Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 12.31.17

State of Kansas

Kansas Department of Health and Environment

Division of Health Care Finance

KanCare
Section 1115 Quarterly Report
Demonstration Year: 5 (1/1/2017-12/31/2017)
Federal Fiscal Quarter: 1/2018 (10/17-12/17)

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I. Introduction

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

On August 6, 2012, the State of Kansas submitted a Medicaid Section 1115 demonstration proposal, entitled KanCare. That request was approved by the Centers for Medicare & Medicaid Services on December 27, 2012, effective from January 1, 2013, through December 31, 2017. The State submitted a one-year temporary extension request of this demonstration to CMS on July 31, 2017. The temporary extension was approved on October 13, 2017.

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

This six year demonstration will:

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

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

- Provide integration and coordination of care across the whole spectrum of health to include physical health, behavioral health, and LTSS/HCBS;
- Improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- Control Medicaid costs by emphasizing health, wellness, prevention and early detection as well as integration and coordination of care; and
- Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms as well.

This quarterly report is submitted pursuant to item #77 of the Centers for Medicare & Medicaid Services Special Terms and Conditions (STCs) issued 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 second quarter known as of December 31, 2017.

Demonstration Population	Enrollees at Close of Qtr. (12/31/2017)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	14,192	15,338	1,146
Population 2: ABD/SD Non Dual	28,716	29,367	651
Population 3: Adults	49,982	53,950	4,058
Population 4: Children	224,482	235,101	10,619
Population 5: DD Waiver	8,954	9,099	145
Population 6: LTC	20,525	21,216	691
Population 7: MN Dual	1,111	1,235	124
Population 8: MN Non Dual	1,060	1,160	100
Population 9: Waiver	4,218	4,363	145
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**353,150**	**370,829**	**17,679**

III. Outreach/Innovation

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

The KanCare Advisory Council consists of 13 members: 3 legislators representing the House and Senate, 1 representing mental health providers, 1 representing CDDOs, 2 representing physicians and hospitals, 3 representing KanCare members, 1 representing the developmental disabilities community, 1 former Kansas Senator, 1 representing pharmacists. The 4th quarter KanCare Advisory Council meeting took place on December 19, 2017 at Memorial Hall Auditorium. The agenda was as follows:

- Welcome
- Review and Approval of Minutes from Council Meeting, October 17, 2017
- KDHE Update – Jon Hamdorf, Director and Medicaid Director, Division of Health Care Finance, Kansas Department of Health and Environment
- KDADS Update – Amy Penrod, Commissioner of Community Supports & Programs, Kansas Department for Aging and Disability Services
- Updates on KanCare with Q&A
    a. Amerigroup Kansas
    b. Sunflower State Health Plan
    c. UnitedHealthcare Community Plan
- Miscellaneous Agenda Items
    a. Associated Press article update on nursing homes denying patient care
- Next Meeting of KanCare Advisory Council – February 27, 2018, Curtis State Office Building, 2:00 to 3:30 p.m.
- Adjourn

The meeting also included the annual KanCare Public Forum which was held from 3:00-4:00pm at Memorial Hall on December 19. There were presentations from KDHE and KDADS. A summary of the Annual Forum is attached to this report.

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

- Autism Advisory Council (quarterly)
- Money Follows the Person (quarterly) – ending this quarter
- PACE Program (quarterly)
- HCBS Provider Forum teleconferences (monthly)
- Long-term Care Roundtable with Department of Children & Families (quarterly)
- Big Tent Coalition meetings to discuss KanCare and stakeholder issues (monthly)
- Interhab (CDDO and I/DD Provider Association) board meetings (monthly)
- KACIL (centers for independent living) board meetings (monthly)
- Presentations, attendance, and information is available as requested by small groups, consumers, stakeholders, providers and associations across Kansas
- Community Mental Health Centers meetings to address billing and other concerns (monthly and quarterly)
- Series of workgroup meetings and committee meetings with the Managed Care Organizations and Community Mental Health Centers
- Regular meetings with the Kansas Hospital Association KanCare implementation technical assistance group
- Series of meetings with behavioral health institutions, private psychiatric hospitals, and Psychiatric Treatment Residential Facilities (PRTFs) to address care coordination and improved integration
- State Mental Health Hospital mental health reform meetings (quarterly)
- Medicaid Functional Eligibility Instrument (FE, PD & TBI) Advisory Workgroup

- 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 nine subcommittees such as Suicide Prevention, Justice Involved Youth and Adult, and Rural and Frontier
- Mental Health Excellence and grant project meetings
- Monthly Nursing Facility Stakeholder Meetings
- KDADS-CDDO-Stakeholder Meetings (quarterly)
- WSU-Community Engagement Institute Special Projects (weekly meeting) including HCBS Access Guide, Policy Gap Analysis, and Capacity Building survey
- KDADS-CDDO Eligibility workgroup tasked to update IDD Eligibility policy and Handbook- policy work meetings ran from 6/22/17 to 1/10/18

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 finalized an interim electronic PDF version of the credentialing forms and it is now posted for provider use on all KanCare credentialing websites. This workgroup is continuing its work with the Fiscal Agent to expand and upgrade the Provider Enrollment Portal, which will eventually incorporate many elements from the credentialing form. This Provider Enrollment Portal will be a centralized portal where providers can submit required documents one time rather than having to complete the same forms up to four different times. The new provider enrollment portal is designed to be intelligent and intuitive. It supports provider application for all for all provider types and specialties in the Kansas Medical Assistance Program. The new Provider Enrollment Wizard will be available March 2018. Training sessions and labs for providers are occurring in February 2018, and members of the credentialing workgroup helped test the training application.

KanCare Consumer and Specialized Issues (CSI) Workgroup

The CSI Workgroup met on December 12, 2017, at the Landon State Office Building in Topeka, KS. The meeting consisted of a written report from the KanCare Ombudsperson, Kerrie Bacon, and a continuation of the discussion on the adequacy of Nurses for the TA waiver. It was brought up by members that they wages paid to direct care worker had not changed in over a decade even though the state had increased payment to providers of HCBS services. Russell Nittler with KDHE gave an overview of the plan for KanCare with the upcoming KanCare 2.0 changes. KDHE accept feedback about the recent statewide KanCare 2.0

informational sessions. Work group members shared that the time slot of 2:00PM to 4:00PM which was not a good time for people to attend the sessions as people were working during that time (although we also had evening sessions). Suggestions of sending out information about the material provided before the presentations were made. As well as a suggestion about having press releases on the statewide informational tours. KDHE and KDADS leadership have chosen to disband the CSI workgroup. As the agencies move forward with KanCare 2.0 we will have quarterly meetings with a variety of advocacy organizations in 2018. These groups will also be part of a larger quarterly meeting with various provider associations.

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:

Amerigroup participated in over 277 events for the fourth quarter of 2017. This included partner development, sponsorships, member outreach and advocacy.

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

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

- KanCare 2.0 Meetings
- KS Health Alliance Meeting
- KS SMART Girls Conference
- KS Saint Francis Parent Meeting

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

The Community Relations Representatives participated in a variety of community events reaching approximately 14,200 Kansans in the fourth quarter. Amerigroup highly values the benefits of these activities which give them the opportunity to obtain valuable feedback and to cover current topics that are relevant to their members, such as: KAN Be Healthy screenings, transportation, diabetes, well child visits, employment, dental care, working with your PCPC, and more.

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

- Kansas Head Start Association
- KIDS Network of Kansas
- Kansas National Alliance on Mental Illness
- Special Olympics Kansas

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

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

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

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

- Member Advisory Committee HCBS
- Kansas Department for Aging and Disability Services
- The Kansas Association for the Medically Underserved (KAMU)
- KS Latino Health For All Coalition Meeting

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

Marketing Activities: During Q4 2017, Sunflower Health Plan sponsored local and statewide member and provider events as well as fundraisers and employee volunteer events. Sunflower's entry into the health insurance marketplace and Medicare Advantage markets helped place us in front of new KanCare and community members with additional amplification of our public health initiatives. Our social media channels have increased their reach, and we use those to engage the public and our members with valuable health information. Notable stakeholder programs and events for marketing during Q4 2017:

- 74th Annual Kansas Public Health Association (KPHA) Conference
- NAMI Conference
- Kearny County Health & Wellness Fair
- Topeka Heart Walk, American Heart Association
- Muscular Dystrophy Walk
- Johnson County's Senior Fair - Live Well, Age Well
- 2017 InterHab Power Up! Conference
- Special Olympics Fall Classic
- CVS In-Store Activation
- Arthritis Foundation, Jingle Bell Run

Outreach Activities**:** Sunflower Health Plan's outreach activities for the 4th Quarter 2017, centered on home visits, disability mentoring, and preventative care gaps. Sunflower's direct mail marketing material for the fourth quarter included member postcards and customized letters addressing preventive health care gaps for important screenings and immunizations. The health plan also continued member outreach for tobacco cessation. Sunflower continued its work with individuals and community agencies to address

the social determinants of health in Kansas communities. Examples of member outreach activities this quarter:

- Participated in 11 community health events serving all populations, including multiple community baby showers and Johnson County's Senior Fair - Live Well, Age Well.
- Held Sunflower Health Plan's quarterly Member and Community Advisory Committee meeting on November 29. The meeting was held online and via phone.
- Our quality improvement department continued to make warm calls to members to encourage them to close care gaps.
- Sunflower volunteered at the Special Olympics Fall Classic.

Advocacy Activities**:** Sunflower Health Plan's advocacy efforts for Q4 2017 centered on supports for people with disabilities, older Kansans and work to help all populations improve individual health literacy. Sunflower participated in the following advocacy activities during Q4 2017:

- Sponsored and participated in three Disability Mentoring Day events
- 2017 InterHab Power Up! Conference
- Wichita Aging Network Meeting
- Topeka Heart Walk, American Heart Association
- Muscular Dystrophy Walk
- NAMI Conference
- 2017 Oral Health Kansas Conference
- Alzheimer's Association Central and Western KS Chapter's Kansas Education Conference on Dementia

Information related to UnitedHealthcare Community Plan marketing, outreach and advocacy activities:
Marketing Activities: UnitedHealthcare Community Plan of Kansas continued to focus on member, provider, and community education regarding KanCare benefits and general health education. Plan staff completed new member welcome calls and Health Risk Assessments. UnitedHealthcare also engaged in other outreach calls to invite members to Community Baby Showers and Clinic Days. New members were sent ID Cards and new member welcome kits in a timely manner. UnitedHealthcare mailed members the HealthTalk Fall newsletter (a quarterly newsletter) with tips on living a healthier life. UnitedHealthcare delivered the quarterly Community Connections Newsletter to Providers with information that is important for their support of UnitedHealthcare Members. Throughout the quarter, UnitedHealthcare hosted a number of meetings and presentations with key providers, hospitals, Federally Qualified Health Centers (FQHC's) and Community Based Organizations like Kansas Food Bank, Hannah's House, Head Start and Parents as Teachers throughout the state that involved discussions around exploring innovative and collaborative opportunities. UHC was also a sponsor for the Oral Health Kansas Conference, the Interhab Power UP! Conference, and sponsored several Disability Mentoring Day events.

Outreach Activities: UnitedHealthcare Community Plan participated in and/or supported 74 member facing activities which included 26 lobby sits at provider offices as well as 22 events/Health Fairs or other educational opportunities for both consumers and providers. In Q4, UHC hosted a very successful Community Baby Shower with Community Partners in Ft. Scott where approximately 100 Consumers were in attendance. In addition, UHC helped organize the quarterly all MCO Wyandotte County Community Baby Shower. UnitedHealthcare also participated in and supported three other Baby Showers that were sponsored by other organizations. UnitedHealthcare leveraged bilingual Community Outreach Specialists that focused on activities targeted within assigned geographical areas across Kansas. These specialists are

fluent in both English and Spanish languages and effectively communicate with members with diverse cultural backgrounds. Additional Outreach Specialists supported activities in their respective territories. The Outreach Specialists regularly support one another working collaboratively to serve UHC Members. The key responsibility of the Outreach Specialist is to conduct educational outreach for members; community based organizations and targeted provider offices about Medicaid benefits, KanCare and UnitedHealthcare. Of key importance is to meet members where they are and help understand their personal goals and how we can help them reach those goals. UnitedHealthcare educates Members and Providers on Value Added Benefits and the features and benefits of KanCare. UnitedHealthcare also interacts with key provider offices and the provider community to assist with issue resolution. Several key outreach initiatives this quarter included lobby sits, "Food for Thought Programs" hosted on-site at provider offices, and several health fairs and clinic days throughout the state. UnitedHealthcare also participated in a number of community stakeholder committee meetings in the fourth quarter of 2017. In particular, a lot of focus and support was provided to the IRC (International Rescue Committee) that offers support to refugees in Kansas through the Wilson-Fish program. This population of refugees in Kansas is medically underserved and in need of help and support to get preventative medical care. UHC Advocates were key speakers and participants in IRC meetings.

Finally, UHC hosted the Q4 Member Advisory Meeting in Olathe. The Health Plan finds it critical to host meetings in different parts of the state in order to hear from those in both urban and rural areas. The meeting focused on UHCs 2018 Value Added Benefit and on the best means for communicating with members. Most in attendance stated a preference to receive information via email.

During the fourth quarter 2017, UnitedHealthcare staff personally met with approximately 8,772 individuals who were members or potential members at community events, at member orientation sessions, and at lobby sits held at key provider offices throughout Kansas.

During the fourth quarter 2017, UnitedHealthcare staff personally met with approximately 999 individuals from community based organizations located throughout Kansas. These organizations work directly with UHC members in various capacities. During the fourth quarter 2017, UnitedHealthcare staff personally met more than 1,626 individuals from provider offices located throughout the State.

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

Throughout this quarter, the team also worked closely with Health Plan Care Coordinators who support the waiver population. The Health Plan staff continued to stress to all members, including those with disabilities the desire to help support the members' personal goals and encouraged them to make informed decisions about enrollment in a KanCare plan. UnitedHealthcare also supported multiple Disability Mentoring Day events across the state with both sponsorships and attendance at the events. At these events, it is not uncommon to meet individuals with a newly acquired disability who need good referrals and basic information about programs and services available to them. Staff will also meet consumers new to KanCare who are trying to understand their benefits. UnitedHealthcare remains committed to providing ongoing support and education to members and offering support to the consumers of Kansas.

Health Plan members also supported multiple committees and coalitions surrounding the challenges faced by consumers navigating the health care world. Examples of some of these committees/ conferences include:

International Rescue Committee (IRC)

- Self-Advocate Coalition of Kansas
- Hays Community Service Council
- Pratt County Community Health & Resource Council
- Thomas County Health Coalition
- Great Bend Interagency Committee
- Migrants Program Committee
- Cultural Relations Board
- Ford County Health Coalition
- Lifestyle Diabetes Coaches Training
- Tobacco Cessation Work Group
- Interhab Power Up! Conference
- Kickin' it with WIC
- Wyandotte CDDO Provider Fair
- Douglas/Jefferson County Transition Council
- Transformers Committee
- Oral Health Kansas Conference
- Parent Leadership Conference
- Meetings with youth in school
- Governor's Conference on the Prevention of Child Abuse & Neglect
- FIMR (Fetal and Infant Mortality Rate) Advocacy Group
- Charting the Life Course Training

IV. Operational Developments/Issues

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

KanCare Amendment 27 was submitted to CMS for review and approval on October 19, 2017. The Amendments extend contracts with the three current MCOs from January 1, 2018 through December 31, 2018. Rates for 2018 were negotiated under separate amendments.

Six State Plan Amendments (SPA) were approved as noted below:

SPA Number	Subject	Submitted Date	Effective Date	Approval Date
17-006	Frontis page	9/19/17	8/18/17	12/20/2017
17-007	DRG outlier payment rates	9/19/17	8/18/17	12/08/2017
17-008	ICF/IDD rates	9/19/17	8/18/17	12/08/2017
17-009	Inpatient hospital rates	9/19/17	8/18/17	12/08/2017
17-010	NF rates	9/19/17	7/01/17	12/12/2017
17-011	Interim Hospital Billing	9/19/17	7/01/17	12/12/2017

The state plan amendment 17-004, NADAC, submitted on June 16, 2017 with an effective date of April 1, 2017 was approved by CMS on July 21, 2017.

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

b. Benefits: All pre-KanCare benefits continue, and the program includes value-added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value added services utilization, per each of the KanCare MCOs, by top three value-added services and total for January-December 2017, follows:

MCO	Value Added Service Jan.-Dec 2017	Units YTD	Value YTD
Amerigroup	Adult Dental Care	4,105	$508,242
	Member Incentive Program	20,284	$401,965
	Mail Order OTC	8,152	$148,404
	Total of all Amerigroup VAS	***34,157***	***$1,208,701***
Sunflower	CentAccount Debit Card	77,198	$827,461
	Dental Visits for Adults	7,260	$363,352
	Pharmacy Consultation	9,766	$232,764
	Total of all Sunflower VAS	***160,100***	***$1,912,716***
United	Rewards for Preventive Visits & Health Actions	45,532	$127,324
	Adult Dental Services	2,148	$124,672
	Home Helper Catalog Supplies	2,977	$97,833
	Total of all United VAS	***70,751***	***$787,393***

c. Enrollment issues: For the fourth quarter of calendar year 2017 there were 6 Native Americans who chose to not enroll in KanCare and who are still eligible for KanCare.

