported a grievance related to Billing and Financial Issues.

Access-Related Grievances

Of 408 grievances categorized in the STC report as received in Q3 CY2016, 41 (10.0%) were categorized as “Access to Service or Care” (see Table 10); and, of 446 grievances resolved in Q3 CY2016, 77 (17.3%) were categorized by the MCOs in their GAR reports as “Access to Service or Care” (see Table 11).

Until Q2 CY2016, there was no specific "Access to Service or Care" grievance category in the GAR report, which made it difficult to compare quarterly changes in the number of access-related grievances resolved. In Q1 CY2016, for example, 44 grievances identified in the STC report as "Access to Service or Care" could potentially have been categorized in the GAR report (based on grievance descriptions) as "Accessibility of Office," "Availability," "Quality of Care," "Level of Care Dispute," "Attitude/Service of Staff," and/or "Timeliness." Adding the "Access to Service or Care" category now allows much more consistent and accurate trend assessments of access-related grievances.

In the STC report, MCOs are asked to "insert a brief summary of trends and any actions taken to prevent recurrence." Amerigroup and UnitedHealthcare did not address trends and repeated the same descriptions from past quarterly STC reports. Sunflower, this quarter, added information on the absolute percentage difference in each category compared to the previous quarter.

- Amerigroup reported six access-related grievances received in Q3 CY2016. As identically described in eight previous STC reports, the summary of trends and actions to prevent recurrence was: "*Members had difficulty or were unable to obtain services or supplies. Plan continues to monitor grievances filed for Access to Service or Care for possible quality of care issues and repeat providers. Plan provider relations staff continues to monitor our network to identify service gaps and work with providers to contract with Amerigroup to perform key services for our members*."
- Sunflower reported 33 access-related grievances received in Q3. In the STC trend summary, Sunflower reported, *"Access to Service or Care consists 21% (33/160) of all total grievances resolved this quarter. This is a 2% increase from last quarter, which reported 19% (18/94) of all total grievances."* While the absolute difference in percentage is 2%, it should be noted that the relative difference was an 83.3% increase (18 access-related grievances in Q2 compared to 33 in Q3).
- UnitedHealthcare reported two access-related grievances received in Q3. These were described in this quarter's STC report and the three previous quarterly STC reports as, "*Service or care disruptions are tracked and trended monthly. Grievances related to service or care disruption this quarter occurred due to members having difficulty obtaining services from providers."*

In the Q3 GAR report, Sunflower categorized 67 resolved grievances as "Access to Service or Care." Based on the grievance descriptions, however, up to 45 of the 67 were misclassified as access-related, including 27 clearly transportation-related. (In the preceding analysis, including Tables 12 and 13, these 27 grievances were included in the 185 "transportation-related" grievances.) Other Sunflower grievances potentially misclassified as "Access to Service or Care" include three "Quality of Care – HCBS," six "Quality of Care, non-HCBS)," one "Pharmacy," six "Customer Service," one "Billing and Financial Issues," and one that appears to be an appeal and not a grievance. An additional 12 grievances received by Sunflower, categorized as "Value-Added Benefit" (five); "Customer Service" (three); "Member's rights dignity" (two), and "Other" (two), may be more correctly categorized as "Access to Service or Care."

Amerigroup categorized nine grievances resolved in Q3 as "Access to Service or Care." Based on the grievance descriptions, four grievances categorized as "Customer Service" may be better categorized as "Access to Service or Care."

UnitedHealthcare characterized one grievance in Q3 as "Access to Service or Care." Due to the lack of detail provided by UHC for grievance descriptions and resolutions, it is not possible to assess whether grievances have been categorized incorrectly.

Excluding the 27 misclassified transportation-related grievances, of 50 grievances reported in the GAR report as "Access to Service or Care" by 44 members in Q3 CY2016, 11 grievances (22%) were from 7 members receiving waiver services, including: one member receiving TBI waiver services (five grievances), three members receiving PD waiver services (three grievances), two members receiving I/DD waiver services, and one member receiving SED services. Of the 11 grievances, however, six may be better categorized as "Customer Service," and one may be better categorized as QOC.