The table below represents the enrollment reason categories for the second quarter of calendar year 2017. All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Newborn Assignment	3
KDHE - Administrative Change	75
WEB - Change Assignment	19
KanCare Default - Case Continuity	157
KanCare Default – Morbidity	218
KanCare Default - 90 Day Retro-reattach	125
KanCare Default - Previous Assignment	401
KanCare Default - Continuity of Plan	588
AOE – Choice	423
Choice - Enrollment in KanCare MCO via Medicaid Application	1207
Change - Enrollment Form	340
Change - Choice	468
Change - Access to Care – Good Cause Reason	3
Change - Case Continuity – Good Cause Reason	5

Change – Due to Treatment not Available in Network – Good Cause	0
Assignment Adjustment Due to Eligibility	12
Total	**4044**

d. Grievances, appeals and state hearing information

MCOs' Grievance Database
CY17 4th quarter report

MCO	AMG	SUN	UHC	Total
QOC (non HCBS, Non Transportation)	11	24	21	56
Customer Service	12	24	12	48
Member Rights Dignity	2	2		4
Access to Service or Care	17	9	6	32
Pharmacy	3	2	8	13
QOC (HCBS)	3	9	3	15
Transportation -Reimbursement	8	9	3	20
Transportation - No Show	15	22	22	59
Transportation - Late	10	30	31	71
Transportation - Safety	9	6	4	19
No Driver Available		1		1
Transportation - Other	15	18	15	48
Value Added Benefits	6	4	4	14
Billing/Financial Issues (non-Transportation)	36	11	72	119
Other	1	1	3	5

MCOs' Appeals Database
Members – CY17 4th quarter report

Member Appeal Reasons AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal
MEDICAL NECESSITY DENIAL				
Criteria Not Met – Durable Medical Equipment	1 24 12	 1 	 13 4	1 10 8
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	2 1 40	1 31	1 2	 1 7
Criteria Not Met - Medical Procedure (NOS)	4 22 1	 	2 12 	2 10 1
Criteria Not Met - Radiology	3 13	 	2 4	1 9
Criteria Not Met - Pharmacy	10 58 48	 5 1	8 22 28	2 31 19
Criteria Not Met - PT/OT/ST	11		6	5
Criteria Not Met - Dental	4 2		1 	3 2

Criteria Not Met or Level of Care - Home Health	3		1	2
Criteria Not Met – Out of network provider, specialist or specific provider request	3		1	2
Criteria Not Met – Inpatient Behavioral Health	2 8			2 8
Criteria Not Met – Behavioral Health Outpatient Services and Testing	4 4 13	 1 	2 2 2	2 1 11
Level of Care - LTSS/HCBS	19 7	5 2	9 1	5 4
Level of Care – HCBS (change in attendant hours)	10 3 1		5	5 3 1
Other- Medical Necessity	3 3 1		 2 1	3 1
NONCOVERED SERVICE DENIAL				
Service not covered - Dental	4 1			4 1
Service not covered - Pharmacy	1			1
Service not covered – Out of Network providers	1			1
Service not covered – Durable Medical Equipment	4 6		2 4	2 2
Service not covered - Behavioral Health	1		1	
Other - Noncovered service	3 6 1	 1	1 5 	2 1
Lock In	1		1	
AUTHORIZATION DENIAL				
Late notification	1		1	
No authorization submitted	1	1		
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **72** **176** **123**	 **6** **10** **33**	 **33** **74** **39**	 **33** **92** **51**

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

MCO's Appeals Database

Member Appeal Summary – CY17 4th quarter report

AMG – Red **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**
Total Number of Appeals Resolved	72 176 123	6 10 33	33 74 39	33 92 51
Percentage Per Category		8% 6% 27%	46% 42% 32%	46% 52% 41%

MCOs' Appeals Database

Provider Appeal Summary – CY17 4th quarter report (appeals resolved)

Provider Appeal Reasons AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	MCO Determined Not Applicable
MEDICAL NECESSITY DENIAL					
Criteria Not Met – Durable Medical Equipment	10		1	9	
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	91 36 42		35 19 8	50 17 34	6
Criteria Not Met - Medical Procedure (NOS)	1			1	
Criteria Not Met - Radiology	11 17		6 5	5 12	
Criteria Not Met - Pharmacy					
Criteria Not Met - PT/OT/ST	2			2	
Criteria Not Met - Dental	4		2	2	
Criteria Not Met – Vision	50		27	22	1
Criteria Not Met – Home Health	1			1	
Criteria Not Met - Hospice	1			1	
Criteria Not Met – Out of network provider, specialist or specific provider request	1			1	
Criteria Not Met – Inpatient Behavioral Health	2 5		 1	1 4	1
Criteria Not Met – Behavioral Health Outpatient Services and Testing	3		3		
Level of Care - LTSS/HCBS	6		2	4	
Level of Care - LTC NF	4		1	3	
Level of Care – HCBS (change in attendant hours)	2		2		
Ambulance (include Air and Ground)	7		2	5	
Other-medical necessity	7		2	5	
BILLING AND FINANCIAL ISSUES					
Recoupment	2 11		2	 8	 3
Claim Denied – Contained Errors	293		34	259	
Claim Denied – by MCO in Error	2		2		
NONCOVERED SERVICE DENIAL					
Service not covered - Dental	5 8	1 2	4 5	 1	
Service not covered – Vision	5			5	
Service not covered - Home Health	7 6		2 1	5 2	 3
Service not covered - Pharmacy	7	3	1	3	
Service not covered – Out of Network Providers	208	1	49	125	33
Service not covered – OT/PT/Speech	2			2	

	4		4		
Service not covered – Durable Medical Equipment	13 9 1	2	8 3	3 6 1	
Service not covered - Behavioral Health	32		2	5	25
Other- not covered service	75 58 186	13 2	28 25	34 33 184	
PRIOR AUTHORIZATION DENIAL					
Late notification	19 28		1 10	14 16	4 2
No authorization submitted	91 31 80	6	33 11 28	52 20 42	 10
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **331** **294** **861**	 **25** **2** **3**	 **121** **124** **124**	 **174** **165** **660**	 **11** **3** **74**

Some categories from the above table that did not have any information to report for the quarter have been removed.
***Due to a system reconfiguration, United HealthCare is able to accurately report out of network provider appeals from CY2017 Qtr. 4 forward.*

MCO's Appeals Database
Provider Appeal Summary – CY17 4th quarter report

AMG – Red **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**	**MCO Determined Not Applicable**
Reconsideration	10267 4352 35713		4336 3185 24694	4462 1167 11019	1469
Resolved at 2nd Appeal Level	694 294 861	 2 3	267 124 124	316 165 660	111 3 74
TOTAL	10961 4646 36574	 2 3	4603 3309 24818	4778 1332 11679	1580 3 74
Percentage Per Category		 0% 0%	42% 71% 68%	44% 29% 32%	14% 0% 0%

MCO's Appeals Database
Provider Appeal – Denied Claim Analysis – CY17 4th quarter report

AMG – Red **SUN – Green** **UHC - Purple**	**Claim Denied- MCO in Error**	**Claim Denied- Provider Mistake or, Incorrect Billing**	**Correctly Billed and Correctly Denied**	**Number Resolved**
MEDICAL NECESSITY DENIAL	2 5	24 38	88 62	114 105
RECOUPMENTS			2	2
NONCOVLERED SERVICE DENIAL	48	48	11	107

	7	18	61	86
PRIOR AUTHORIZATION DENIAL	30 1	66 18	14 35	110 54
Total	80 13	138 74	113 160	331 247

**Due to system configuration errors United HealthCare was unable to provide us data to populate this table.*

State of Kansas Office of Administrative Fair Hearings
Members – CY17 4th 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**
Criteria Not Met – Durable Medical Equipment	1	2						
Criteria Not Met – Inpatient Admissions (Non-Behavioral Health)	1							
Criteria Not Met - Medical Procedure (NOS)		3						
Criteria Not Met – Radiology						1		
Criteria Not Met - Pharmacy		1				1		
Criteria Not Met - PT/OT/ST								
Criteria Not Met – Dental			2					
Criteria Not Met – out of network provider, specialist or specific provider request		1						
Criteria Not Met – Behavioral Health Outpatient Services and Testing			1					
Level of Care - LTSS/HCBS	1 1	1		1	1		1 2 1	
Level of Care – HCBS (change in attendant hours)	2				1		1	
NONCOVERED SERVICE DENIAL								

Service not covered – Pharmacy							1	
Other – Noncovered service					1 1			
TOTAL **AMG – Red** **SUN – Green** **UHC – Purple**	 3 3	 5 2 1	 3	 1	 2 1 1	 2	 2 3 1	

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

State of Kansas Office of Administrative Fair Hearings

Providers – CY17 4th 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**
MEDICAL NECESSITY DENIAL								
Criteria Not Met – Durable Medical Equipment							1	
Criteria Not Met – Inpatient Admissions (Non-Behavioral Health)	1 1 10	1	1				1	
Criteria Not Met - Pharmacy	 1		1	 7				
Criteria Not Met – Out of Network providers	1							
Level of Care – LTSS/HCBS						1		
Level of Care – Mental Health							1	
Service not covered – Pharmacy			1					
Service not covered – Out of Network providers	1							
Other - Noncovered service	1	1	 1			1		
BILLING AND FINANCIAL ISSUES								
Claim Denied – contained errors	1 1 4	8 3 3	5 5 11	 1	1	 6		
Claim Denied – by MCO in Error	 1	6 4	2 2	1		1		

		5						
Recoupment	20	10	1				2	
PRIOR AUTHORIZATION DENIAL								
No authorization submitted	5	3	1					
TOTAL **AMG – Red** **SUN – Green** **UHC – Purple**	 29 3 16	 29 7 8	 11 8 12	 2 1 7		 3 6	 2 2 1	

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

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

f. Changes in provider qualifications/standards: None.

g. Access: As noted in previous reports, members who are not in their open enrollment period are unable to change plans without a good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs. In Q3 2017, the volume reduced to 83 requests and, in Q4 2017, the number dropped to 47 requests.

The majority of good cause requests (GCRs) are due to members mistakenly believing that they can file good cause requests because they prefer a provider outside of their assigned MCO's network. GCRs still occur due to providers advising patients to file GCRs to switch plans. And as in previous quarters, GCRs filed after the choice period are denied as not reflective of good cause if the request is based solely on the member's preference, when other participating providers are available within access standards. In these cases, the MCOs are tasked with offering to assist the member in scheduling an appointment with one of their participating providers. The remaining requests show varied reasons and causes for changing plans.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the fourth quarter of 2017, there were no state fair hearings filed for a denied GCR. A summary of GCR actions this quarter is as follows:

Status	October	November	December
Total GCRs filed	24	12	11
Approved	2	0	0
Denied	15	5	7
Withdrawn (resolved, no need to change)	1	4	2
Dismissed (due to inability to contact the member)	6	3	2
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.

The method of data retrieval was changed in quarter one of 2017 to reflect the number of unique providers per name, NPI and city. Previously, the report indicated unique providers by name and NPI, eliminating multiple records for providers who served in more than one city. Since Kansas is a highly rural state with many providers serving in multiple clinic locales, this report was revised to be a more accurate reflection of network capacity. The MCOs continue to review and correct their data, which explains the changes in numbers:

KanCare MCO	# of Unique Providers as of 3/31/17	# of Unique Providers as of 6/30/17	# of Unique Providers as of 9/30/17	# of Unique Providers as of 12/31/17
Amerigroup	16,498/23,758	25,904	25,396	27,107
Sunflower	22,313/30,992	31,780	31,506	31,168
UHC	23,777/39,881	32,216	30,610	31,247

MLTSS implementation and operation: In the fourth quarter of 2017, Kansas continued to process the offers accepted by individuals on the HCBS-PD Program waiting list in September, as well as individuals on the HCBS-I/DD Program waiting list. Kansas offered services to 300 people on the HCBS-PD waiver wait list in the month of September. Of the 300 offers, 170 were accepted, for an overall acceptance rate of 56%. Following the September offer round, wait list cleanup began to reflect changes and update the wait list.

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

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 DY5.

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

- The State continues to work with stakeholders to formulate the most effective way to implement the Serious Emotional Disturbance (SED) waiver changes. The State is working closely with the MCOs and Community Mental Health centers to transition the plan of care creation in a smooth and efficient way. The State has continued to work with interested parties to identify a third party contractor capable of completing a statistically significant sample of CAFAS assessments as the new waiver dictates.
- The State continues to work with the MCOs and interested providers to build capacity needs for the Autism Waiver (AU) and State Plan services.

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 November 28 and 29, 2017, to review the current state of KanCare and HCBS services.
   - The committee received KanCare program updates from KDHE, including eligibility determinations, KanCare contracts re-procurement schedule, opioid crisis plan, CHIP reauthorization update, and MCO financial status.
   - The committee received information from KDADS about state hospital issues, HCBS waiver waiting list updates, and an update on PACE.
   - The committee also received presentations from each of the KanCare MCOs, 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, monthly KanCare Steering Committee and monthly joint and one-on-one meetings between KDHE, KDADS and MCO leadership. Policy changes are also communicated to MCOs through other scheduled and ad hoc meetings as necessary to ensure leadership and program staff are aware of the changes. All policies affecting the operation of the Kansas Medicaid program and MMIS are addressed through a defined and well-developed process that is inclusive (obtaining input from and receiving review by user groups, all affected business areas, the state Medicaid policy team, the state's fiscal agent and Medicaid leadership) and results in documentation of the approved change.

VI. Financial/Budget Neutrality Development/Issues

Budget neutrality: 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 DXC, the State's fiscal agent. The budget neutrality monitoring spreadsheet for QE 12.31.17 is attached. Utilizing the DXC-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 DXC, 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	*2017-10*	*2017-11*	*2017-12*	*Grand Total*
Population 1: ABD/SD Dual	14,840	14,433	14,196	43,469
Population 2: ABD/SD Non Dual	29,054	28,948	28,722	86,724
Population 3: Adults	51,234	51,033	49,893	152,160
Population 4: Children	226,329	226,364	224,487	677,180
Population 5: DD Waiver	9,003	9,006	8,956	26,965
Population 6: LTC	20,598	20,685	20,579	61,862
Population 7: MN Dual	1,204	1,144	1,111	3,459
Population 8: MN Non Dual	1,134	1,081	1,061	3,276
Population 9: Waiver	4,248	4,220	4,218	12,686
Grand Total	**357,644**	**356,914**	**353,223**	**1,067,781**

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

VIII. Consumer Issues

Consumer issues remain static. A summary of fourth quarter of 2017 consumer issues remains:

Issue	Resolution	Action Taken to Prevent Further Occurrences
Member spenddown issues – spenddown incorrectly applied by plans, causing unpaid claims and inflated patient out of pocket amounts.	MCOs work with the State to monitor and adjust incorrect spenddown amounts. Weekly spreadsheets are sent to the State, showing the MCO remediation efforts.	All affected plans have system correction projects and reprocessing projects continuing in progress. This information is posted on each plan's Issue logs, and the KanCare Claims Resolution Log for providers and the State to review and monitor. MCOs must report spenddown files to the State that track the spenddown files. Unfortunately, this has been a difficult system issue to resolve.
Delays in HCBS services when the member transitions from one MCO to another, or from one setting to another.	There are many reasons this can occur. If the provider must report transition (like a nursing facility) sometimes they fail to turn in the correct forms. We require certain forms before we can switch the level of care coding in MMIS. Sometimes KDADS or KDHE failed to do something to	MCOs are reviewing their notification processes to ensure that transitions go smoothly. An expedited review process is in place when level of care issues are found by MCOs – notice is sent to KDHE and KDADS to speed the

Issue	Resolution	Action Taken to Prevent Further Occurrences
	switch the MMIS coding. Finally the MCOs could fail to transfer service plans and other information when a member switches from one MCO to another.	process. Finally provider reps stress to nursing facilities the importance in the level of care change forms.
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.	MCOs are instructed to report Open/Closed panels for all provider types. MCOS have begun to report this information in 2017, and to actively collect and report this data in the quarterly reporting template. The State is also developing guidelines for the provider directory to be implemented soon as mandated by CMS.
Retroactively eligible members are denied authorizations or claims denied for timely filing.	Members are denied authorization, services and care coordination due to retroactive eligibility.	Some of the MCO processes require manual intervention, which may lead to errors. Also some MCOs require a claim to be submitted and denied before they can implement the retroactive eligibility protocol. All authorization and customer service employees receive frequent updates on how to deal with retro authorizations.

Support and assistance for consumers around the state for KanCare was provided by KDHE's out-stationed eligibility workers (OEW). OEW staff assisted in determining eligibility for 4,047 consumers during this quarter. OEW also assisted in resolving 2,882 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. These OEW staff assisted with 1,593 consumer phone calls.

During this quarter, OEW staff also participated in 18 community events providing KanCare program outreach, education and information for various Schools, Health Departments, FQHC clinics, public health fairs, Latino and Asian Wellness groups, Early Childhood Coordination Associations, Community Baby Showers, etc.

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

The following sources of information guide the ongoing review of and updates to the KanCare QIS:

Results of KanCare managed care organization (MCO) and state reporting, quality monitoring/onsite reviews and other KanCare contract monitoring results; external quality review findings and reports; feedback from governmental agencies, the KanCare MCOs, Medicaid providers, Medicaid members/consumers, and public health advocates; and leadership's review of and feedback regarding the overall KanCare quality plan. This combined information assists the 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 are regularly reviewed and operational details are continually evaluated, adjusted and put into use.

The State values a collaborative approach that allows 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 fourth quarter of 2017, some of the key quality assurance/monitoring activities have included:

- Business meetings between KDHE's MCO Management team and cross-function/leadership MCO staff to continue to further develop operational details regarding the KanCare State Quality Strategy. Specific attention was paid to development of the performance measures, pay-for-performance measures and performance improvement projects in the KanCare program.
- Ongoing automated report management, review and feedback between the State and the MCOs. Reports from the MCOs consist of a wide range of data reported on standardized templates.

- Ongoing interagency and cross-agency collaboration, and coordination with MCOs, to develop and communicate both specific templates to be used for reporting key components of performance for the KanCare program, as well as the protocols, processes and timelines to be used for the ongoing receipt, distribution, review and feedback regarding submitted reports. The process of report management, review and feedback is now automated to ensure efficient access to reported information and maximum utilization/feedback related to the data.
- Implementation and monitoring of the External Quality Review Organization (EQRO) work plan for 2017, 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.
- Meetings with the EQRO along with the MCOs, KDADS and KDHE to discuss EQRO activities and concerns.
- Compilation of the comprehensive 2016 annual compliance review 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 efficiency.
- Ongoing analysis and workgroups reviewing the new Managed Care rules with the associated changes for quality.
- Medicaid Fraud Control Unit monthly meetings to address fraud, waste, and abuse cases, referrals to MCOs and State, and collaborate on solutions to identify and prevent fraud, waste and abuse.
- Continued state staff participation in cross-agency long-term care meetings to report quality assurance and programmatic activities to KDHE for oversight and collaboration.
- Continued participation in weekly calls with each MCO to discuss ongoing provider and member issues, and to troubleshoot operational problems. Progress is monitored through these calls and through issue logs. Additionally, top management staff from KDADS, KDHE and the three MCOs meet monthly face-to-face to discuss issues and improvements to KanCare.
- Monitor large, global system issues through a weekly log issued to all MCOs and the State's fiscal agent. The resulting log is posted out on the KanCare website for providers and other interested parties to view. Continue monthly meetings to discuss trends and progress.
- Monitor member or provider specific issues through a tracking database that is shared with MCOs and KDADS for weekly review.
- For the programs administered by KDADS: The Quality Assurance (QA) process is designed to give continuous feedback to KDADS, KDHE and stakeholders regarding the quality of services being provided to KanCare members. KDADS quality assurance staff are integrated in the Survey, Certification and Credentialing Commission (SCCC) to align staff resources for efficient and timely performance measurement. QA staff review random samples of individual case files to monitor and report compliance with performance measures designated in Attachment J of the MCO contracts.
- Also for the programs administered by KDADS: These measures are monitored and reviewed in collaboration with program staff in the Community Services and Programs Commission and reported through the Financial and Information Services Commission at KDADS. This oversight is enhanced through collaboration with the Department of Children and Families and the Department of Health and Environment. During this quarter, HCBS performance measures were reported to CMS via the 372 reporting process. A quality assurance protocol and interpretative guidelines are utilized to document this process and have been established with the goal of ensuring consistency in the reviews. *HCBS Quality Review reports for April through June 2017 are attached to this report.*

- Below is the timeline that the KDADS Quality Review Team follows regarding the quality review process.

HCBS Quality Review Rolling Timeline							
	FISC/IT	**SCC**	**MCO/Assess**	**SCC**	**FISC**	**SCC**	**CSP**
Review Period (look back period)	Samples Pulled *Posted to QRT	Notification to MCO/Assess or Samples posted	MCO/Assessor Upload Period *(60 days)	Review of MCO data *(90 days)	Data pulled & Compiled (14 days)	Data & Findings Reviewed at LTC Meeting ***	Remediation Reviewed at LTC Meeting
01/01 – 03/31	4/1 – 4/15	4/16	4/16 – 6/15	5/16 – 8/15	8/30	October	November
04/01 – 06/30	7/1 – 7/15	7/16	7/16 – 9/15	8/16 – 11/15	11/30	January	February
07/01 – 09/30	10/1 – 10/15	10/16	10/16 – 12/15	11/16 – 2/15	3/2	April	May
10/01 – 12/31	1/1 – 1/15	1/16	1/16 – 3/15	2/16 – 5/15	5/30	July	August

X. Managed Care Reporting Requirements

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

- Summary and Comparison of Physical and Behavioral Health Network is posted at http://www.kancare.ks.gov/docs/default-source/policies-and-reports/network-adequacy-reporting/mco-network-access-2017.pdf?sfvrsn=6. This report pulls together a summary table from each MCO and provides a side-by-side comparison of the access maps for each plan by specialty.
- HCBS Service Providers by County: http://www.kancare.ks.gov/docs/default-source/policies-and-reports/network-adequacy-reporting/hcbs-providers-by-waiver-service---2017.pdf?sfvrsn=4, 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-December 2017:

KanCare Customer Service Report – Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:25	2.73%	181,639
Sunflower	0:17	1.48%	168,146
United	0:35	0.58%	173,544
DXC – Fiscal Agent	0.00	0.0%	15,737

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:28	2.61%	91,550
Sunflower	0:11	1.07%	97,802
United	1:06	.93%	90,375
DXC – Fiscal Agent	0.00	0.0%	16,245

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 – CY17 4th Quarter

Amerigroup 4th Qtr. Grievance Trends		
Total # of Resolved Grievances	148	
Top 5 Trends		
Trend 1: Billing/Financial Issues (Non Transportation)	36	24%
Trend 2: Access to Service or Care	17	11%
Trend 3: Transportation No Show	15	10%
Trend 4: Transportation - Other	15	10%
Trend 5: Customer Service	12	8%
***Transportation (Including Reimbursement) changed to Transportation Reimbursement in CY2017 4th Qtr. to include only Transportation Reimbursement Grievances. The category Transportation - Other was added in CY2017 Qtr. 4.**		

<u>Amerigroup Member Grievances:</u>

- The top five Amerigroup member grievances account for 95 (64%) of the total 141 member grievances for CY2017 Qtr. 4
- The largest number of member grievances submitted is Billing/Financial Issues (Non-Transportation) of which 22 (61%) of the 36 grievances are for providers balance billing
- Transportation member grievances for all six categories account for 36% of Amerigroup's member grievances this quarter which is an increase of 5% from CY2017 Qtr. 3

Sunflower 4th Qtr. Grievance Trends		
Total # of Resolved Grievances	172	
Top 5 Trends		
Trend 1: Transportation Late	30	17%
Trend 2: Quality of Care (non HCBS)	24	14%
Trend 3: Customer Service	24	14%
Trend 4: Transportation No Show	22	13%

Trend 5: Transportation - Other	18	10%
***Transportation (Including Reimbursement) changed to Transportation Reimbursement in CY2017 4th Qtr. to include only Reimbursement Grievances. The category Transportation - Other was added in CY2017 Qtr. 4.**		

Sunflower Member Grievances:

- The top five Sunflower member grievances account for 118 (69%) of the total 172 member grievances for CY2017 Qtr. 4.
- Transportation member grievances for all six categories account for 50% of Sunflower's member grievances this quarter which is an increase of 5% from CY2017 Qtr. 3.

United 4th Qtr. Grievance Trends		
Total # of Resolved Grievances	204	
Top 5 Trends		
Trend 1: Billing/Financial Issues (Non Transportation)	72	35%
Trend 2: Transportation Late	31	15%
Trend 3: Transportation (No Show)	22	11%
Trend 4: Quality of Care (non HCBS)	21	10%
Trend 5: Transportation - Other	15	7%
***Transportation (Including Reimbursement) changed to Transportation Reimbursement in CY2017 4th Qtr. to include only Reimbursement Grievances. The category Transportation - Other was added in CY2017 Qtr. 4.**		

United Member Grievances:

- The top five United member grievances account for 161 (79%) of the total 204 member grievances for CY2017 Qtr. 4
- Transportation member grievances for all six categories account for 37% of United's member grievances this quarter which is a decrease of 9% from CY2017 Qtr. 3

MCOs' Appeals Trends

Member/Provider – CY17 4th Quarter

Amerigroup 4th Qtr. Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	72		**Total # of Resolved Provider Appeals**	331	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Level of Care - LTSS/HCBS	19	26%	Trend 1: Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	91	27%
Trend 2: Criteria Not Met - Pharmacy	10	14%	Trend 2: No Authorization Submitted	91	27%
Trend 3: Level of Care - HCBS (change in attendant hours)	10	14%	Trend 3: Other - Not Covered Service	75	23%
Trend 4: Criteria Not Met - Medical Procedure (NOS) / Criteria Not Met - Behavioral Health Outpatient Services and Testing	4	6%	Trend 4: Late Notification	19	6%
Trend 5: Service not Covered - Dental / Service not Covered - Durable Medical Equipment	4	6%	Trend 5: Service Not Covered - Durable Medical Equipment	13	4%

Amerigroup Member Appeals:

- The top five Amerigroup member appeals account for 47 (65%) of the total 72 member appeals for CY2017 Qtr. 4
- The third largest number of member appeals submitted is Level of Care – HCBS (change in attendant hours) which is a significant increase from CY2017 Qtr. 3. This is the first quarter for CY2017 we have received any member appeals for this category

Amerigroup Provider Appeals:

- The top five Amerigroup provider appeals account for 289 (87%) of the total 331 provider appeals for CY2017 Qtr. 4
- The largest number of provider appeals submitted is Criteria Not Met – Inpatient Admissions (Non-Behavioral Health) with 91 provider appeals this quarter a significant increase of 61 from CY2017 Qtr. 3
- The second largest number of provider appeals submitted is No Authorization Submitted with 91 provider appeals this quarter a significant increase of 89 from CY2017 Qtr. 3
- The third largest number of provider appeals submitted is Other – Not Covered Service with 75 provider appeals this quarter a significant increase of 73 from CY2017 Qtr. 3
- The fifth largest number of provider appeals submitted is Service Not Covered – Durable Medical Equipment with 13 provider appeals this quarter a significant increase of 12 from CY2017 Qtr. 3.
- Amerigroup's total of 331 provider appeals this quarter is a significant decrease of 207 from CY2017 Qtr. 3 total of 538 provider appeals

Sunflower 4th Qtr. Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	176		**Total # of Resolved Provider Appeals**	294	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Criteria Not Met - Pharmacy	58	33%	Trend 1: Other - Not Covered Service	58	20%
Trend 2: Criteria Not met - Durable Medical Equipment	24	14%	Trend 2: Criteria Not Met - Vision	50	17%
Trend 3: Criteria Not Met - Medical Procedures (NOS)	22	13%	Trend 3: Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	36	12%
Trend 4: Criteria Not met - Radiology	13	7%	Trend 4: No Authorization Submitted	31	11%
Trend 5: Criteria Not Met - PT/OT/ST	11	6%	Trend 5: Late Notification	28	10%

Sunflower Member Appeals:

- The top five Sunflower member appeals account for 128 (73%) of the total 176 member appeals for CY2017 Qtr. 4
- The fifth largest number of member appeals submitted is Criteria Not Met – PT/OT/ST which is a significant increase of 10 from CY2017 Qtr. 3

Sunflower Provider Appeals:

- The top five Sunflower provider appeals account for 203 (69%) of the total 294 provider appeals for CY2017 Qtr. 4
- The largest number of provider appeals submitted is Other – Not Covered Service with 58 provider appeals this quarter a significant increase of 47 from CY2017 Qtr. 3
- The second largest number of provider appeals submitted is Criteria Not Met – Vision with 50 provider appeals this quarter a significant increase of 13 from CY2017 Qtr. 3

- Sunflower's total of 294 provider appeals this quarter is a significant decrease of 142 from CY2017 Qtr. 3 total of 436 provider appeals

United 4th Qtr. Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	123		**Total # of Resolved Provider Appeals**	861	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Criteria Not Met - Pharmacy	48	39%	Trend 1: Claim Denied - Contained Errors	293	34%
Trend 2: Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	40	33%	Trend 2: Criteria Not Met - Out of network provider, specialist or specific provider request	208	24%
Trend 3: Criteria Not Met - Behavioral Health Outpatient Services and Testing	13	11%	Trend 3: Other - Not Covered Service	186	22%
Trend 4: Criteria Not Met - Durable Medical Equipment	12	10%	Trend 4: No Authorization Submitted	80	9%
Trend 5: Criteria Not Met - Out of network provider, specialist or specific provider request	3	2%	Trend 5: Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	42	5%

United Member Appeals:

- The top five United member appeals account for 116 (94%) of the total 123 member appeals for CY2017 Qtr. 4
- The second number of member appeals submitted is Criteria Not Met – Inpatient Admissions (Non-Behavioral Health) with 40 member appeals this quarter a significant increase of 12 from CY2017 Qtr. 3

United Provider Appeals:

- The top five United provider appeals account for 809 (99%) of the total 861 provider appeals for CY2017 Qtr. 4
- The largest number of provider appeals submitted is Claim Denied – Contained Errors with 293 provider appeals this quarter a significant increase of 11 from CY2017 Qtr. 3
- The second number of provider appeals submitted is Criteria Not Met – Out of Network Provider, Specialist or Specific Provider Request with 208 provider appeals this quarter a significant increase of 208 from CY2017 Qtr. 3. United HealthCare reconfigured their system to accurately report out of network appeals in CY2017 Qtr. 4 going forward
- The third number of provider appeals submitted is Other – Not Covered Service with 186 provider appeals this quarter a significant increase of 166 from CY2017 Qtr. 3
- The fourth number of provider appeals submitted is No Authorization Submitted with 80 provider appeals this quarter a significant increase of 25 from CY2017 Qtr. 3
- United's total of 861 provider appeals this quarter is a significant increase of 418 from CY2017 Qtr. 3 total of 443 provider appeals

MCOs' State Fair Hearing Reversed Decisions
Member/Provider – CY17 4th Quarter

- There was a total of 30 Member State Fair Hearings for all three MCOs. No decisions were reversed by OAH.

- There was a total of 147 Provider State Fair Hearings for all three MCOs. No decisions were reversed by OAH.

Amerigroup 4th Qtr.					
Total # of Member SFH	12		Total # of Provider SFH	76	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%

Sunflower 4th Qtr.					
Total # of Member SFH	14		Total # of Provider SFH	27	
OAH reversed MCO decision	1	9%	OAH reversed MCO decision	0	0%

United 4th Qtr.					
Total # of Member SFH	4		Total # of Provider SFH	44	
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 fourth quarter of 2017 is attached.

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

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

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

- Developing an automatic feed to pull APS and CPS reports into the AIR system
- Creating reports for each performance measure – specifically unexpected death, restraint, seclusion and restrictive interventions.
- Making final revisions to AIR, if needed, by KDADS IT

- Training MCO representatives once all system changes are in place
- Scheduling monthly meetings with each MCO to provide the appropriate amount of oversight of the AIR system, analyze trends and drill down in to any specific cases as necessary.

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

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

AIR is not intended to replace the State reporting system for abuse, neglect and exploitation (ANE) of individuals who are served on the behavioral health and HCBS programs. ANE substantiations are reported separately to KDADS from the Department of Children and Families (DCF) and monitored by the KDADS program integrity team. The program integrity team ensures individuals with reported ANE are receiving adequate supports and protections available through KDADS programs, KanCare, and other community resources. A summary of the 2017 AIRS reports through the quarter ending December 31, 2017 follows:

Critical Incidents	**1st Qtr.**	**2nd Qtr.**	**3rd Qtr.**	**4th Qtr.**	**YTD**
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	**TOTALS**
Reviewed	1,610	1,903	1,776	1,658	6,947
Pending Resolution	0	0	0	0	0
Total Received	1,610	1,903	1,776	1,658	6,947
APS Substantiations*	58	93	114	119	384

**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 fourth quarter HCAIP UCC Pool payment was made December 7, 2017. The LPTH/BCCH Pool fourth quarter payment will be made in February 2018.

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

XII. Demonstration Evaluation

The entity selected by KDHE to conduct KanCare Evaluation reviews and reports is the Kansas Foundation for Medical Care (KFMC). The draft KanCare evaluation design was submitted by Kansas to CMS on April 26, 2013. CMS conducted review and provided feedback to Kansas on June 25, 2013. Kansas addressed that feedback, and the final design was completed and submitted by Kansas to CMS on August 23, 2013. On September 11, 2013, Kansas was informed that the Evaluation Design had been approved by CMS with no changes. KFMC developed and submitted quarterly evaluation reports, annual evaluation reports for 2013, 2014 and 2015, as well as a revised evaluation design in March 2015.

For the quarter ending 12.31.17, 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-December, 2016, is attached.

b. Waiting List Management

PD Waiting List Management

For the quarter ending December 31, 2017:

- Current number of individuals on the PD Waiting List: 1,560
- Number of individuals added to the waiting list: 429
- Number of individuals removed from the waiting list: 272
    - 99 started receiving HCBS-PD waiver services
    - 9 were deceased
    - 164 were removed for other reasons (refused services, voluntary removal, etc.)

I/DD Waiting List Management

For the quarter ending December 31, 2017:

- Current number of individuals on the I/DD Waiting List: 3,697
- Number of individuals added to the waiting list: 158
- Number of individuals removed from the waiting list: 250
    - 168 started receiving HCBS-I/DD waiver services
    - 3 were deceased
    - 79 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 8,954 individuals.

XIV. Enclosures/Attachments

Section of Report Where Attachment Noted	Description of Attachment
III	2017 Annual Forum Summary
VI	KanCare Budget Neutrality Monitoring Spreadsheet for QE 12.31.17
IX	HCBS Quality Data Report for April-June 2017
X(e)	Summary of KanCare Ombudsman Activities for QE 12.31.17
XI	KanCare Safety Net Care Pool Report for QE 12.31.17
XII	KFMC KanCare Evaluation Report for QE 12.31.17
XIII(a)	KDHE Summary of Claims Adjudication Statistics for January-December 2016

XV. State Contacts

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Jeff.Andersen@ks.gov
Jonathan.Hamdorf@ks.gov

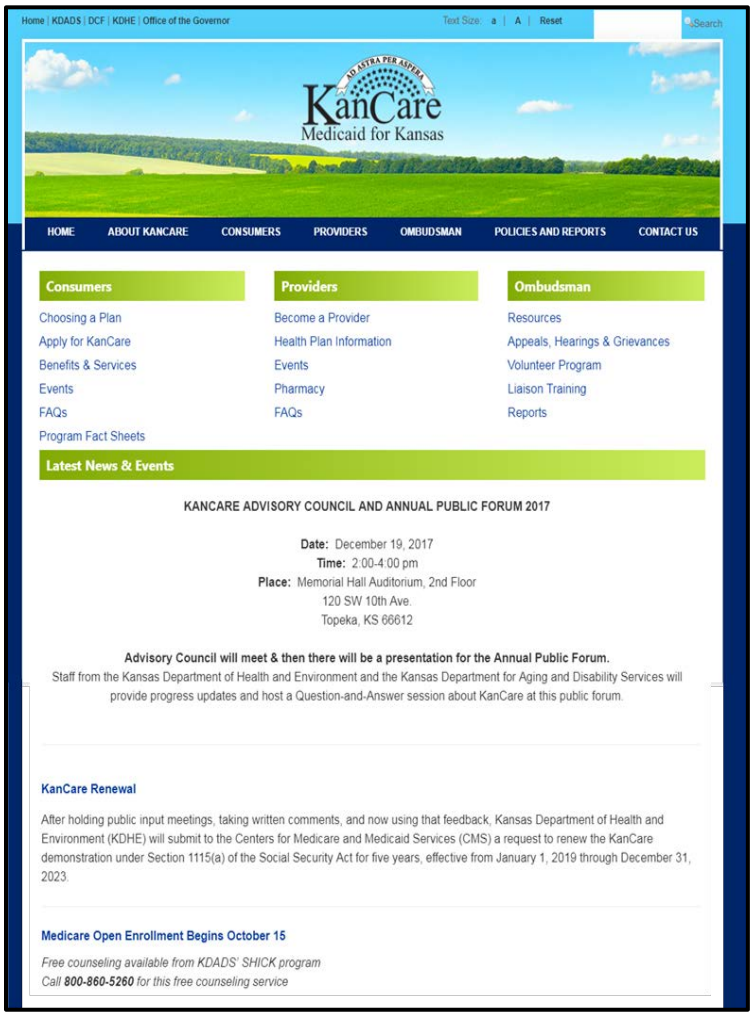
XVI. Date Submitted to CMS

March 14, 2018

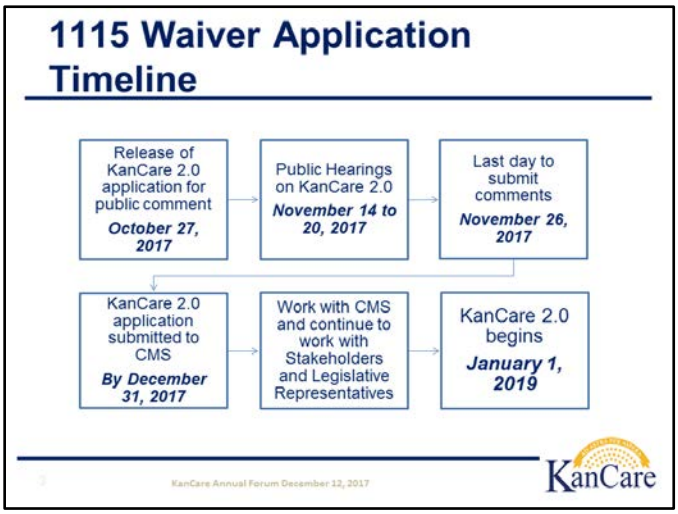
Summary of KanCare Annual Post Award Forum Held 12.19.17

The KanCare Special Terms and Conditions, at item #15, provide that annually "the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. … The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in STC77, associated with the quarter in which the forum was held. The state must also include the summary of its annual report as required in STC78."