Quality-Related Grievances

In Q3 CY2016, 28 (6.9%) of 408 grievances received were categorized in the STC report as being related to "Quality of Care or Service" (QOC). In the MCO Q3 GAR reports, 54 (12.1%) of 446 grievances reported as resolved were categorized as QOC, 46 as "Quality of Care (non-HCBS)" and eight "Quality of Care - HCBS.

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

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

- UnitedHealthcare did not provide descriptions of the 14 QOC grievances received in Q3. As in previous STC reports, they included the following language: "*Quality of Service or Care issues represented a wide variety of issues from unprofessional behavior to allegations of misdiagnosis. Provider relations advocates work together with facilities and physicians' offices to ensure member satisfaction and quality care is being provided. Quality of care grievances go through the MCOs confidential peer review process.*"
- Amerigroup reported receiving six QOC grievances in Q3. As in previous STC reports, Amerigroup summarized this quarter's grievance with the following language: "*Members felt they received inappropriate treatment from their treating provider*. *These issues were monitored by Quality Management Nurses as potential Quality of Care concerns. Plan continues to monitor providers and concerns for possible trends. Concerns that were investigated and substantiated were elevated to the medical director who followed up with providers on corrective action."*
- Sunflower reported eight QOC grievances received in Q3, and that, "*Quality of Service or Care grievances accounts for 5% (8/160) of all total grievances for this quarter. This is a 4 % decrease from last quarter, which reported 9% (8/94) of all total grievances."* (While the percentage the absolute percentage decreased, the number of QOC grievances reported in Q3 is the same as the previous quarter.)

Of the 54 QOC-related grievances reported by 51 members in the GAR report as resolved in Q3 CY2016, 13 (excluding one transportation-related) were from 13 members receiving waiver services, including:

- Four QOC (non-HCBS) grievances from four members – two PD waiver members, members, one FE waiver member, and one I/DD waiver member; and
- Eight HCBS-related QOC grievances from eight members – four PD waiver members, one TBI waiver members, and three I/DD waiver members.

In reviewing the descriptions of resolved grievances in the three MCOs' GAR reports for Q3, KFMC identified nine grievances categorized as QOC that would, based on the category criteria, be better

categorized as "Customer Service" (four UHC grievances), "Value-added Benefit" (one SSHP grievance), and four that may be better categorized as appeals. Due to the limited information and cut-off text descriptions of UHC grievance and resolution descriptions, it is not possible to assess whether grievances categorized by UnitedHealthcare are or are not related to QOC.

Recommendations

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

Ombudsman's Office

- ***Track the Number and Type of Assistance Provided by the Ombudsman's Office.***
- ***Evaluate Trends Regarding Types of Questions and Grievances Submitted to the Ombudsman's Office.***

Data Sources

The primary data source in Q3 CY2016 is the quarterly KanCare Ombudsman Update report.

Current Quarter and Trend over Time

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

The volunteer coordinator's responsibilities include recruitment of volunteers statewide to provide information and assistance to KanCare members, and referral as needed, to the Ombudsman or other State agency staff through the KanCare Ombudsman Volunteer Program. Recruitment of volunteers began in June 2015. The volunteer training includes three days of on-line training and two days of in-person training that include case studies and practice. Volunteers then receive three weeks of in-person mentoring by the Ombudsman and program coordinator. Volunteers provide assistance by phone and by appointment in person with filling out applications. In Q3 CY2016, the Wichita volunteer office had four active volunteers plus two volunteers in training, and provided assistance to 118 individuals (over 500 to date). A second satellite office, opened in July 2016 in Johnson County, now has four fully trained volunteers available to provide assistance, beginning with 39 contacts in Q3. Plans are underway for a third satellite office in Wyandotte County.

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.

The Ombudsman's office tracks contacts by contact method, caller type, and by specific issues. Beginning in Q4 CY2016, contacts to the satellite offices will be included in the tracking reports. The Ombudsman's Office is also required to track contacts by geographic area; trends by geography, however, are not included in the Ombudsman's quarterly reports. According to Kerrie Bacon, Ombudsman, callers' cities are often tracked, but many of the calls to the office are too short to gather additional demographic data and/or the callers prefer to not provide identifying information.

In Q1 CY2016, the number of contacts to the Ombudsman's office was more than double that of the previous quarter; in Q1 there were 1,130 total contacts, compared with 462 to 579 in the previous eight quarters, primarily due to requests for assistance related to Medicaid eligibility (see Table 14). In Q2 CY2016, the number of contacts dropped by 25% to 846, and dropped another 18.8% in Q3 to 687. The 687 contacts in Q3, however, was still higher than in Q1-Q4 of CY2014 and CY2015, and does not yet include contacts received in the satellite offices. In Q3 CY2016, 20.5% (141 of 687) of the contacts were MCO-related.

Table 14. Ombudsman's Office Contacts - All and MCO-Related, Q1 CY2014 to Q3 CY2016

	All Contacts	MCO-Related Contacts	% MCO-Related Contacts
CY2016			
Q1	1,130	250	22.1%
Q2	846	150	17.7%
Q3	687	141	20.5%
CY2015			
Q1	510	224	43.9%
Q2	462	208	45.0%
Q3	579	187	32.3%
Q4	524	139	26.5%
CY2014			
Q1	545	214	39.3%
Q2	474	210	44.3%
Q3	526	256	48.7%
Q4	547	210	38.4%

Since some contacts include more than one issue, the Ombudsman's Office tracks the number of certain issues addressed during contacts. Table 15 includes the counts of issue types, comparing Q3 CY2016 with Q1 and Q2 CY2016. The top two issues in Q1 to Q3 CY2016 were the same –"Medicaid Eligibility

Issues" and HCBS-related issues. In Q3 CY2016, however, there were 42 HCBS-related issues compared to 71 in Q2 and 144 in Q1 CY2016. The number of "Medicaid Eligibility Issues" also dropped from 512 in Q1 CY2016 to 244 in Q2, and then to 173 in Q3

The Ombudsman's Office also tracks and reports the number of the issues that are MCO-related (Table 15) and the timing to resolve the issues for those who contact the Ombudsman's Office each quarter. Tracking of resolutions of issues from KanCare members may be enhanced by review by the Ombudsman of the grievance details provided by the MCOs to the State in the quarterly GAR reports.

Table 15. Issues Submitted to Ombudsman's Office - All and MCO-Related, Q1 to Q3 CY2016

	Q1 CY2016			Q2 CY2016			Q3 CY2016		
	All	MCO-Related		All	MCO-Related		All	MCO-Related	
	#	#	%	#	#	%	#	#	%
Medicaid Eligibility Issues	512	72	14.1%	244	19	7.8%	173	20	11.6%
Appeals, Grievances	49	29	59.2%	42	20	47.6%	36	14	38.9%
Medical Service Issues	29	15	51.7%	20	11	55.0%	10	7	70.0%
Billing	43	20	46.5%	39	18	46.2%	37	18	48.6%
Durable Medical Equipment	7	7	100%	7	5	71.4%	2	1	50.0%
Pharmacy	24	14	58.3%	13	4	30.8%	11	8	72.7%
HCBS									
HCBS General Issues	69	39	56.5%	32	17	53.1%	16	6	37.5%
HCBS Eligibility Issues	45	17	37.8%	33	15	45.5%	21	9	42.9%
HCBS Reduction in Hours of Service	12	8	66.7%	4	4	100%	3	2	66.7%
HCBS Waiting List	18	3	16.7%	2	1	50.0%	2	1	50.0%
Care Coordinator Issues	7	6	85.7%	3	2	66.7%	6	6	100%
Transportation	6	4	66.7%	8	3	37.5%	6	5	83.3%
Nursing Facility Issues	40	7	17.5%	7	5	71.4%	22	4	18.2%
Housing Issues	8	1	12.5%	2	1	50.0%	2	0	0.0%
Access to Providers	7	4	57.1%	6	3	50.0%	9	4	44.4%
Change MCO	15	7	46.7%	3	2	66.7%	0	0	0%
Dental	4	2	50.0%	5	5	100%	5	3	60.0%
Other	332	56	16.9%	377	48	12.7%	381	64	16.8%
Total Issues & Percent MCO-Related	1,227	311	25.3%	847	183	21.6%	742	172	23.2%