Consistent with this provision, Kansas held its 2017 KanCare Public Forum, providing updates and opportunity for input, on Tuesday, December 19, 2016, from 3:00-4:00 pm at the Memorial Hall Auditorium, 2nd Floor, 120 SW 10th Avenue, Topeka, Kansas. The forum was published as a "Latest News and Events" on the face page banner of the www.KanCare.ks.gov website, starting on November 6, 2017. A screen shot of the notice linked from the KanCare website face page banner is as follows:



At the public forum, approximately 20 KanCare program stakeholders (providers, members, and families) attended, as well staff from the Kansas Department of Health and Environment; staff from the Kansas Department of Aging and Disability Services; and staff from the KanCare managed care organizations. A summary of the information presented by state staff is included in the following PowerPoint documents:



KanCare Utilization

- Members have used their Primary Care Physician 19% more with KanCare.
- Members are more likely to attend their appointments; Transportation up 58%.
- Costly inpatient hospital stays have been reduced by 30%.
- Emergency Room use down by 6%.

KanCare Utilization
KanCare vs. Pre-KanCare (2012)

Type of Service	% Utilization Difference
Primary Care Physician	19%
Transporation	58%
Outpatient Non-ER	9%
Inpatient	-30%
Outpatient ER	-6%
Dental	30%
Pharmacy	2%
Vision	17%

As of October 2017

KanCare HCBS Waiver Utilization

- Waiver members have used their Primary Care Physician 19% more with KanCare.
- Members are more likely to attend their appointments; Non-Emergency transportation use up 52%.
- Costly inpatient hospital stays have been reduced by 16%.
- Emergency Room use up by 1%

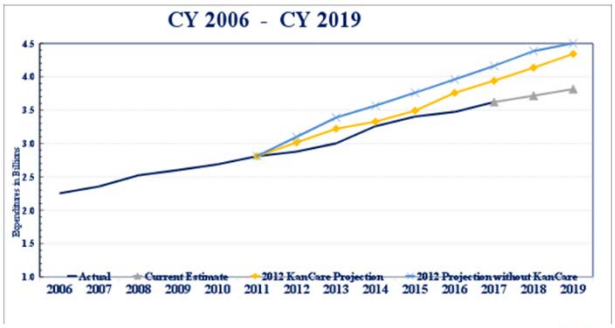
KanCare Utilization In Waiver Population
KanCare vs. Pre-KanCare (2012)

Type of Service	% Utilization Difference
Primary Care Physician	19%
Transporation NEMT	52%
Outpatient Non-ER	6%
Inpatient	-16%
Outpatient ER	1%
Dental	23%
Pharmacy	12%
Vision	27%
HCBS Services	31%

SED, DD, PD, FE, Autism, TA, and TBI

As of October 2017

KanCare Cost Comparison

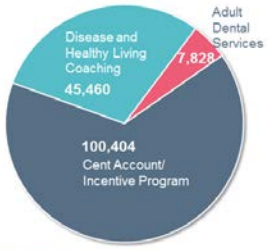


KanCare New Services

at no cost to the State

Top 3 Services by Expenditure

Top 3 Services Accessed by Members



Since the beginning of KanCare, members have been provided more than $18 million dollars in total value of services they did not have access to under old Medicaid at no cost to the state.

KanCare
Calender Year 2017 YTD

CHIP Reauthorization

Current Funds Expire in March 2018

CHIP Reauthorization legislation currently discussed in House and Senate bills

Kansas Medicaid has developed contingency plans if CHIP is reauthorized or if it is not. This plan includes:

- New eligibility category to align with CHIP eligibility
- System changes to support new eligibility determination
- Notification plan for individuals enrolled in CHIP
- Transition from CHIP to Medicaid

KanCare

CHIP Reauthorization

Additional State Expenditures from CHIP not being reauthorized:

SFY 2018 Forecasted budget impact:

SGF: $37,719,937

SFY 2019 Forecasted budget impact:

SGF: $53,355,911

KanCare

Opioid Strategy

5 Key Domains:

1. Opioid Supply Policy
Reduce number of opioids prescribed and in medicine cabinets in Kansas.

2. Opioid Demand Policy
Introduce alternative pain strategies and develop step-down protocols to reduce the number of people needing intensive opioid-based pain management regimens.

3. Opioid Treatment Policy
Expand access to proven treatments for opioid use disorder and dependence.

Opioid Strategy

5 Key Domains:

4. Opioid Prevention Policy
Implement programs to educate on dangers of opioids and on preventive measures to reduce the number of conditions that require intensive pain management.

5. Opioid Enforcement Policy
Work with law enforcement and the Attorney General's office to identify and prosecute illegal sales and trafficking of synthetic and diversion opioids.

Current KanCare Opioid Activities

1. KanCare Prescribing Guidelines
Update KanCare Opioid prescribing guidelines to be reviewed by KDHE leadership and ultimately presented to the Drug Utilization Review (DUR) board in January 2018.
- Led by KDHE Leadership and DHCF,
- Supply-side policy to reduce opioid prescriptions.

2. Kansas Prescription Drug Prevention Workgroup
Grant funded workgroup targeting treatment and recovery activities, with the remainder going to prevention, early intervention and public education.
- Led by Bureau of Health Promotion, and KDADS,
- Treatment and prevention policy directive.

Current KanCare Opioid Activities

(Continued)

3. KanCare 2.0 – 1115 Waiver
Institutions for Mental Diseases (IMD) Exclusion as part of 1115 waiver

4. Other Meetings with key stakeholders
Attorney general (enforcement initiatives), University of Kansas Heart and Stroke Collaborative (PCORI opioid grant proposal), Board of Pharmacy (K-TRACS roadmap),

KanCare Corrective Action Plan (CAP) Update

- Kansas Medicaid Enterprise (KME) is on schedule to complete all tasks by December 2017 as required in the CAP
- KME has met with CMS bi-weekly throughout CY 2017 to obtain CMS support and approval for completing CAP tasks
- Where CMS identified deficiencies, KME is developing operating procedures to better guide staff monitoring tasks
- KME is finalizing system components for real-time reporting of long-term services and supports (LTSS) critical incidents
- KDADS is revising policies for its person-centered planning process to be more member-centric for members receiving home and community-based services (HCBS)

KanCare Corrective Action Plan (CAP) Update (Continued)

CAP Progress by Task Area	
Task Area	**% of Tasks Completed**
Administrative Authority	77%
Person-Centered Planning	82%
Provider Access and Network Adequacy	85%
Participant Protections	79%
Support for Beneficiaries	92%
Stakeholder Engagement Process Development	100%
Overall % of CAP Tasks Complete	**83%**

KanCare Advisory Council and Annual Public Forum

KDADS Update

December 19, 2017

1

HCBS November Monthly Summary

HCBS Program	Description of Services	Number of People Eligible to Receive HCBS Services		Number of People on Wait List	Number of Proposed Recipients
		Without MFP	MFP		
Autism	This program provides services to children with Autism to receive early intensive intervention treatment and allow primary caregivers to receive needed support through services.	55			279 (as of 11/30/17)
SED (Serious Emotional Disturbance)	The Home and Community Based Services (HCBS) Serious Emotional Disturbance (SED) Waiver serves as an alternative to inpatient psychiatric treatment for children and youth with mental health disorders.	3,189			
TA (Technology Assisted)	This program serves individuals who are age 0 through 21 years, chronically ill or medically fragile and dependent upon a ventilator or medical device to compensate for the loss of vital bodily function and require substantial and ongoing daily care by a nurse or other qualified caregiver under the supervision of a nurse to avert death or	496			
FE (Frail Elderly)	This program provides an option for Kansas seniors who receive Medicaid and qualify functionally to receive community based services as an alternative to nursing facility care. Services include personal case, household tasks, and health services.	4,817	58		
TBI (Traumatic Brain Injury)	This program is for individuals who have sustained a traumatic brain injury and provides rehabilitative services and the needed assistance after injury to insure that individuals can stay in their homes and be as independent as possible in a safe, healthy environment. The HCBS/TBI program serves individuals 16 years of age and	449	4		
I/DD (Intellectual and Developmental Disabilities)	This program serves individuals age 5 and older who meet the definition of Intellectual disability or having a developmental disability or are eligible for care in an Intermediate Care Facility for people with Mental Retardation (ICF/MR).	8,965	28	3,630	
PD (Physical Disability)	This program serves individuals age 16 and older who meet the criteria for nursing facility placement due to their physical disability, who are determined disabled by social security standards, and who are Medicaid eligible.	5,922	103	1,467	

2

2017 Waiver Renewals:

Autism Waiver Renewal:

- KDADS received CMS Approval for the Autism waiver on 6/14/17.
- 60 currently receive services; more children will get services due to transfer of some autism waiver services to the State Plan under the new waiver.

SED Waiver Renewal:

- KDADS received CMS approval for the SED waiver on 4/28/17.
- Currently the CMHC provides all eligibility determinations, plan of care development, and provision of services.
- KDADS is pursuing a contact with third-party assessors to perform side by side assessments to address conflict of interest issues.

3

Waiting List: Current Efforts

I/DD Waiting List

- 8,965 individuals on the HCBS I/DD Program as of 12/15/2017
- Current number of individuals on the Waiting List is 3,630
- 374 people have been offered services for CY 2017
- 200 I/DD Wait list offers were made in August

PD Waiting List

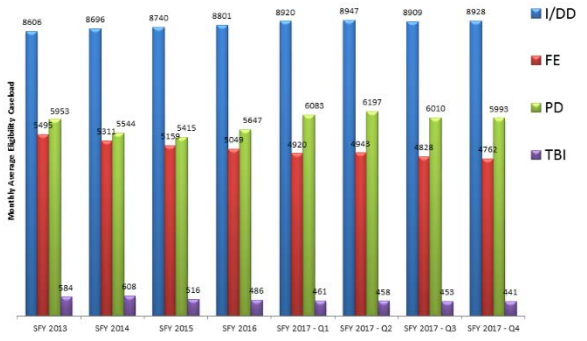
- 5,922 individuals on the HCBS PD Program
- Current number of individuals on the Waiting List is 1,467
- 1,162 people have been offered services for CY 2017
- 300 PD waitlist offers were made in September

The HCBS Monthly Summary is posted on the HCBS page at www.kdads.ks.gov

4

KanCare

Average Monthly Caseload for HCBS



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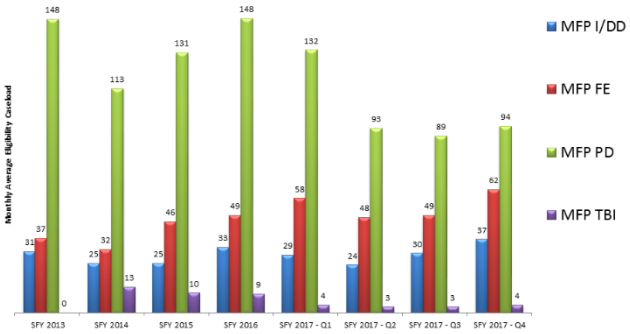
Average Monthly Caseload for HCBS MFP



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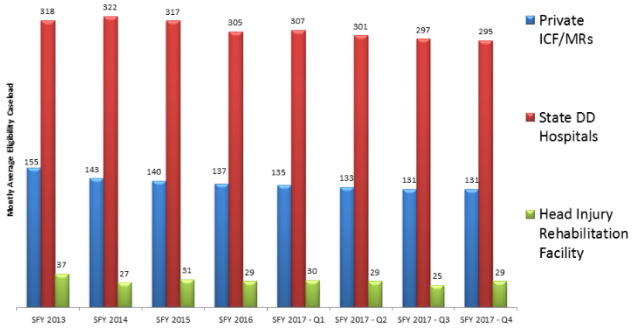
Average Monthly Caseload for State Institutions and Long-Term Care Facilities



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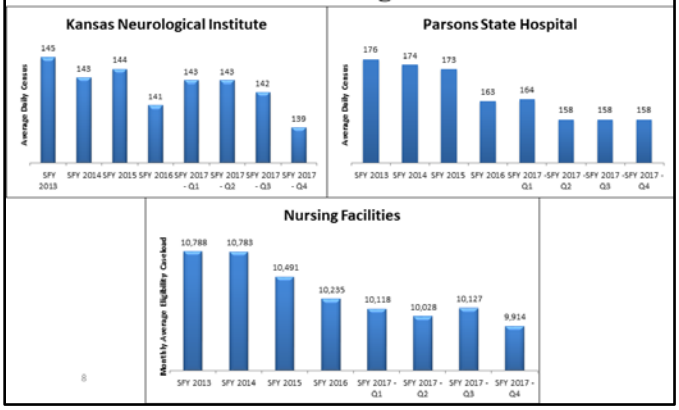
Average Census for State Institutions and Long-Term Care Facilities



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Behavioral Health Initiatives:

Kansas Systems of Care:

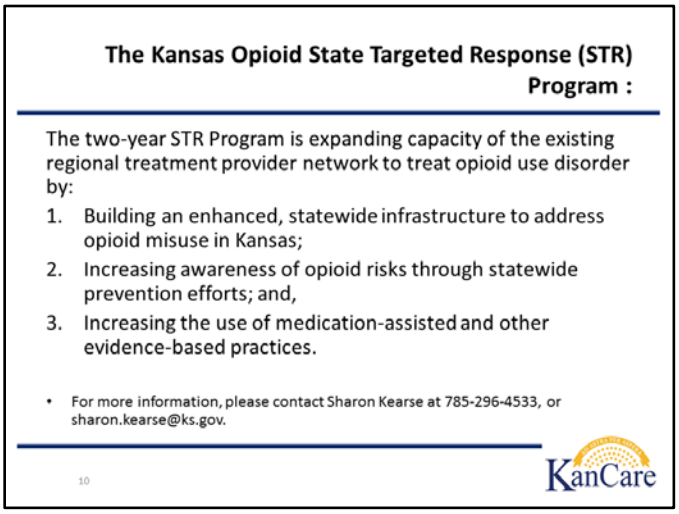
- KDADS received a four-year federal grant to create, expand, and sustain trauma-informed care, family-driven and youth-guided SOC approach for addressing the needs of children and youth with SEDs and their families. This will be accomplished through a partnership between KDADS, the Community Engagement Institute and four regional CMHCs.
- For more information, please see: www.kdads.ks.gov/SOC

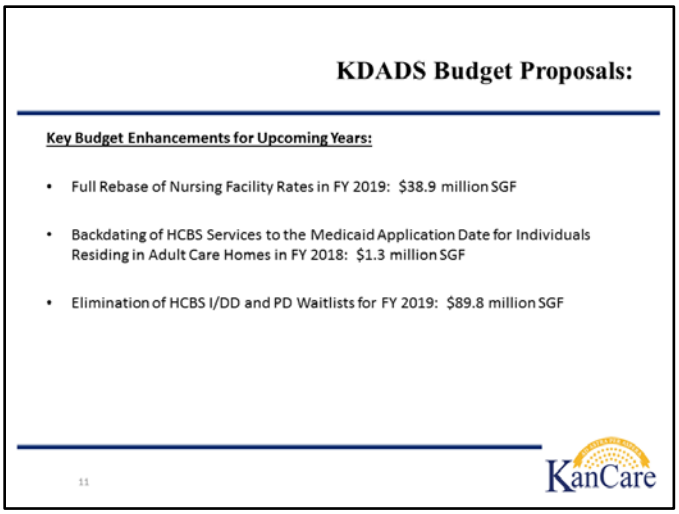
NFMH Training:

- To address a lack of access to training on mental health for direct service workers, particularly in Nursing Facilities for Mental Health, KDADS has established a grant program to provide funding to support and expand mental health education within Medicaid and/or Medicare certified nursing homes in Kansas.

9

KanCare





After presentation of the update information from both KDHE and KDADS, participants were offered the opportunity to present questions or comments for discussion. Most of the comments and questions were related to the proposed 1115 waiver renewal, including how the proposed work requirement would affect KanCare eligibility. Several stakeholders expressed concern that the requirement would result in KanCare members losing coverage without jobs that provide health insurance. Three stakeholders expressed concern with state HCBS data, stating that it is not consistent with other sources. One commenter expressed a desire for more frequent meetings with stakeholders. One person stated that even if new money was available to significantly reduce HCBS waiting lists, there is not sufficient capacity in the community. He argued that the State needs a plan for developing this capacity. Finally, one person asked for strong permanent language in the proposed new KanCare managed care contracts related to participant self-directed services.