Beginning in Q3 CY2014, due to improvements in the tracking system, the Ombudsman's Office began reporting contact issues by waiver-related type as well. As shown in Table 16, the number of waiver-related contacts dropped to 61 in Q3 CY2016, a 59.9% decrease compared to Q1 CY2016 (152 contacts) and a 30% decrease compared to Q2 (87 contacts). From Q3 CY2014 through Q3 CY2016, the number of waiver-related inquiries ranged from 61 this quarter (Q3 CY2016) to 152 in Q1 CY2016. The most frequent waiver-related issues were again for/from KanCare members receiving waiver services for Intellectual/Developmental Disability (I/DD) and Physical Disability (PD); of 61 waiver-related inquiries in Q3 CY2016, 21 were from members receiving I/DD waiver services and 13 were from members receiving PD waiver services.

Table 16. Waiver-Related Inquiries to the Ombudsman's Office, Q3 CY2014 to Q3 CY2016									
	CY2014		CY2015				CY2016		
Waiver	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Intellectual/Developmental Disability (I/DD)	42	36	35	25	29	28	48	27	**21**
Physical Disability (PD)	43	29	57	48	33	28	48	22	**13**
Technology Assisted (TA)	8	15	11	13	11	13	10	9	**4**
Frail Elderly (FE)	16	11	15	12	16	18	23	19	**10**
Traumatic Brain Injury (TBI)	19	10	10	9	7	9	10	3	**7**
Serious Emotional Disturbance (SED)	5	4	1	7	5	4	4	0	**1**
Autism	4	1	4	3	4	5	1	2	**2**
Money Follows the Person (MFP)	6	4	2	2	3	1	8	5	**3**
Total	**143**	**110**	**135**	**119**	**108**	**106**	**152**	**87**	**61**

Recommendations

1. Copies of the quarterly GAR reports should be made available to the Ombudsman to allow more complete review of grievance resolutions, particularly for members who have contacted the Ombudsman's office related to these grievances.
2. As the STCs include a requirement to track geographic residences of those who contact the Ombudsman's Office, regional trends in contacts (for example, by general area of the State, by county type, etc.) are recommended for inclusion in the Ombudsman's Office quarterly reports.

Conclusions Summary

Timely Resolution of Customer Service Inquiries

- In Q3 CY2016, 99.61% of the 97,059 member customer service inquiries received by the MCOs and 99.97% of the 43,809 provider customer service inquiries were resolved within two business days. All three MCOs in Q2 CY2016 met contractual requirements for resolving at least 98% of customer service inquiries within five business days.
- Two of the three MCOs (AGP and SSHP) met the contractual requirements to resolve 100% of inquiries within 15 business days; UHC reported 13 member customer inquiries not resolved within 15 business days. All provider inquiries were identified as resolved within 15 business days.
- The criteria used by the MCOs to categorize member and provider inquiries continue to vary by MCO. As a result, aggregated data for certain categories are more representative of only one of the MCOs rather than all three.
- Member customer service inquiries
  - Of the 97,059 member customer service inquiries in Q3 CY2016, 42.9% were received by Sunflower, 38.9% by UnitedHealthcare, and 18.2% by Amerigroup.
  - Benefit inquiries were the highest percentage (22.3%) of member inquiries.
  - As in previous quarters, there were categories where two thirds or more of the inquiries in the quarter were reported by one MCO; two of the five with over 70% of the inquiries reported by one MCO for the past eight quarters. This seems likely to be due to differing interpretations of

the criteria for several of the categories in the reporting template. The categories where over two thirds of the reported inquiries were from one MCO include:

- "Member emergent or crisis call" – 99.2% of 597 inquiries in Q3 CY2016 were reported by Sunflower. (CY2016: Q2 – 99.6%; Q1 99.7%; CY2015: Q4 – 99.4%; Q3 – 99.4%; Q2 - 99.8%; Q1 – 99.7%; CY2014: Q4 – 99.7%)
- "Update demographic information" – 79.2% of 14,985 inquiries in Q3 CY2016 were reported by Sunflower. (CY2016: Q2 – 78.9%; Q1 – 78.1%; CY2015: Q4 – 81.4%; Q3 – 82.1%; Q2 - 82.3%; Q1 – 82.1%; CY2014: Q4 – 71.0%)
- "Enrollment information" – 69.3% of 2,558 inquiries were reported in Q3 CY2016 by Amerigroup. (CY2016: Q1 – 75.8%; Q1 – 85.4%; CY2015: Q4 – 80.5%; Q3 – 76.8%; Q2 - 76.4%; Q1 CY2015 - 76.6%; CY2014: Q4 – 80.5%)
- "Care management or health plan program" – 86.4% of 1,363 inquiries in Q3 CY2016 were reported by Amerigroup. (Q2 – 82.1%)
- "Concern with access to service or care; or concern with service or care disruption" – 75.1% of 1,681 inquiries were reported in Q3 CY2016 by Sunflower. (Q2 – 69.7%)

  - The member customer service inquiry category "Concern with access to service or care; or concern with service or care disruption" seems to potentially describe contacts tracked as "grievances" or "appeals" in the State's STC and GAR reports. In Q3 CY2016, the MCOs received 1,681 contacts in this category that were in addition to the grievances and appeals reported by members.

- Provider customer service inquiries
  - Of the 43,809 provider inquiries received by MCOs in Q3 CY2016, Amerigroup received 36.5%, Sunflower 42.8%, and UnitedHealthcare 20.7%.
  - For providers, claim status inquiries were again the highest percentage (47.2%) of the 43,809 provider inquiries.
  - Categories where two thirds or more of the provider inquiries in Q3 were reported by only one MCO included:
    - "Authorization – New" – 98.3% of 1,870 inquiries in Q3 CY2016 were reported by Amerigroup. (CY2016: Q2 – 99.0%; Q1 – 99.0%; CY2015: Q4 – 98.6%, Q3– 98.0%; Q2– 99.1%; Q1– 99.1%; CY2014: Q4 – 98.1%)
    - "Update demographic information" – 95.3% of 549 inquiries were reported in Q3 CY2016 by Sunflower. (CY2016: Q2 – 95.4%; Q1 – 95.3%; CY2015: Q4 – 93.7%, Q3 – 96.2%; Q2 - 91.4%; Q1 - 95.5%; CY2014: Q4 - 99.5%)
    - "Coordination of benefits" – 79.5% of 429 inquiries were reported in Q3 CY2016 by UnitedHealthcare. (CY2016: Q2 – 77.5%; Q1 – 73.7%; CY2015: Q4 – 87.9%, Q3– 85.5%; Q2 - 76.8%; Q1 - 90.7%; CY2014: Q4 - 91.0%)
    - "Claim denial inquiry" – 68.6% of 5,540 inquiries in Q3 CY2016 were reported by UnitedHealthcare.
    - "Other" – 71.5% of 1,784 inquiries in Q3 CY2016 were reported by Sunflower. (CY2016: Q2 – 64.7%; Q1 – 74.7%)
  - Of the 17 provider inquiry categories, seven are focused on claims; the range of inquiries for each of the seven varied greatly by MCO. The combined total number of inquiries for these seven categories may allow better comparison of overall claims-related inquiries.

Timeliness of Claims Processing

- **Timeliness of meeting contractual requirements for processing clean claims within 30 days, non-clean claims within 60 days, and all claims within 90 days**
  - In Q2 CY2016, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days. Of 4,247,972 clean claims received in Q2 CY2016, 99.966% were processed within 30 days. Of the 1,465 clean claims not processed within 30 days, 91.2% (1,336) were claims received by Sunflower; 4.5% (66) were claims received by Amerigroup; and 4.3% (63) were claims received by UnitedHealthcare.
  - In Q2 CY2016, all of the MCOs reported that they met the contractual requirement of processing at least 99% of non-clean claims within 60 days. Of 155,776 non-clean claims received in Q2 CY 2016, 99.892% were processed within 60 days. Of the 168 non-clean claims not processed within 60 days, 91 (54.26%) were claims received by Amerigroup, 76 (45.2%) were claims received by Sunflower; and 1 (0.6%) was a claim received by UnitedHealthcare.
  - Of 4,403,748 "all claims" received in Q2 CY2016, 99.997% were processed within 90 days. Of the 118 claims not processed within 90 days, 66 (55.9%) were claims received by Amerigroup; 43 (36.4%) were claims received by Sunflower; and 9 (7.6%) were claims received by UnitedHealthcare.