DY 5
Start Date: 1/1/2017
End Date: 12/31/2017

Quarter 4
Start Date: 10/1/2017
End Date: 12/31/2017

	Total Expenditures	Total Member-Months
Oct-17	$251,184,204	349,914
Nov-17	$253,134,196	364,259
Dec-17	$257,425,125	370,625
Q4 Total	$761,743,526	1,084,798

	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
Oct-17									
Expenditures	$1,247,464	$37,139,993	$27,560,557	$50,914,925	$43,354,907	$75,556,917	$690,751	$1,985,728	$12,732,962
Member-Months	6,736	37,860	52,910	214,933	9,118	21,488	1,328	1,177	4,364
Nov-17									
Expenditures	$1,267,967	$37,394,026	$27,110,583	$53,323,870	$43,100,976	$75,588,144	$731,937	$2,006,576	$12,610,117
Member-Months	6,825	37,624	53,037	229,874	9,095	21,045	1,336	1,151	4,272
Dec-17									
Expenditures	$1,247,073	$37,559,396	$28,584,822	$54,510,887	$43,637,837	$76,753,179	$534,849	$2,121,381	$12,475,700
Member-Months	6,826	37,840	53,898	234,543	9,186	21,510	1,264	1,177	4,380
Q4 Total									
Expenditures	$3,762,504	$112,093,415	$83,255,962	$158,749,682	$130,093,720	$227,898,241	$1,957,537	$6,113,686	$37,818,779
Member-Months	20,387	113,324	159,844	679,350	27,400	64,043	3,928	3,505	13,017
DY 5 - Q4 PMPM	$185	$989	$521	$234	$4,748	$3,559	$498	$1,744	$2,905

Home and Community Based Services Quality Review Report

April - June 2017

February 6, 2018

KDADS HCBS Quality Review Report

Administrative Authority
PM 1: Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency
Numerator: Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency
Denominator: Number of Quality Review reports
Review Period: 04/01/2017 - 06/30/2017
Data Source: Quality Review Reports to KDHE

Compliance By Waiver	Statewide
PD	**100%**
Numerator	1
Denominator	1
FE	**100%**
Numerator	1
Denominator	1
IDD	**100%**
Numerator	1
Denominator	1
TBI	**100%**
Numerator	1
Denominator	1
TA	**100%**
Numerator	1
Denominator	1
Autism	**100%**
Numerator	1
Denominator	1
SED	**100%**
Numerator	1
Denominator	1

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Statewide	25%	25%	25%	75%	100%	100%
FE						
Statewide	25%	25%	25%	75%	100%	100%
IDD						
Statewide	25%	25%	25%	75%	100%	100%
TBI						
Statewide	25%	25%	25%	75%	100%	100%
TA						
Statewide	25%	25%	25%	75%	100%	100%
Autism						
Statewide	25%	25%	25%	75%	100%	100%
SED						
Statewide	25%	25%	25%	75%	100%	100%

Explanation of Findings:

Remediation:

KDADS HCBS Quality Review Report

Administrative Authority
PM 2: Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agen
Numerator: Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS
Denominator: Total number of waiver amendments and renewals
Review Period: 04/01/2017 - 06/30/2017
Data Source: Number of waiver amendments and renewals sent to KDHE

Compliance By Waiver	Statewide
PD	**N/A**
Numerator	0
Denominator	0
FE	**N/A**
Numerator	0
Denominator	0
IDD	**N/A**
Numerator	0
Denominator	0
TBI	**N/A**
Numerator	0
Denominator	0
TA	**N/A**
Numerator	0
Denominator	0
Autism	**N/A**
Numerator	0
Denominator	0
SED	**N/A**
Numerator	0
Denominator	0

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Statewide	N/A	100%	100%	100%	N/A	N/A
FE						
Statewide	not a measure	100%	100%	100%	N/A	N/A
IDD						
Statewide	100%	100%	100%	100%	N/A	N/A
TBI						
Statewide	100%	100%	100%	100%	N/A	N/A
TA						
Statewide	100%	100%	N/A	100%	N/A	N/A
Autism						
Statewide	100%	100%	N/A	N/A	N/A	N/A
SED						
Statewide	100%	100%	N/A	N/A	N/A	N/A

Explanation of Findings:

Remediation:

KDADS HCBS Quality Review Report

Administrative Authority
PM 3: Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency
Numerator: Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency
Denominator: Number of waiver policy changes implemented by the Operating Agency
Review Period: 04/01/2017 - 06/30/2017
Data Source: Presentation of waiver policy changes to KDHE

Compliance By Waiver	Statewide
PD	**100%**
Numerator	2
Denominator	2
FE	**100%**
Numerator	2
Denominator	2
IDD	**100%**
Numerator	4
Denominator	4
TBI	**100%**
Numerator	2
Denominator	2
TA	**100%**
Numerator	2
Denominator	2
Autism	**100%**
Numerator	1
Denominator	1
SED	**100%**
Numerator	1
Denominator	1

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Statewide	N/A	N/A	100%	N/A	100%	100%
FE						
Statewide	N/A	N/A	100%	N/A	100%	100%
IDD						
Statewide	100%	N/A	100%	100%	100%	100%
TBI						
Statewide	100%	N/A	100%	100%	100%	100%
TA						
Statewide	N/A	N/A	N/A	N/A	100%	100%
Autism						
Statewide	N/A	N/A	N/A	N/A	100%	100%
SED						
Statewide	N/A	N/A	N/A	N/A	100%	100%

Explanation of Findings:

Remediation:

KDADS HCBS Quality Review Report

Administrative Authority
PM 4: Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports
Numerator: Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports
Denominator: Number of Long-Term Care meetings
Review Period: 04/01/2017 - 06/30/2017
Data Source: Meeting Minutes

Compliance By Waiver	Statewide
PD	**100%**
Numerator	3
Denominator	3
FE	**100%**
Numerator	3
Denominator	3
IDD	**100%**
Numerator	3
Denominator	3
TBI	**100%**
Numerator	3
Denominator	3
TA	**100%**
Numerator	3
Denominator	3
Autism	**100%**
Numerator	3
Denominator	3
SED	**100%**
Numerator	3
Denominator	3

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Statewide	Not a measure	45%	67%	70%	100%	100%
FE						
Statewide	100%	82%	50%	70%	100%	100%
IDD						
Statewide	Not a measure	91%	Not Available	70%	100%	100%
TBI						
Statewide	Not a measure	73%	Not Available	70%	100%	100%
TA						
Statewide	Not a measure	64%	Not Available	70%	100%	100%
Autism						
Statewide	Not a measure	91%	100%	70%	100%	100%
SED						
Statewide	Not a measure	100%	Not Available	70%	100%	100%

Explanation of Findings:

Remediation:

KDADS HCBS Quality Review Report

Level of Care
PM 1: Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services
Numerator: Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services
Denominator: Total number of enrolled waiver participants
Review Period: 04/01/2017 - 06/30/2017
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**83%**
Numerator	5
Denominator	6
FE	**100%**
Numerator	11
Denominator	11
IDD	**100%**
Numerator	4
Denominator	4
TBI	**89%**
Numerator	8
Denominator	9
TA	**100%**
Numerator	7
Denominator	7
Autism	**100%**
Numerator	2
Denominator	2
SED	**95%**
Numerator	62
Denominator	65

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Statewide	64%	83%	96%	86%	100%	83%
FE						
Statewide	81%	91%	93%	98%	100%	100%
IDD						
Statewide	99%	94%	90%	100%	100%	100%
TBI						
Statewide	62%	89%	81%	85%	100%	89%
TA						
Statewide	97%	89%	100%	98%	100%	100%
Autism						
Statewide	82%	No Data	100%	N/A	83%	100%
SED						
Statewide	99%	89%	88%	91%	92%	95%

Explanation of Findings:

The intial Assessment tool was not completed and/or provided for review.

Remediation:

SCC to send remediation template to assessing entity for completion on applicable waivers.

SCC to provide to fallout data to applicable assessing entity for review.

SCC will continue to address consistency with interpretive guidance.

KDADS HCBS Quality Review Report

Level of Care
PM 2: Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination
Numerator: Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination
Denominator: Number of waiver participants who received Level of Care redeterminations
Review Period: 04/01/2017 - 06/30/2017
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**74%**
Numerator	63
Denominator	85
FE	**67%**
Numerator	55
Denominator	82
IDD	**72%**
Numerator	63
Denominator	88
TBI	**69%**
Numerator	31
Denominator	45
TA	**94%**
Numerator	46
Denominator	49
Autism	**67%**
Numerator	8
Denominator	12
SED	**93%**
Numerator	42
Denominator	45

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Statewide	47%	52%	64%	69%	64%	74%
FE						
Statewide	68%	70%	76%	79%	69%	67%
IDD						
Statewide	97%	74%	75%	77%	65%	72%
TBI						
Statewide	39%	50%	62%	65%	42%	69%
TA						
Statewide	94%	90%	86%	96%	95%	94%
Autism						
Statewide	68%	No Data	75%	78%	86%	67%
SED						
Statewide	93%	88%	94%	88%	91%	93%

Explanation of Findings:

The reassessment was not completed within the required timeframe or the assessment was not provided for review.

Remediation:

SCC to send remediation template to assessing entity for completion on appliable waivers.

SCC to provide to fallout data to applicable assessing entity for review.

SCC will continue to address consistency with interpretive guidance.

Level of Care
PM 3: Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool
Numerator: Number of waiver participants whose Level of Care determinations used the approved screening tool
Denominator: Number of waiver participants who had a Level of Care determination
Review Period: 04/01/2017 - 06/30/2017
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**89%**
Numerator	81
Denominator	91
FE	**90%**
Numerator	84
Denominator	93
IDD	**100%**
Numerator	92
Denominator	92
TBI	**83%**
Numerator	45
Denominator	54
TA	**100%**
Numerator	56
Denominator	56
Autism	**100%**
Numerator	14
Denominator	14
SED	**92%**
Numerator	60
Denominator	65

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Statewide	93%	84%	79%	80%	77%	89%
FE						
Statewide	88%	91%	91%	92%	89%	90%
IDD						
Statewide	97%	95%	99%	99%	99%	100%
TBI						
Statewide	64%	81%	79%	77%	78%	83%
TA						
Statewide	93%	98%	100%	100%	98%	100%
Autism						
Statewide	88%	No Data	90%	88%	92%	100%
SED						
Statewide	77%	79%	83%	88%	89%	92%

Explanation of Findings:

No current assesssment provided for the review period.
Incorrect assessment was completed based on waiver or the assessment was incomplete (assessment was not readable).

Remediation:

TBI is only waiver below 87 percent.

SCC to send remediation template to applicable assessing entity for completion on applicable waiver.

SCC to provide to fallout data to assessing entity for review.

SCC will continue to address consistency with interpretive guidance.

KDADS HCBS Quality Review Report

Level of Care
PM 4: Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor
Numerator: Number of initial Level of Care (LOC) determinations made by a qualified assessor
Denominator: Number of initial Level of Care determinations
Review Period: 04/01/2017 - 06/30/2017
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**88%**
Numerator	80
Denominator	91
FE	**90%**
Numerator	84
Denominator	93
IDD	**98%**
Numerator	90
Denominator	92
TBI	**83%**
Numerator	45
Denominator	54
TA	**86%**
Numerator	48
Denominator	56
Autism	**86%**
Numerator	12
Denominator	14
SED	**94%**
Numerator	66
Denominator	70

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Statewide	19%	68%	81%	80%	78%	88%
FE						
Statewide	24%	86%	91%	92%	87%	90%
IDD						
Statewide	92%	85%	96%	97%	97%	98%
TBI						
Statewide	57%	73%	83%	77%	78%	83%
TA						
Statewide	93%	100%	99%	100%	98%	86%
Autism						
Statewide	0%	No Data	57%	68%	85%	86%
SED						
Statewide	99%	71%	88%	86%	88%	94%

Explanation of Findings:

The current/ applicable assessment tool was missing, so unable to determine if the assessor was qualified.
The assessors name was not on the approved assessors listing.

Remediation:

SCC to send remediation template to assessing entity to complete for TBI, TA and SED waivers.

SCC to provide to fallout data to applicable assessing entity for review.

SCC will continue to address consistency with interpretive guidance.

KDADS HCBS Quality Review Report

Level of Care
PM 5: Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied
Numerator: Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied
Denominator: Number of initial Level of Care determinations
Review Period: 04/01/2017 - 06/30/2017
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**83%**
Numerator	5
Denominator	6
FE	**100%**
Numerator	11
Denominator	11
IDD	**100%**
Numerator	4
Denominator	4
TBI	**89%**
Numerator	8
Denominator	9
TA	**100%**
Numerator	7
Denominator	7
Autism	**100%**
Numerator	2
Denominator	2
SED	**95%**
Numerator	62
Denominator	65

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Statewide	73%	83%	96%	80%	80%	83%
FE						
Statewide	91%	90%	96%	91%	100%	100%
IDD						
Statewide	98%	95%	91%	98%	100%	100%
TBI						
Statewide	58%	81%	83%	76%	100%	89%
TA						
Statewide	93%	98%	100%	100%	100%	100%
Autism						
Statewide	89%	No Data	100%	88%	83%	100%
SED						
Statewide	99%	88%	87%	89%	89%	95%

Explanation of Findings:

Initial assessment was not provided or was incomplete for the review period.

Remediation:

SCC to send remediation template to PD waiver assessing entity for completion on appliable waivers.

SCC to provide to fallout data to applicable assessing entity for review.

SCC will continue to address consistency with interpretive guidance.

KDADS HCBS Quality Review Report

Qualified Providers
PM 1: Number and percent of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services
Numerator: Number of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services
Denominator: Number of all new licensed/certified waiver providers
Review Period: 04/01/2017 - 06/30/2017
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

Process in development, implementation pending.

Remediation:

Remediation not available at this time.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup				N/A		
Sunflower				N/A		
United				N/A		
Statewide	100%			N/A		
FE						
Amerigroup				5%		
Sunflower				30%		
United				N/A		
Statewide	100%			9%		
IDD						
Amerigroup				N/A		
Sunflower				N/A		
United				N/A		
Statewide	98%			N/A		
TBI						
Amerigroup				N/A		
Sunflower				N/A		
United				N/A		
Statewide	91%			N/A		
TA						
Amerigroup				N/A		
Sunflower				N/A		
United				N/A		
Statewide	93%			N/A		
Autism						
Amerigroup				N/A		
Sunflower				N/A		
United				N/A		
Statewide	100%			N/A		
SED						
Amerigroup				N/A		
Sunflower				N/A		
United				N/A		
Statewide	100%			N/A		

KDADS HCBS Quality Review Report

Qualified Providers
PM 2: Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards
Numerator: Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards
Denominator: Number of enrolled licensed/certified waiver providers
Review Period: 04/01/2017 - 06/30/2017
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

Process in development, implementation pending.

Remediation:

Remediation not available at this time.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup				0%		
Sunflower				0%		
United				0%		
Statewide	100%			0%		
FE						
Amerigroup				12%		
Sunflower				23%		
United				0%		
Statewide	Not a measure			11%		
IDD						
Amerigroup				0%		
Sunflower				0%		
United				0%		
Statewide	98%			0%		
TBI						
Amerigroup				0%		
Sunflower				0%		
United				0%		
Statewide	89%			0%		
TA						
Amerigroup				0%		
Sunflower				0%		
United				0%		
Statewide	93%			0%		
Autism						
Amerigroup				14%		
Sunflower				0%		
United				0%		
Statewide	100%			4%		
SED						
Amerigroup				0%		
Sunflower				0%		
United				0%		
Statewide	100%			0%		

KDADS HCBS Quality Review Report

Qualified Providers
PM 3: Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services
Numerator: Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services
Denominator: Number of all new non-licensed/non-certified providers
Review Period: 04/01/2017 - 06/30/2017
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

Process in development, implementation pending.

Remediation:

Remediation not available at this time.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup				N/A		
Sunflower				N/A		
United				N/A		
Statewide	75%			N/A		
FE						
Amerigroup				N/A		
Sunflower				N/A		
United				N/A		
Statewide	100%			N/A		
IDD						
Amerigroup				N/A		
Sunflower				N/A		
United				N/A		
Statewide	Not a measure			N/A		
TBI						
Amerigroup				N/A		
Sunflower				N/A		
United				N/A		
Statewide	88%			N/A		
TA						
Amerigroup				N/A		
Sunflower				N/A		
United				N/A		
Statewide	No Data			N/A		
Autism						
Amerigroup				N/A		
Sunflower				N/A		
United				N/A		
Statewide	82%			N/A		
SED						
Amerigroup				N/A		
Sunflower				N/A		
United				N/A		
Statewide	Not a measure			N/A		

KDADS HCBS Quality Review Report

Qualified Providers
PM 4: Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements
Numerator: Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements
Denominator: Number of enrolled non-licensed/non-certified providers
Review Period: 04/01/2017 - 06/30/2017
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

Process in development, implementation pending.

Remediation:

Remediation not available at this time.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup				3%		
Sunflower				1%		
United				0%		
Statewide	75%			1%		
FE						
Amerigroup				0%		
Sunflower				0%		
United				0%		
Statewide	Not a measure			0%		
IDD						
Amerigroup				0%		
Sunflower				8%		
United				0%		
Statewide	Not a measure			2%		
TBI						
Amerigroup				8%		
Sunflower				0%		
United				0%		
Statewide	88%			3%		
TA						
Amerigroup				13%		
Sunflower				0%		
United				0%		
Statewide	No Data			4%		
Autism						
Amerigroup				8%		
Sunflower				0%		
United				0%		
Statewide	91%			2%		
SED						
Amerigroup				N/A		
Sunflower				N/A		
United				N/A		
Statewide	89%			N/A		

KDADS HCBS Quality Review Report

Qualified Providers
PM 5: Number and percent of active providers that meet training requirements
Numerator: Number of providers that meet training requirements
Denominator: Number of active providers
Review Period: 04/01/2017 - 06/30/2017
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

Process in development, implementation pending.

Remediation:

Remediation not available at this time.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup				0%		
Sunflower				0%		
United				0%		
Statewide	No Data			0%		
FE						
Amerigroup				0%		
Sunflower				0%		
United				0%		
Statewide	No Data			0%		
IDD						
Amerigroup				0%		
Sunflower				0%		
United				0%		
Statewide	99%			0%		
TBI						
Amerigroup				0%		
Sunflower				0%		
United				0%		
Statewide	No Data			0%		
TA						
Amerigroup				0%		
Sunflower				0%		
United				0%		
Statewide	No Data			0%		
Autism						
Amerigroup				20%		
Sunflower				36%		
United				0%		
Statewide	No Data			11%		
SED						
Amerigroup				0%		
Sunflower				0%		
United				0%		
Statewide	88%			0%		

KDADS HCBS Quality Review Report

Service Plan
PM 1: Number and percent of waiver participants whose service plans address participants' goals
Numerator: Number of waiver participants whose service plans address participants' goals
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2017 - 06/30/2017
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**81%**	**77%**	**85%**	**81%**
Numerator	26	24	23	73
Denominator	32	31	27	90
FE	**74%**	**76%**	**91%**	**81%**
Numerator	17	26	30	73
Denominator	23	34	33	90
IDD	**85%**	**57%**	**83%**	**72%**
Numerator	23	24	19	66
Denominator	27	42	23	92
TBI	**83%**	**69%**	**78%**	**79%**
Numerator	25	9	7	41
Denominator	30	13	9	52
TA	**97%**	**50%**	**100%**	**82%**
Numerator	28	9	9	46
Denominator	29	18	9	56
Autism	**75%**	**20%**	**20%**	**36%**
Numerator	3	1	1	5
Denominator	4	5	5	14
SED	**100%**	**100%**	**100%**	**100%**
Numerator	27	19	23	69
Denominator	27	19	23	69

Explanation of Findings:

The documentation reflecting the goal of the individual had no valid signature by the person/ guardian/ representative.
Service plan was missing or incompete (goals not documented or not addressed in the plan) for the review period.

Remediation:

SCC to send remediation template to applicable MCO for completion on applicable waivers.

SCC to provide to fallout data to applicable MCO for review.

SCC will continue to address consistency with interpretive guidance.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup		55%	33%	63%	68%	81%
Sunflower		57%	64%	59%	80%	77%
United		33%	49%	86%	87%	85%
Statewide	55%	50%	48%	69%	77%	81%
FE						
Amerigroup		50%	42%	54%	69%	74%
Sunflower		56%	51%	75%	74%	76%
United		45%	56%	81%	93%	91%
Statewide	Not a measure	50%	49%	70%	78%	81%
IDD						
Amerigroup		36%	32%	53%	75%	85%
Sunflower		56%	56%	61%	77%	57%
United		52%	41%	73%	87%	83%
Statewide	99%	49%	45%	62%	79%	72%
TBI						
Amerigroup		37%	41%	58%	66%	83%
Sunflower		37%	38%	80%	69%	69%
United		22%	55%	78%	100%	78%
Statewide	44%	34%	43%	68%	71%	79%
TA						
Amerigroup		50%	44%	69%	72%	97%
Sunflower		73%	85%	82%	63%	50%
United		64%	32%	70%	89%	100%
Statewide	93%	61%	54%	73%	72%	82%
Autism						
Amerigroup		84%	56%	35%	80%	75%
Sunflower		47%	50%	50%	33%	20%
United		63%	36%	17%	0%	20%
Statewide	58%	69%	49%	37%	50%	36%
SED						
Amerigroup		91%	99%	98%	96%	100%
Sunflower		92%	95%	87%	100%	100%
United		89%	100%	98%	93%	100%
Statewide	98%	90%	98%	95%	96%	100%

KDADS HCBS Quality Review Report

Service Plan
PM 2: Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment
Numerator: Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2017 - 06/30/2017
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**84%**	**77%**	**85%**	**82%**
Numerator	27	24	23	74
Denominator	32	31	27	90
FE	**74%**	**76%**	**85%**	**79%**
Numerator	17	26	28	71
Denominator	23	34	33	90
IDD	**85%**	**67%**	**91%**	**78%**
Numerator	23	28	21	72
Denominator	27	42	23	92
TBI	**87%**	**85%**	**78%**	**85%**
Numerator	26	11	7	44
Denominator	30	13	9	52
TA	**93%**	**50%**	**100%**	**80%**
Numerator	27	9	9	45
Denominator	29	18	9	56
Autism	**75%**	**20%**	**20%**	**36%**
Numerator	3	1	1	5
Denominator	4	5	5	14
SED	**100%**	**95%**	**100%**	**99%**
Numerator	27	18	23	68
Denominator	27	19	23	69

Explanation of Findings:

Service plan was not signed and dated by the individual/guardian/representative.
Missing the service plan(s) or assessment for the review period.
Assessed needs and capabilities are not addressed in the service plan. Assessment was not completed in it's entirety.
Uploaded information did not cover some or all of the review period.

Remediation:

SCC to send remediation template to applicable MCO for completion on applicable waivers.

SCC to provide to fallout data to applicable MCO for review.

SCC will continue to address consistency with interpretive guidance.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup		83%	55%	74%	68%	84%
Sunflower		90%	56%	63%	87%	77%
United		89%	68%	92%	87%	85%
Statewide	86%	87%	59%	76%	79%	82%
FE						
Amerigroup		79%	66%	74%	73%	74%
Sunflower		90%	53%	73%	68%	76%
United		88%	68%	84%	96%	85%
Statewide	87%	86%	61%	77%	78%	79%
IDD						
Amerigroup		85%	67%	64%	71%	85%
Sunflower		77%	36%	65%	68%	67%
United		72%	47%	78%	91%	91%
Statewide	99%	78%	48%	68%	75%	78%
TBI						
Amerigroup		67%	48%	65%	59%	87%
Sunflower		82%	28%	82%	62%	85%
United		70%	62%	80%	100%	78%
Statewide	72%	73%	45%	72%	65%	85%
TA						
Amerigroup		93%	58%	70%	68%	93%
Sunflower		98%	62%	74%	75%	50%
United		97%	58%	79%	89%	100%
Statewide	96%	96%	59%	73%	74%	80%
Autism						
Amerigroup		81%	59%	33%	80%	75%
Sunflower		50%	45%	47%	17%	20%
United		63%	21%	22%	0%	20%
Statewide	59%	68%	46%	36%	42%	36%
SED						
Amerigroup		91%	99%	98%	96%	100%
Sunflower		91%	92%	87%	87%	95%
United		89%	98%	96%	78%	100%
Statewide	92%	90%	97%	94%	87%	99%

KDADS HCBS Quality Review Report

Service Plan
PM 3: Number and percent of waiver participants whose service plans address health and safety risk factors
Numerator: Number of waiver participants whose service plans address health and safety risk factors
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2017 - 06/30/2017
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**84%**	**87%**	**85%**	**82%**
Numerator	27	27	23	74
Denominator	32	31	27	90
FE	**78%**	**76%**	**85%**	**80%**
Numerator	18	26	28	72
Denominator	23	34	33	90
IDD	**85%**	**67%**	**91%**	**78%**
Numerator	23	28	21	72
Denominator	27	42	23	92
TBI	**90%**	**69%**	**78%**	**83%**
Numerator	27	9	7	43
Denominator	30	13	9	52
TA	**93%**	**50%**	**100%**	**80%**
Numerator	27	9	9	45
Denominator	29	18	9	56
Autism	**75%**	**20%**	**20%**	**36%**
Numerator	3	1	1	5
Denominator	4	5	5	14
SED	**100%**	**100%**	**100%**	**100%**
Numerator	27	19	23	69
Denominator	27	19	23	69

Explanation of Findings:

Missing the service plan or assessment(s) for all or part of the review period. Service plan was not signed or dated by individual/guardian/representative. Assessment was incomplete.
Needs assessment did not match the Service plan.

Remediation:

SCC to send remediation template to applicable MCO for completion on applicable waivers. All waivers less SED on this measure.

SCC to provide to fallout data to applicable MCO for review.

SCC will continue to address consistency with interpretive guidance.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup		90%	44%	73%	68%	84%
Sunflower		89%	49%	67%	83%	87%
United		96%	67%	90%	87%	85%
Statewide	90%	91%	51%	76%	78%	82%
FE						
Amerigroup		92%	55%	75%	73%	78%
Sunflower		92%	50%	73%	71%	76%
United		95%	70%	82%	96%	85%
Statewide	Not a measure	93%	57%	76%	80%	80%
IDD						
Amerigroup		90%	61%	67%	68%	85%
Sunflower		97%	36%	65%	75%	67%
United		89%	45%	78%	91%	91%
Statewide	99%	93%	46%	69%	77%	78%
TBI						
Amerigroup		79%	45%	64%	62%	90%
Sunflower		91%	26%	84%	62%	69%
United		83%	64%	80%	100%	78%
Statewide	84%	84%	43%	72%	67%	83%
TA						
Amerigroup		96%	49%	73%	72%	93%
Sunflower		95%	61%	76%	69%	50%
United		94%	58%	79%	89%	100%
Statewide	96%	96%	54%	75%	74%	80%
Autism						
Amerigroup		79%	59%	30%	80%	75%
Sunflower		61%	45%	47%	17%	20%
United		86%	21%	17%	0%	20%
Statewide	64%	74%	46%	34%	42%	36%
SED						
Amerigroup		90%	99%	97%	96%	100%
Sunflower		89%	95%	87%	100%	100%
United		86%	100%	97%	93%	100%
Statewide	99%	88%	98%	94%	96%	100%

KDADS HCBS Quality Review Report

Service Plan
PM 4: Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver
Numerator: Number of waiver participants whose service plans were developed according to the processes in the approved waiver
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2017 - 06/30/2017
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**91%**	**81%**	**85%**	**86%**
Numerator	29	25	23	77
Denominator	32	31	27	90
FE	**78%**	**85%**	**91%**	**86%**
Numerator	18	29	30	77
Denominator	23	34	33	90
IDD	**85%**	**76%**	**91%**	**83%**
Numerator	23	32	21	76
Denominator	27	42	23	92
TBI	**90%**	**77%**	**78%**	**85%**
Numerator	27	10	7	44
Denominator	30	13	9	52
TA	**97%**	**50%**	**100%**	**82%**
Numerator	28	9	9	46
Denominator	29	18	9	56
Autism	**75%**	**40%**	**20%**	**43%**
Numerator	3	2	1	6
Denominator	4	5	5	14
SED	**100%**	**100%**	**100%**	**100%**
Numerator	27	19	23	69
Denominator	27	19	23	69

Explanation of Findings:

Missing the service plan for the review period.
Service plan was not signed and dated by the individual/guardian/representative.
Service plan was incomplete or blank.

Remediation:

SCC to send remediation template to applicable MCO for completion on applicable waivers. All waivers less SED on this measure.

SCC to provide to fallout data to applicable MCO for review.

SCC will continue to address consistency with interpretive guidance.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup		88%	68%	76%	71%	91%
Sunflower		87%	69%	73%	93%	81%
United		85%	77%	92%	87%	85%
Statewide	80%	87%	70%	80%	83%	86%
FE						
Amerigroup		84%	76%	78%	73%	78%
Sunflower		88%	61%	84%	85%	85%
United		86%	79%	87%	96%	91%
Statewide	Not a measure	86%	71%	83%	85%	86%
IDD						
Amerigroup		80%	80%	73%	71%	85%
Sunflower		80%	59%	74%	86%	76%
United		82%	55%	79%	91%	91%
Statewide	98%	81%	64%	75%	83%	83%
TBI						
Amerigroup		76%	53%	64%	62%	90%
Sunflower		86%	43%	86%	69%	77%
United		77%	69%	85%	100%	78%
Statewide	64%	80%	53%	74%	69%	85%
TA						
Amerigroup		84%	68%	71%	72%	97%
Sunflower		97%	86%	85%	69%	50%
United		96%	58%	79%	89%	100%
Statewide	No Data	91%	72%	77%	74%	82%
Autism						
Amerigroup		74%	59%	35%	80%	75%
Sunflower		51%	50%	47%	17%	40%
United		65%	29%	17%	0%	20%
Statewide	55%	65%	49%	36%	42%	43%
SED						
Amerigroup		92%	99%	98%	96%	100%
Sunflower		90%	94%	86%	100%	100%
United		87%	98%	97%	93%	100%
Statewide	Not a measure	90%	97%	94%	96%	100%

KDADS HCBS Quality Review Report

Service Plan
PM 5: Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan
Numerator: Number of waiver participants (or their representatives) who were present and involved in the development of their service plan
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2017 - 06/30/2017
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**94%**	**84%**	**85%**	**88%**
Numerator	30	26	23	79
Denominator	32	31	27	90
FE	**78%**	**85%**	**91%**	**86%**
Numerator	18	29	30	77
Denominator	23	34	33	90
IDD	**85%**	**71%**	**91%**	**80%**
Numerator	23	30	21	74
Denominator	27	42	23	92
TBI	**87%**	**77%**	**78%**	**83%**
Numerator	26	10	7	43
Denominator	30	13	9	52
TA	**97%**	**50%**	**100%**	**82%**
Numerator	28	9	9	46
Denominator	29	18	9	56
Autism	**75%**	**20%**	**0%**	**29%**
Numerator	3	1	0	4
Denominator	4	5	5	14
SED	**100%**	**100%**	**100%**	**100%**
Numerator	27	19	23	69
Denominator	27	19	23	69

Explanation of Findings:

Service plan was not signed and dated by the individual/ guardian/ representative. Missing all or part of service plan for the review period.

Remediation:

SCC to send remediation template to applicable MCO for completion on applicable waivers. All waivers less SED on this measure.

SCC to provide to fallout data to applicable MCO for review.

SCC will continue to address consistency with interpretive guidance.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup		88%	70%	79%	74%	94%
Sunflower		87%	70%	74%	93%	84%
United		84%	79%	89%	87%	85%
Statewide	Not a measure	87%	72%	81%	84%	88%
FE						
Amerigroup		83%	78%	76%	77%	78%
Sunflower		86%	60%	83%	85%	85%
United		87%	83%	88%	96%	91%
Statewide	90%	85%	72%	83%	86%	86%
IDD						
Amerigroup		84%	76%	73%	71%	85%
Sunflower		82%	60%	74%	84%	71%
United		88%	51%	79%	91%	91%
Statewide	Not a measure	84%	63%	75%	82%	80%
TBI						
Amerigroup		73%	51%	65%	66%	87%
Sunflower		84%	45%	86%	69%	77%
United		80%	69%	59%	100%	78%
Statewide	Not a measure	78%	52%	74%	71%	83%
TA						
Amerigroup		83%	75%	71%	72%	97%
Sunflower		97%	86%	84%	69%	50%
United		97%	58%	79%	89%	100%
Statewide	Not a measure	91%	76%	76%	74%	82%
Autism						
Amerigroup		77%	59%	35%	80%	75%
Sunflower		53%	55%	50%	17%	20%
United		71%	36%	17%	0%	0%
Statewide	Not a measure	69%	52%	37%	42%	29%
SED						
Amerigroup		92%	98%	97%	96%	100%
Sunflower		90%	95%	86%	100%	100%
United		87%	99%	96%	93%	100%
Statewide	93%	90%	98%	94%	96%	100%

KDADS HCBS Quality Review Report

Service Plan
PM 6: Number and percent of service plans reviewed before the waiver participant's annual redetermination date
Numerator: Number of service plans reviewed before the waiver participant's annual redetermination date
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2017 - 06/30/2017
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**63%**	**54%**	**85%**	**67%**
Numerator	10	7	11	28
Denominator	16	13	13	42
FE	**70%**	**71%**	**88%**	**77%**
Numerator	7	12	15	34
Denominator	10	17	17	44
IDD	**69%**	**68%**	**71%**	**70%**
Numerator	9	13	10	32
Denominator	13	19	14	46
TBI	**58%**	**40%**	**80%**	**59%**
Numerator	7	2	4	13
Denominator	12	5	5	22
TA	**94%**	**44%**	**86%**	**78%**
Numerator	15	4	6	25
Denominator	16	9	7	32
Autism	**67%**	**25%**	**50%**	**44%**
Numerator	2	1	1	4
Denominator	3	4	2	9
SED	**100%**	**93%**	**84%**	**92%**
Numerator	18	13	16	47
Denominator	18	14	19	51

Explanation of Findings:

Service plan was not signed and dated by individual/guardian/representative.
Missing service plan(s) for part or all of the review period.
Service plan was not reviewed within the specified waiver timelines.

Remediation:

SCC to send remediation template to applicable MCO for completion on applicable waivers.

SCC to provide to fallout data to applicable MCO for review.

SCC will continue to address consistency with interpretive guidance.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup		73%	67%	71%	47%	63%
Sunflower		82%	72%	72%	79%	54%
United		92%	73%	83%	75%	85%
Statewide	82%	82%	70%	75%	64%	67%
FE						
Amerigroup		81%	67%	63%	64%	70%
Sunflower		85%	57%	78%	78%	71%
United		90%	69%	84%	100%	88%
Statewide	81%	85%	64%	76%	80%	77%
IDD						
Amerigroup		75%	77%	68%	46%	69%
Sunflower		81%	66%	65%	72%	68%
United		91%	48%	54%	75%	71%
Statewide	97%	82%	66%	63%	66%	70%
TBI						
Amerigroup		65%	44%	56%	42%	58%
Sunflower		84%	40%	88%	60%	40%
United		77%	65%	70%	75%	80%
Statewide	60%	76%	47%	68%	52%	59%
TA						
Amerigroup		81%	78%	72%	67%	94%
Sunflower		94%	89%	85%	67%	44%
United		96%	59%	70%	75%	86%
Statewide	92%	89%	79%	76%	68%	78%
Autism						
Amerigroup		67%	52%	40%	75%	67%
Sunflower		43%	47%	38%	50%	25%
United		33%	38%	7%	N/A	50%
Statewide	64%	57%	48%	31%	67%	44%
SED						
Amerigroup		89%	97%	94%	89%	100%
Sunflower		89%	91%	79%	94%	93%
United		83%	99%	85%	86%	84%
Statewide	80%	87%	96%	86%	89%	92%

KDADS HCBS Quality Review Report

Service Plan
PM 7: Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change
Numerator: Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2017 - 06/30/2017
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**40%**	**57%**	**75%**	**60%**
Numerator	2	4	6	12
Denominator	5	7	8	20
FE	**100%**	**43%**	**75%**	**64%**
Numerator	3	3	3	9
Denominator	3	7	4	14
IDD	**100%**	**0%**	**0%**	**20%**
Numerator	1	0	0	1
Denominator	1	3	1	5
TBI	**80%**	**25%**	**33%**	**50%**
Numerator	4	1	1	6
Denominator	5	4	3	12
TA	**100%**	**33%**	**100%**	**71%**
Numerator	5	2	3	10
Denominator	5	6	3	14
Autism	**100%**	**50%**	**0%**	**60%**
Numerator	2	1	0	3
Denominator	2	2	1	5
SED	**100%**	**88%**	**100%**	**96%**
Numerator	11	7	6	24
Denominator	11	8	6	25

Explanation of Findings:

Service plan was missing or was not signed and dated by individual/guardian/representative.