- **Turnaround time (TAT) ranges for processing clean claims**
  - In Q3 CY2016, the average TAT for total services (excluding pharmacy claims) was 5.8 to 10.6 days in Q3 CY2016, compared with 5.2 to 9.1 days in Q2 CY2016.
  - The average TAT for processing clean claims for individual service types again varied by service type and by MCO.
    - Pharmacy - Clean pharmacy claims had the shortest turnaround times and were consistently processed on a same day basis by each of the three MCOs.
    - Hospital Inpatient – Hospital Inpatient claims had TATs in Q3 CY2016 ranging from 8.3 to 18.2 days, an increase compared to Q2 CY2016 (7.1 to 12.4) and Q1 CY2016 (8.1 to 15.1). Amerigroup had the shortest TATs in Q3 (8.3 to 10.0 days), an increase, however, compared to previous quarters. UnitedHealthcare had the highest TATs in Q3 (12.3 to 18.2 days), an increase compared to previous quarters. Sunflower's Q3 TAT (12.2 to 12.6) were higher than Q2 (11.6 to 12.4), but lower than in Q1 CY2016 (13.4 to 15.1).
    - Dental - Dental claims TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 6.0 to 13.0 days in Q3 CY2016. Sunflower had the shortest TATs each month (6.0 to 7.0 days); Amerigroup and UnitedHealthcare had TATs of 13.0 days in Q3 CY2016 and the previous three quarters.
    - Nursing Facilities – Nursing Facility claims had TATs ranging from 4.8 to 9.7 days in Q3, an increase compared to Q2 CY2016 (4.7 to 9.0 days). Amerigroup had the shortest TATs (4.8 to 5.7 days). Sunflower had the longest (8.8 to 9.7 days) in Q3, an increase compared to Q2 (8.6 to 9.0 days) and Q1 (7.5 to 9.0 days). UnitedHealthcare's TATs also increased in Q3 (7.6 to 8.8 days) compared to the previous two quarters.
    - HCBS – HCBS claims had monthly TATs in Q3 ranging from 7.8 to 10.8 days, an increase compared to Q2 (6.0 to 8.7 days). Amerigroup had the shortest TATs (7.8 to 8.3 days), compared to Sunflower (9.1 to 9.3 days) and UnitedHealthcare (8.1 to 10.8 days).
    - Behavioral Health (BH) – BH claims TATs ranged from 4.5 to 11.7 days in Q3 CY2016, an increase compared to Q2 (4.2 to 9.3 days) and Q1 (4.2 to 10.3 days). Amerigroup had the shortest TATs (4.5 to 5.4 days), compared to Sunflower (9.8 to 11.7 days) and UnitedHealthcare (8.3 to 10.0 days).

- Non-emergency transportation (NEMT) - Clean claims for NEMT had monthly average TATs ranging from 9.7 to 13.5 days in Q3, compared to 9.5 to 14.4 days in Q2 CY2016. Amerigroup had the longest TATs in Q3, ranging from 11.5 to 13.5 days, compared to 9.7 to 10.0 for Sunflower and 9.8 to 9.9 for UnitedHealthcare.
- Vision – The average TATs were consistently a week or longer in Q3 and previous quarters for all of the MCOs. In Q3 CY2016, the average monthly TATs ranged from 7.0 to 11.9 days, comparable to 7.0 to 12.0 in Q2.