Remediation:

SCC to send remediation template to applicable MCO for completion on applicable waivers.

SCC to provide to fallout data to applicable MCO for review.

SCC will continue to address consistency with interpretive guidance.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup		20%	36%	67%	50%	40%
Sunflower		53%	58%	50%	60%	57%
United		50%	63%	80%	100%	75%
Statewide	75%	39%	53%	65%	60%	60%
FE						
Amerigroup		24%	71%	42%	0%	100%
Sunflower		39%	51%	63%	50%	43%
United		50%	47%	87%	100%	75%
Statewide	78%	38%	54%	65%	57%	64%
IDD						
Amerigroup		7%	60%	27%	0%	100%
Sunflower		38%	16%	25%	43%	0%
United		16%	30%	30%	100%	0%
Statewide	97%	23%	28%	28%	44%	20%
TBI						
Amerigroup		24%	42%	61%	33%	80%
Sunflower		54%	27%	75%	100%	25%
United		46%	50%	75%	N/A	33%
Statewide	53%	38%	38%	67%	50%	50%
TA						
Amerigroup		32%	73%	56%	100%	100%
Sunflower		54%	89%	63%	67%	33%
United		38%	43%	60%	100%	100%
Statewide	92%	42%	75%	60%	80%	71%
Autism						
Amerigroup		10%	0%	17%	50%	100%
Sunflower		17%	25%	50%	0%	50%
United		0%	0%	9%	N/A	0%
Statewide	45%	11%	11%	16%	33%	60%
SED						
Amerigroup		90%	90%	97%	89%	100%
Sunflower		83%	79%	68%	89%	88%
United		84%	93%	83%	67%	100%
Statewide	85%	86%	88%	83%	81%	96%

KDADS HCBS Quality Review Report

Service Plan
PM 8: Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan
Numerator: Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2017 - 06/30/2017
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**84%**	**84%**	**85%**	**84%**
Numerator	27	26	23	76
Denominator	32	31	27	90
FE	**74%**	**85%**	**88%**	**83%**
Numerator	17	29	29	75
Denominator	23	34	33	90
IDD	**85%**	**79%**	**83%**	**82%**
Numerator	23	33	19	75
Denominator	27	42	23	92
TBI	**87%**	**69%**	**78%**	**81%**
Numerator	26	9	7	42
Denominator	30	13	9	52
TA	**97%**	**50%**	**100%**	**82%**
Numerator	28	9	9	46
Denominator	29	18	9	56
Autism	**75%**	**20%**	**20%**	**36%**
Numerator	3	1	1	5
Denominator	4	5	5	14
SED	**100%**	**100%**	**100%**	**100%**
Numerator	27	19	23	69
Denominator	27	19	23	69

Explanation of Findings:

Service plan was not signed and dated by the individual/guardian/representative. Log notes or documentation is missing so unable to make determination. Unable to locate a worker that individual could work with.

Remediation:

SCC to send remediation template to applicable MCO for completion on applicable waivers. All waivers less SED on this measure.

SCC to provide to fallout data to applicable MCO for review.

SCC will continue to address consistency with interpretive guidance.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup		94%	69%	79%	65%	84%
Sunflower		96%	72%	76%	93%	84%
United		96%	78%	91%	91%	85%
Statewide	85%	95%	72%	81%	82%	84%
FE						
Amerigroup		83%	76%	75%	69%	74%
Sunflower		96%	64%	86%	85%	85%
United		96%	79%	89%	96%	88%
Statewide	87%	92%	72%	83%	84%	83%
IDD						
Amerigroup		78%	84%	73%	68%	85%
Sunflower		97%	62%	77%	86%	79%
United		100%	59%	81%	87%	83%
Statewide	98%	92%	68%	77%	81%	82%
TBI						
Amerigroup		81%	55%	63%	59%	87%
Sunflower		95%	46%	84%	69%	69%
United		85%	71%	83%	86%	78%
Statewide	70%	87%	56%	72%	65%	81%
TA						
Amerigroup		98%	73%	79%	68%	97%
Sunflower		100%	86%	82%	69%	50%
United		96%	58%	82%	89%	100%
Statewide	100%	98%	74%	80%	72%	82%
Autism						
Amerigroup		89%	59%	37%	80%	75%
Sunflower		100%	55%	50%	17%	20%
United		50%	21%	17%	0%	20%
Statewide	50%	86%	49%	38%	42%	36%
SED						
Amerigroup		91%	99%	95%	96%	100%
Sunflower		96%	94%	84%	100%	100%
United		92%	99%	91%	89%	100%
Statewide	13%	93%	98%	90%	95%	100%

KDADS HCBS Quality Review Report

Service Plan
PM 9: Number and percent of survey respondents who reported receiving all services as specified in their service plan
Numerator: Number of survey respondents who reported receiving all services as specified in their service plan
Denominator: Number of waiver participants interviewed by QMS staff
Review Period: 04/01/2017 - 06/30/2017
Data Source: Customer Interview

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**87%**	**95%**	**94%**	**91%**
Numerator	20	18	15	53
Denominator	23	19	16	58
FE	**100%**	**96%**	**93%**	**96%**
Numerator	21	26	25	72
Denominator	21	27	27	75
IDD	**100%**	**95%**	**100%**	**97%**
Numerator	8	20	5	33
Denominator	8	21	5	34
TBI	**79%**	**71%**	**80%**	**77%**
Numerator	15	5	4	24
Denominator	19	7	5	31
TA	**100%**	**100%**	**83%**	**97%**
Numerator	18	11	5	34
Denominator	18	11	6	35
Autism	**100%**	**33%**	**100%**	**71%**
Numerator	2	1	2	5
Denominator	2	3	2	7
SED	**Not a waiver performance measure**			
Numerator				
Denominator				

Explanation of Findings:

Individual is unable to find and keep staff.
Not receiving all or part of the needed/promised services.
Individual indicates they are unaware of what is on the plan of care.
Individual states they are in need of more hours of service.
Workers have transportation issues that prevent them from being dependable.
Individual indicates trouble making contact with MCO staff.

Remediation:

SCC to send remediation template to applicable MCO for completion on applicable waivers. All waivers less SED on this measure.

SCC to provide to fallout data to applicable MCO for review.

SCC will continue to address consistency with interpretive guidance.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup		97%			86%	87%
Sunflower		92%			100%	95%
United		93%			90%	94%
Statewide	Not a measure	94%	No Data	No Data	91%	91%
FE						
Amerigroup		85%			93%	100%
Sunflower		86%			95%	96%
United		82%			87%	93%
Statewide	87%	84%	No Data	No Data	91%	96%
IDD						
Amerigroup		92%				100%
Sunflower		96%				95%
United		93%				100%
Statewide	Not a measure	94%	No Data	No Data	No Data	97%
TBI						
Amerigroup		81%				79%
Sunflower		88%				71%
United		83%				80%
Statewide	Not a measure	83%	No Data	No Data	No Data	77%
TA						
Amerigroup		89%			94%	100%
Sunflower		84%			83%	100%
United		85%			100%	83%
Statewide	Not a measure	87%	No Data	No Data	93%	97%
Autism						
Amerigroup		74%			100%	100%
Sunflower		70%			100%	33%
United		60%			N/A	100%
Statewide	Not a measure	71%	No Data	No Data	100%	71%
SED	**Not a waiver performance measure**					
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Service Plan
PM 10: Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers
Numerator: Number of waiver participants whose record contains documentation indicating a choice of waiver service providers
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2017 - 06/30/2017
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**94%**	**77%**	**85%**	**86%**
Numerator	30	24	23	77
Denominator	32	31	27	90
FE	**83%**	**82%**	**91%**	**86%**
Numerator	19	28	30	77
Denominator	23	34	33	90
IDD	**81%**	**69%**	**91%**	**78%**
Numerator	22	29	21	72
Denominator	27	42	23	92
TBI	**87%**	**77%**	**78%**	**83%**
Numerator	26	10	7	43
Denominator	30	13	9	52
TA	**97%**	**44%**	**100%**	**80%**
Numerator	28	8	9	45
Denominator	29	18	9	56
Autism	**75%**	**40%**	**40%**	**50%**
Numerator	3	2	2	7
Denominator	4	5	5	14
SED	**96%**	**89%**	**100%**	**96%**
Numerator	26	17	22	65
Denominator	27	19	22	68

Explanation of Findings:

Missing the documentation to show "choice" was reviewed with the individual for the review period. Choice is on the service plan but does not have a valid signature.

Remediation:

SCC to send remediation template to applicable MCO for completion on applicable waivers.

SCC to provide to fallout data to applicable MCO for review.

SCC will continue to address consistency with interpretive guidance.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup		68%	56%	68%	53%	94%
Sunflower		58%	69%	73%	90%	77%
United		69%	73%	89%	87%	85%
Statewide	52%	65%	65%	76%	74%	86%
FE						
Amerigroup		68%	59%	64%	65%	83%
Sunflower		76%	59%	82%	85%	82%
United		77%	75%	85%	100%	91%
Statewide	56%	74%	63%	77%	84%	86%
IDD						
Amerigroup		51%	45%	68%	64%	81%
Sunflower		68%	42%	69%	80%	69%
United		75%	55%	76%	91%	91%
Statewide	99%	64%	46%	70%	78%	78%
TBI						
Amerigroup		54%	50%	53%	55%	87%
Sunflower		75%	40%	86%	69%	77%
United		70%	74%	83%	100%	78%
Statewide	44%	65%	52%	67%	65%	83%
TA						
Amerigroup		87%	65%	68%	56%	97%
Sunflower		84%	80%	77%	69%	44%
United		92%	58%	79%	89%	100%
Statewide	96%	86%	68%	72%	66%	80%
Autism						
Amerigroup		67%	67%	47%	80%	75%
Sunflower		44%	45%	50%	50%	40%
United		88%	21%	17%	0%	40%
Statewide	40%	63%	49%	42%	58%	50%
SED						
Amerigroup		94%	91%	98%	100%	96%
Sunflower		91%	72%	84%	91%	89%
United		84%	97%	88%	88%	100%
Statewide	98%	89%	88%	90%	94%	96%

KDADS HCBS Quality Review Report

Service Plan
PM 11: Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services
Numerator: Number of waiver participants whose record contains documentation indicating a choice of waiver services
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2017 - 06/30/2017
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**94%**	**16%**	**81%**	**63%**
Numerator	30	5	22	57
Denominator	32	31	27	90
FE	**83%**	**12%**	**91%**	**59%**
Numerator	19	4	30	53
Denominator	23	34	33	90
IDD	**85%**	**29%**	**87%**	**60%**
Numerator	23	12	20	55
Denominator	27	42	23	92
TBI	**77%**	**15%**	**78%**	**62%**
Numerator	23	2	7	32
Denominator	30	13	9	52
TA	**97%**	**17%**	**89%**	**70%**
Numerator	28	3	8	39
Denominator	29	18	9	56
Autism	**75%**	**0%**	**20%**	**29%**
Numerator	3	0	1	4
Denominator	4	5	5	14
SED	**96%**	**89%**	**100%**	**96%**
Numerator	26	17	21	64
Denominator	27	19	21	67

Explanation of Findings:

Service plan was not signed by individual/guardian/representative to indicate choice. Missing the documentation to show "choice" was reviewed with the individual.

Remediation:

SCC to send remediation template to applicable MCO for completion on applicable waivers.

SCC to provide to fallout data to applicable MCO for review.

SCC will continue to address consistency with interpretive guidance.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup		68%	53%	62%	47%	94%
Sunflower		72%	50%	71%	86%	16%
United		77%	73%	84%	52%	81%
Statewide	64%	72%	57%	72%	62%	63%
FE						
Amerigroup		67%	57%	67%	65%	83%
Sunflower		86%	47%	82%	71%	12%
United		85%	74%	84%	57%	91%
Statewide	59%	80%	57%	78%	65%	59%
IDD						
Amerigroup		55%	46%	70%	57%	85%
Sunflower		68%	35%	69%	64%	29%
United		77%	50%	74%	78%	87%
Statewide	No Data	66%	42%	71%	65%	60%
TBI						
Amerigroup		56%	50%	52%	52%	77%
Sunflower		80%	23%	86%	46%	15%
United		74%	67%	80%	86%	78%
Statewide	53%	68%	45%	66%	55%	62%
TA						
Amerigroup		86%	65%	71%	52%	97%
Sunflower		97%	53%	79%	63%	17%
United		94%	55%	64%	44%	89%
Statewide	96%	91%	60%	72%	54%	70%
Autism						
Amerigroup		79%	52%	47%	80%	75%
Sunflower		50%	27%	61%	50%	0%
United		88%	14%	17%	0%	20%
Statewide	55%	72%	35%	46%	58%	29%
SED						
Amerigroup		94%	92%	98%	100%	96%
Sunflower		91%	72%	84%	91%	89%
United		84%	97%	88%	85%	100%
Statewide	98%	89%	88%	90%	92%	96%

KDADS HCBS Quality Review Report

Service Plan
PM 12: Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative
Numerator: Number of waiver participants whose record contains documentation indicating a choice of community-based services
Denominator: Number of waiver participants whose files are reviewed for the documentation
Review Period: 04/01/2017 - 06/30/2017
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**94%**	**81%**	**85%**	**87%**
Numerator	30	25	23	78
Denominator	32	31	27	90
FE	**83%**	**85%**	**91%**	**87%**
Numerator	19	29	30	78
Denominator	23	34	33	90
IDD	**81%**	**74%**	**91%**	**80%**
Numerator	22	31	21	74
Denominator	27	42	23	92
TBI	**87%**	**77%**	**78%**	**83%**
Numerator	26	10	7	43
Denominator	30	13	9	52
TA	**97%**	**50%**	**100%**	**82%**
Numerator	28	9	9	46
Denominator	29	18	9	56
Autism	**100%**	**80%**	**60%**	**79%**
Numerator	4	4	3	11
Denominator	4	5	5	14
SED	**96%**	**89%**	**100%**	**96%**
Numerator	26	17	22	65
Denominator	27	19	22	68

Explanation of Findings:

Choice is on the service plan but is is not signed. Missing the document for all or part of the review period to show "choice" was reviewed with the individual.

Remediation:

SCC to send remediation template to applicable MCO for completion on applicable waivers. All waivers less SED on this measure.

SCC to provide to fallout data to applicable MCO for review.

SCC will continue to address consistency with interpretive guidance.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup		76%	57%	67%	53%	94%
Sunflower		74%	67%	73%	93%	81%
United		80%	78%	88%	87%	85%
Statewide	Not a measure	76%	66%	75%	76%	87%
FE						
Amerigroup		67%	58%	72%	62%	83%
Sunflower		87%	56%	82%	79%	85%
United		85%	79%	84%	100%	91%
Statewide	65%	80%	63%	79%	81%	87%
IDD						
Amerigroup		47%	47%	66%	64%	81%
Sunflower		69%	41%	68%	80%	74%
United		78%	57%	79%	91%	91%
Statewide	No Data	64%	46%	70%	78%	80%
TBI						
Amerigroup		55%	51%	54%	55%	87%
Sunflower		79%	40%	86%	69%	77%
United		73%	74%	83%	100%	78%
Statewide	No Data	67%	52%	68%	65%	83%
TA						
Amerigroup		87%	65%	69%	56%	97%
Sunflower		98%	80%	81%	69%	50%
United		94%	55%	79%	89%	100%
Statewide	No Data	92%	68%	74%	66%	82%
Autism						
Amerigroup		86%	67%	65%	80%	100%
Sunflower		47%	59%	67%	67%	80%
United		75%	43%	33%	0%	60%
Statewide	No Data	72%	59%	60%	67%	79%
SED						
Amerigroup		94%	92%	98%	100%	96%
Sunflower		91%	72%	84%	91%	89%
United		85%	98%	88%	85%	100%
Statewide	99%	90%	89%	91%	92%	96%

KDADS HCBS Quality Review Report

Service Plan
PM 13: Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care
Numerator: Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care
Denominator: Number of waiver participants whose files are reviewed for the documentation
Review Period: 04/01/2017 - 06/30/2017
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**88%**	**81%**	**85%**	**84%**
Numerator	28	25	23	76
Denominator	32	31	27	90
FE	**83%**	**85%**	**85%**	**84%**
Numerator	19	29	28	76
Denominator	23	34	33	90
IDD	**78%**	**64%**	**91%**	**75%**
Numerator	21	27	21	69
Denominator	27	42	23	92
TBI	**77%**	**69%**	**78%**	**75%**
Numerator	23	9	7	39
Denominator	30	13	9	52
TA	**83%**	**50%**	**100%**	**75%**
Numerator	24	9	9	42
Denominator	29	18	9	56
Autism	**Self-direction is not offered for this waiver**			
Numerator				
Denominator				
SED	**Self-direction is not offered for this waiver**			
Numerator				
Denominator				

Explanation of Findings:

Missing documentation to show "choice" was reviewed with the individual for part or all of the review period. Choice is on the service plan, but is not signed by the individual/ guardian. Choice box was not marked on the choice form and/or the service plan, form was not fully completed.

Remediation:

SCC to send remediation template to applicable MCO for completion on applicable waivers. All waivers less Autism and SED on this measure.

SCC to provide to fallout data to applicable MCO for review.

SCC will continue to address consistency with interpretive guidance.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup		64%	58%	72%	59%	88%
Sunflower		73%	68%	72%	93%	81%
United		77%	78%	88%	87%	85%
Statewide	Not a measure	71%	66%	77%	78%	84%
FE						
Amerigroup		64%	59%	73%	58%	83%
Sunflower		84%	59%	81%	85%	85%
United		77%	79%	85%	96%	85%
Statewide	65%	75%	64%	79%	81%	84%
IDD						
Amerigroup		34%	47%	64%	54%	78%
Sunflower		61%	39%	60%	64%	64%
United		77%	57%	73%	91%	91%
Statewide	No Data	53%	46%	64%	67%	75%
TBI						
Amerigroup		50%	50%	56%	62%	77%
Sunflower		85%	43%	82%	69%	69%
United		70%	74%	83%	100%	78%
Statewide	No Data	66%	52%	68%	69%	75%
TA						
Amerigroup		82%	56%	66%	60%	83%
Sunflower		98%	82%	79%	69%	50%
United		100%	58%	79%	89%	100%
Statewide	No Data	90%	64%	72%	68%	75%
Autism	**Self-direction is not offered for this waiver**					
Amerigroup						
Sunflower						
United						
Statewide						
SED	**Self-direction is not offered for this waiver**					
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Health and Welfare
PM 1: Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes
Numerator: Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2017 - 06/30/2017
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

Adverse Incident Reporting (AIR) system process in development, implementation pending.