Grievances

- Beginning in Q2 CY2016, grievances were reported using categories revised by State staff. The revised categories, defined criteria, and examples provided in the template and in the MCO staff training should result in clearer, more accurate, and more consistent reporting over time. Based on review of grievance descriptions in the GAR reports, up to 38% of Sunflower's grievances appear to be misclassified. UnitedHealthcare again this quarter provided only limited descriptions of grievances and grievance resolutions in the GAR report, making it difficult to assess whether other grievances are categorized appropriately.
- Grievance categories differ in the STC and GAR reports. Using the same categories in both reports would allow better comparisons over time of grievances received and resolved each quarter.
- Of 446 grievances reported as closed in Q3 CY2016, 86.8% (387) were resolved within 30 business days. The 59 grievances, received by Sunflower, not resolved within 30 days were resolved within 60 business days.
- In the STC and GAR reports, MCOs reported they received 452 grievances in Q3 CY2016. In the STC report, the MCOs reported that 391 of the 452 were resolved within the quarter. The total number of grievances categorized in the STC Q3 report adds up to 408 (instead of 452) due to errors in Amerigroup's STC report; Amerigroup reported receiving 118 grievances, but subcategories added up to 107.
- Descriptions by Amerigroup and UnitedHealthcare in the STC report of "trends and any actions taken to prevent recurrence" for most of the grievance categories include the same language each quarter whether there were three grievances or 33 grievances in the category that quarter. Sunflower added trend information this quarter, reporting "trend" based on the absolute percentage change (which may vary greatly depending on the number of grievances received).
- The grievance categories with the highest number of grievances were those related to transportation - 185 (41.5% of 446) grievances received in Q3. The 185 transportation-related grievances include 30 grievances misclassified as "Access to Service or Care" (27), "Customer Service" (1), "Quality of Care" (1), and "Member Rights/Dignity" (1). Billing-related grievances were second highest with 52 grievances, less than half the number reported in Q2 CY2016.
- Of 446 grievances reported as resolved by MCOs in Q3 CY2016, 132 (29.6%) were reported by 108 members receiving waiver services.
- Of the 446 grievances reported as resolved in Q3, 77 (17.3%) were categorized in the GAR report as "Access to Service or Care." At least 45 of these grievances, however, including 27 transportation-related grievances, appear to be incorrectly categorized.
- In Q3 CY2016, 54 grievances (12.1% of 446) were categorized as QOC, 46 as non-HCBS and eight HCBS-related. Of the 54 QOC-related grievances, 13 were from members receiving waiver services.

Ombudsman's Office

- As of Q3 CY2016, the Wichita volunteer office had four active volunteers plus two volunteers in training, and has provided assistance to over 500 individuals this year. A second satellite office,

opened in July 2016 in Johnson County, now has four fully trained volunteers available to provide assistance. Plans are underway for a third satellite office in Wyandotte County.

- In Q3 CY2016, the Ombudsman's Office tracked issues in 687 contacts and calls received, a decrease of 18.8% compared to the previous quarter, but higher than eight of the nine previous quarters.
- In Q3 CY2016, 20.5% (141 of 687) of the contacts were MCO-related, compared to 17.7% (150 of 846) in Q2 CY2016.
- The highest number of issues and inquiries in Q1 to Q3 CY2016 were related to Medicaid Eligibility and HCBS-related issues. In Q3 CY2016, however, there were 42 HCBS-related issues compared to 71 in Q2 and 144 in Q1 CY2016. The number of "Medicaid Eligibility Issues" also dropped from 512 in Q1 CY2016 to 244 in Q2, and then to 173 in Q3.
- The number of waiver-related contacts dropped to 61 in Q3 CY2016, a 59.9% decrease compared to Q1 CY2016 (152 contacts) and a 30% decrease compared to Q2 (87 contacts). From Q3 CY2014 through Q3 CY2016, the number of waiver-related inquiries ranged from 61 this quarter (Q3 CY2016) to 152 in Q1 CY2016. The most frequent waiver-related issues were again for/from KanCare members receiving waiver services for Intellectual/Developmental Disability (I/DD) and Physical Disability (PD); of 61 waiver-related inquiries in Q3 CY2016, 21 were from members receiving I/DD waiver services and 13 were from members receiving PD waiver services.

Recommendations Summary

Timely Resolution of Customer Service Inquiries

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

- The State should provide clear criteria to the MCOs for the member customer service category "*Concern with access to service or care; or concern with service or care disruption*" to ensure grievance and appeals contacts are not misclassified as customer service inquiries.
- Clear criteria for the seven claims-related provider customer service inquiry categories should be provided to allow better comparisons by MCO.

Timeliness of Claims Processing

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

Grievances

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

5. STC assessments of trend should be based not only on relative changes in percentage, but also on changes in the total number of grievances received by category.
6. UnitedHealthcare should provide more detailed descriptions of the grievances resolved each quarter and should ensure that text descriptions are not cut off mid-sentence. Resolution details should not be limited to verification that a letter of resolution was sent.

Ombudsman's Office

1. Copies of the quarterly GAR reports should be made available to the Ombudsman to allow more complete review of grievance resolutions, particularly for members who have contacted the Ombudsman's office related to these grievances.
2. As the STCs include a requirement to track geographic residences of those who contact the Ombudsman's Office, regional trends in contacts (for example, by general area of the State, by county type, etc.) are recommended for inclusion in the Ombudsman's Office quarterly reports.

End of report

KDHE Summary of Claims Adjudication Statistics –

January through September 2016 – KanCare MCOs

AMERIGROUP Service Type	Total claim count - YTD cumulative	total claim count $ value YTD cumulative	# claims denied – YTD cumulative	$ value of claims denied YTD cumulative	% claims denied – YTD cumulative
Hospital Inpatient	32,140	$1,071,867,696.78	4,730	$166,152,453.20	14.72%
Hospital Outpatient	258,193	$616,911,419.55	34,114	$72,984,675.95	13.21%
Pharmacy	1,512,500	$102,619,772.94	437,780	Not Applicable	28.94%
Dental	103,094	$27,586,604.07	7,991	$2,156,600.30	7.75%
Vision	62,206	$16,356,215.82	12,580	$3,793,787.46	20.22%
NEMT	89,201	$2,976,866.21	312	$17,271.50	0.35%
Medical (physical health not otherwise specified)	1,485,376	$901,392,723.58	188,233	$120,101,115.86	12.67%
Nursing Facilities-Total	70,974	$165,908,827.11	8,568	$15,006,203.78	12.07%
HCBS	149,469	$88,274,886.54	8,096	$4,986,171.14	5.42%
Behavioral Health	496,423	$66,829,920.40	49,191	$6,192,912.01	9.91%
Total All Services	4,259,576	$3,060,724,933.00	751,595	$391,391,191.20	17.64%

SUNFLOWER Service Type	Total claim count - YTD cumulative	total claim count $ value YTD cumulative	# claims denied – YTD cumulative	$ value of claims denied YTD cumulative	% claims denied – YTD cumulative
Hospital Inpatient	29,968	$1,073,929,561	7,609	$317,987,918	25.39%
Hospital Outpatient	276,665	$639,146,198	49,055	$109,571,154	17.73%
Pharmacy	2,363,159	$230,421,654.96	659,347	$125,262,003.19	27.90%
Dental	121,023	$30,572,050.61	11,867	$2,041,171.03	9.81%
Vision	75,391	$17,400,230.33	9,641	$2,317,884.03	12.79%
NEMT	112,530	$3,031,718.67	552	$14,365.33	0.49%
Medical (physical health not otherwise specified)	1,359,245	$707,830,205	184,687	$128,527,364	13.59%
Nursing Facilities-Total	102,247	$222,638,753	13,214	$37,721,328	12.92%
HCBS	437,653	$183,087,325	20,557	$8,887,677	4.70%
Behavioral Health	498,960	$80,580,482	53,057	$11,188,760	10.63%
Total All Services	5,376,841	$3,188,638,179	1,009,586	$743,519,623	18.78%

UNITED Service Type	Total claim count - YTD cumulative	total claim count $ value YTD cumulative	# claims denied – YTD cumulative	$ value of claims denied YTD cumulative	% claims denied – YTD cumulative
Hospital Inpatient	20,589	$752,674,005.84	5,120	$255,502,384.55	24.86%
Hospital Outpatient	231,326	$559,375,481.37	40,677	$121,858,097.91	17.58%
Pharmacy	1,298,200	$144,922,717.07	269,674	$56,723,902.55	20.77%
Dental	107,156	$29,348,114.77	8,117	$2,287,524.19	7.57%
Vision	60,301	$12,063,978.86	6,667	$1,465,546.17	11.06%
NEMT	118,710	$3,232,134.51	471	$15,467.41	0.40%
Medical (physical health not otherwise specified)	1,493,442	$688,774,042.45	221,509	$172,621,816.04	14.83%
Nursing Facilities-Total	68,782	$168,115,156.62	10,027	$29,511,586.41	14.58%
HCBS	268,166	$66,208,119.60	16,850	$4,134,723.17	6.28%
Behavioral Health	178,771	$66,515,145.90	11,252	$9,377,561.69	6.29%
Total All Services	3,845,443	$2,491,228,897	590,364	$653,498,610	15.35%