Remediation:

Remediation not available at this time.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup						
Sunflower						
United						
Statewide						
FE						
Amerigroup						
Sunflower						
United						
Statewide						
IDD						
Amerigroup						
Sunflower						
United						
Statewide						
TBI						
Amerigroup						
Sunflower						
United						
Statewide						
TA						
Amerigroup						
Sunflower						
United						
Statewide						
Autism						
Amerigroup						
Sunflower						
United						
Statewide						
SED						
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Health and Welfare
PM 2: Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures
Numerator: Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures as in the approved waiver
Denominator: Number of unexpected deaths
Review Period: 04/01/2017 - 06/30/2017
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

Adverse Incident Reporting (AIR) system process in development, implementation pending.

Remediation:

Remediation not available at this time.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup						
Sunflower						
United						
Statewide						
FE						
Amerigroup						
Sunflower						
United						
Statewide						
IDD						
Amerigroup						
Sunflower						
United						
Statewide						
TBI						
Amerigroup						
Sunflower						
United						
Statewide						
TA						
Amerigroup						
Sunflower						
United						
Statewide						
Autism						
Amerigroup						
Sunflower						
United						
Statewide						
SED						
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Health and Welfare
PM 3: Number and percent of unexpected deaths for which the appropriate follow-up measures were taken
Numerator: Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiver
Denominator: Number of unexpected deaths
Review Period: 04/01/2017 - 06/30/2017
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

Adverse Incident Reporting (AIR) system process in development, implementation pending.

Remediation:

Remediation not available at this time.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup						
Sunflower						
United						
Statewide						
FE						
Amerigroup						
Sunflower						
United						
Statewide						
IDD						
Amerigroup						
Sunflower						
United						
Statewide						
TBI						
Amerigroup						
Sunflower						
United						
Statewide						
TA						
Amerigroup						
Sunflower						
United						
Statewide						
Autism						
Amerigroup						
Sunflower						
United						
Statewide						
SED						
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Health and Welfare
PM 4: Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation
Numerator: Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation
Denominator: Number of waiver participants interviewed by QMS staff or whose records are reviewed
Review Period: 04/01/2017 - 06/30/2017
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**94%**	**84%**	**85%**	**88%**
Numerator	30	26	23	79
Denominator	32	31	27	90
FE	**87%**	**85%**	**91%**	**88%**
Numerator	20	29	30	79
Denominator	23	34	33	90
IDD	**85%**	**79%**	**91%**	**84%**
Numerator	23	33	21	77
Denominator	27	42	23	92
TBI	**90%**	**77%**	**78%**	**85%**
Numerator	27	10	7	44
Denominator	30	13	9	52
TA	**97%**	**56%**	**100%**	**84%**
Numerator	28	10	9	47
Denominator	29	18	9	56
Autism	**75%**	**40%**	**20%**	**43%**
Numerator	3	2	1	6
Denominator	4	5	5	14
SED	**19%**	**11%**	**4%**	**12%**
Numerator	5	2	1	8
Denominator	27	19	23	69

Explanation of Findings:

Review of ANE was on the Service plan but it was not signed & dated by the individual or Guardian. Documentation was not provided for review.
Service plan indicates "no" regarding consumer being educated on ANE.

Remediation:

SCC to send remediation template to applicable MCO for completion on applicable waivers.

SCC to provide to fallout data to assessing entity for review.

SCC will continue to address consistency with interpretive guidance.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup		51%	19%	67%	74%	94%
Sunflower		88%	72%	74%	93%	84%
United		90%	80%	88%	87%	85%
Statewide	65%	72%	53%	76%	84%	88%
FE						
Amerigroup		59%	16%	61%	73%	87%
Sunflower		86%	62%	84%	88%	85%
United		92%	80%	88%	100%	91%
Statewide	80%	78%	50%	78%	88%	88%
IDD						
Amerigroup		23%	6%	59%	71%	85%
Sunflower		87%	59%	75%	84%	79%
United		100%	56%	79%	91%	91%
Statewide	99%	68%	42%	71%	82%	84%
TBI						
Amerigroup		30%	12%	56%	66%	90%
Sunflower		94%	45%	84%	62%	77%
United		80%	76%	85%	100%	78%
Statewide	57%	63%	34%	69%	69%	85%
TA						
Amerigroup		61%	38%	75%	72%	97%
Sunflower		99%	86%	84%	69%	56%
United		97%	61%	79%	89%	100%
Statewide	86%	82%	57%	78%	74%	84%
Autism						
Amerigroup		62%	8%	23%	80%	75%
Sunflower		33%	29%	39%	67%	40%
United		43%	14%	6%	0%	20%
Statewide	90%	50%	16%	26%	67%	43%
SED						
Amerigroup		88%	64%	27%	10%	19%
Sunflower		80%	53%	22%	13%	11%
United		78%	63%	19%	4%	4%
Statewide	89%	82%	60%	23%	9%	12%

KDADS HCBS Quality Review Report

Health and Welfare
PM 5: Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames
Numerator: Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver
Denominator: Number of participants' reported critical incidents
Review Period: 04/01/2017 - 06/30/2017
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

Adverse Incident Reporting (AIR) system process in development, implementation pending.

Remediation:

Remediation not available at this time.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup						
Sunflower						
United						
Statewide						
FE						
Amerigroup						
Sunflower						
United						
Statewide						
IDD						
Amerigroup						
Sunflower						
United						
Statewide						
TBI						
Amerigroup						
Sunflower						
United						
Statewide						
TA						
Amerigroup						
Sunflower						
United						
Statewide						
Autism						
Amerigroup						
Sunflower						
United						
Statewide						
SED						
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Health and Welfare
PM 6: Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures
Numerator: Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver
Denominator: Number of reported critical incidents
Review Period: 04/01/2017 - 06/30/2017
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

Adverse Incident Reporting (AIR) system process in development, implementation pending.

Remediation:

Remediation not available at this time.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup						
Sunflower						
United						
Statewide						
FE						
Amerigroup						
Sunflower						
United						
Statewide						
IDD						
Amerigroup						
Sunflower						
United						
Statewide						
TBI						
Amerigroup						
Sunflower						
United						
Statewide						
TA						
Amerigroup						
Sunflower						
United						
Statewide						
Autism						
Amerigroup						
Sunflower						
United						
Statewide						
SED						
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Health and Welfare
PM 7: Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver
Numerator: Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver
Denominator: Number of restraint applications, seclusion or other restrictive interventions
Review Period: 04/01/2017 - 06/30/2017
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

Adverse Incident Reporting (AIR) system process in development, implementation pending.

Remediation:

Remediation not available at this time.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup						
Sunflower						
United						
Statewide						
FE						
Amerigroup						
Sunflower						
United						
Statewide						
IDD						
Amerigroup						
Sunflower						
United						
Statewide						
TBI						
Amerigroup						
Sunflower						
United						
Statewide						
TA						
Amerigroup						
Sunflower						
United						
Statewide						
Autism						
Amerigroup						
Sunflower						
United						
Statewide						
SED						
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Health and Welfare
PM 8: Number and percent of unauthorized uses of restrictive interventions that were appropriately reported
Numerator: Number of unauthorized uses of restrictive interventions that were appropriately reported
Denominator: Number of unauthorized uses of restrictive interventions
Review Period: 04/01/2017 - 06/30/2017
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

Adverse Incident Reporting (AIR) system process in development, implementation pending.

Remediation:

Remediation not available at this time.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup						
Sunflower						
United						
Statewide						
FE						
Amerigroup						
Sunflower						
United						
Statewide						
IDD						
Amerigroup						
Sunflower						
United						
Statewide						
TBI						
Amerigroup						
Sunflower						
United						
Statewide						
TA						
Amerigroup						
Sunflower						
United						
Statewide						
Autism						
Amerigroup						
Sunflower						
United						
Statewide						
SED						
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Health and Welfare
PM 9: Number and percent of waiver participants who received physical exams in accordance with State policies
Numerator: Number of HCBS participants who received physical exams in accordance with State policies
Denominator: Number of HCBS participants whose service plans were reviewed
Review Period: 04/01/2017 - 06/30/2017
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**9%**	**45%**	**19%**	**24%**
Numerator	3	13	5	21
Denominator	32	29	27	88
FE	**22%**	**24%**	**9%**	**18%**
Numerator	5	8	3	16
Denominator	23	34	33	90
IDD	**15%**	**45%**	**5%**	**27%**
Numerator	4	19	1	24
Denominator	26	42	22	90
TBI	**3%**	**42%**	**0%**	**12%**
Numerator	1	5	0	6
Denominator	29	12	8	49
TA	**17%**	**56%**	**50%**	**35%**
Numerator	5	10	4	19
Denominator	29	18	8	55
Autism	**0%**	**40%**	**20%**	**21%**
Numerator	0	2	1	3
Denominator	4	5	5	14
SED	**74%**	**32%**	**48%**	**54%**
Numerator	20	6	11	37
Denominator	27	19	23	69

Explanation of Findings:

Documentation is missing in the file to indicate a "physical exam" was completed as required. Date of physical exam is missing in the provided documentation. Physical exam was not completed within the required timeframe.

Remediation:

SCC to send remediation template to applicable MCO for completion on applicable waivers.

SCC to provide to fallout data to assessing entity for review.

SCC will continue to address consistency with interpretive guidance.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup		78%			15%	9%
Sunflower		81%			30%	45%
United		88%			86%	19%
Statewide	Not a measure	82%	No Data	No Data	38%	24%
FE						
Amerigroup		89%			25%	22%
Sunflower		97%			42%	24%
United		97%			75%	9%
Statewide	Not a measure	95%	No Data	No Data	47%	18%
IDD						
Amerigroup		91%			30%	15%
Sunflower		99%			53%	45%
United		99%			61%	5%
Statewide	Not a measure	97%	No Data	No Data	48%	27%
TBI						
Amerigroup		84%			23%	3%
Sunflower		94%			25%	42%
United		93%			33%	0%
Statewide	Not a measure	90%	No Data	No Data	25%	12%
TA						
Amerigroup		100%			45%	17%
Sunflower		100%			57%	56%
United		97%			71%	50%
Statewide	Not a measure	100%	No Data	No Data	53%	35%
Autism						
Amerigroup		100%			60%	0%
Sunflower		92%			67%	40%
United		100%			0%	20%
Statewide	Not a measure	98%	No Data	No Data	58%	21%
SED						
Amerigroup		54%			70%	74%
Sunflower		55%			15%	32%
United		46%			39%	48%
Statewide	Not a measure	52%	No Data	No Data	44%	54%

KDADS HCBS Quality Review Report

Health and Welfare
PM 10: Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan
Numerator: Number of waiver participants who have a disaster red flag designation with a related disaster backup plan
Denominator: Number of waiver participants with a red flag designation
Review Period: 04/01/2017 - 06/30/2017
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**94%**	**84%**	**85%**	**88%**
Numerator	30	26	23	79
Denominator	32	31	27	90
FE	**83%**	**79%**	**91%**	**84%**
Numerator	19	27	30	76
Denominator	23	34	33	90
IDD	**81%**	**67%**	**83%**	**75%**
Numerator	22	28	19	69
Denominator	27	42	23	92
TBI	**90%**	**85%**	**78%**	**87%**
Numerator	27	11	7	45
Denominator	30	13	9	52
TA	**97%**	**72%**	**100%**	**89%**
Numerator	28	13	9	50
Denominator	29	18	9	56
Autism	**75%**	**100%**	**20%**	**64%**
Numerator	3	5	1	9
Denominator	4	5	5	14
SED	**Not a waiver performance measure**			
Numerator				
Denominator				

Explanation of Findings:

The BUP is on the service plan but is not signed and/or dated by the individual.
Missing the BUP for all or part of the review period. BUP is very vague or only partially complete (does not address all identified health and safety risks and staffing issues). BUP is not specific to the individual.

Remediation:

SCC to send remediation template to applicable MCO for completion on applicable waivers. All waivers less SED on this measure.

SCC to provide to fallout data to assessing entity for review.

SCC will continue to address consistency with interpretive guidance.

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Amerigroup		59%	53%	73%	74%	94%
Sunflower		77%	49%	66%	77%	84%
United		64%	80%	88%	83%	85%
Statewide	Not a measure	67%	58%	75%	77%	88%
FE						
Amerigroup		61%	62%	72%	73%	83%
Sunflower		72%	56%	72%	68%	79%
United		76%	81%	85%	93%	91%
Statewide	59%	70%	65%	76%	77%	84%
IDD						
Amerigroup		67%	61%	65%	68%	81%
Sunflower		58%	32%	59%	75%	67%
United		70%	58%	73%	87%	83%
Statewide	Not a measure	64%	47%	64%	76%	75%
TBI						
Amerigroup		46%	49%	62%	62%	90%
Sunflower		68%	42%	80%	85%	85%
United		56%	74%	80%	100%	78%
Statewide	Not a measure	56%	52%	70%	73%	87%
TA						
Amerigroup		75%	54%	79%	72%	97%
Sunflower		91%	58%	77%	81%	72%
United		86%	63%	79%	89%	100%
Statewide	Not a measure	83%	57%	78%	78%	89%
Autism						
Amerigroup		77%	44%	32%	80%	75%
Sunflower		53%	27%	67%	83%	100%
United		38%	7%	6%	0%	20%
Statewide	Not a measure	64%	30%	40%	75%	64%
SED	**Not a waiver performance measure**					
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Financial Accountability
PM 1: Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract
Numerator: Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract
Denominator: Total number of provider claims
Review Period: 04/01/2017 - 06/30/2017
Data Source: MCO Claims Data

Compliance By Waiver	Statewide
HCBS Waivers	**95%**
Numerator	277,900
Denominator	293,268

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
All HCBS Waivers						
Statewide	not a measure	90%	88%	95%	95%	95%

Explanation of Findings:

Remediation:

KDADS HCBS Quality Review Report

Financial Accountability

PM 2: Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS
Numerator: Number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS
Denominator: Total number of capitation (payment) rates
Review Period: 04/01/2017 - 06/30/2017
Data Source: KDHE

Compliance By Waiver	Statewide
PD	**100%**
Numerator	24
Denominator	24
FE	**100%**
Numerator	24
Denominator	24
IDD	**100%**
Numerator	48
Denominator	48
TBI	**100%**
Numerator	12
Denominator	12
TA	**100%**
Numerator	12
Denominator	12
Autism	**100%**
Numerator	12
Denominator	12
SED	**100%**
Numerator	12
Denominator	12

Compliance Trends	2013	2014	2015	2016	Jan-Mar 2017	Apr-June 2017
PD						
Statewide	not a measure	100%	100%	100%	100%	100%
FE						
Statewide	not a measure	100%	100%	100%	100%	100%
IDD						
Statewide	not a measure	100%	100%	100%	100%	100%
TBI						
Statewide	not a measure	100%	100%	100%	100%	100%
TA						
Statewide	not a measure	100%	100%	100%	100%	100%
Autism						
Statewide	not a measure	100%	100%	100%	100%	100%
SED						
Statewide	not a measure	100%	100%	100%	100%	100%

Explanation of Findings:

Remediation:

KanCare Ombudsman Quarterly Report

Kerrie J. Bacon, KanCare Ombudsman
4th Quarter 2017 Report

Executive Summary Dashboard

1. Contacts have increased from fourth quarter 2016 to fourth quarter 2017 by 99% (523 to 1040). Page 2.

Contacts by Office	Q4/16	Q4/17
Main	432	718
Johnson County	21	62
Wichita	70	260
Total	**523**	**1,040**

Contact Method	Q3/17	Q4/17
Email	143	122
Face-to-Face Meeting	6	8
Letter	0	0
ONLINE	0	0
Other	5	4
Telephone	816	906
Total	**970**	**1,040**

	Q3/17	Q4/17
Avg. Days to Resolve Issue	9	7
% files resolved in one day or less	34%	45%
% files closed	90%	83%

2. Top five issues for fourth quarter (without Other):

Issues	Q4/17
Medicaid Eligibility Issues	300
Medicaid Application Assistance	179
HCBS Eligibility issues	61
Medicaid Renewal	58
HCBS General Issues	49

Accessibility by Ombudsman's Office

The KanCare Ombudsman was available to members and potential members of KanCare (Medicaid) by phone, email, written communication and in person during the fourth quarter of 2017. The number of contacts for the Ombudsman's office received during 4th quarter doubled from 2016 to 2017 (523 to 1040); the percent of increase is 99%. Fourth quarter continued the trend of increasing contacts each quarter since the beginning of 2017 ending only 90 contacts short of the highest quarter (Q1, 2016) during the five years of the Ombudsman's office time of operation.

Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Qtr. Avg.	Comments
2013	615	456	436	341		this year does not include emails
2014	545	474	526	547	523	
2015	510	462	579	524	519	
2016	**1,130**	846	687	523	797	
2017	825	835	970	**1,040**	918	January 2018, 464 contacts
2016 vs. 2017	-27%	-1%	41%	99%	15%	

In the chart below, the "percent of files closed" is relatively low for Q4/17 in comparison to other quarters in the past two years. Because of the higher call volume, the Ombudsman's assistant, whose task is to close a certain percentage of cases, was given a lower goal in closing and was prioritized to answering emails coming to the Ombudsman's office (due to the higher contact volume).

	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17	Q4/17
Avg. Days to Resolve Issue	7	5	6	4	11	9	9	7
% files resolved in one day or less	50%	56%	54%	52%	34%	44%	34%	45%
% files closed	77%	88%	87%	80%	88%	92%	90%	83%

Outreach by Ombudsman's office

Presentations: (educational, networking, referrals)

- 2017 Live Well Age Well, a JOCO 50+ Clubs Event (Overland Park, KS) (October 19, 2017)
- Spoke at InterHab Conference (October 25, 2017)
- St. Mary's University Career and Graduate School Fair (Kansas City, KS) (November 8, 2017)
- Governor's Conference November 1st through the 3rd. Maintained booth interacted with approximately 60 people.
- KanCare Listening Session (Dodge City) (November 14, 2017) (2 sessions approximately 30 people per session.
- KanCare Listening session (Wichita (November 16, 2017) 2 sessions approximately 20 people per session.
- Schlagle High School Health Fair (Kansas City, KS) (December 11, 2017)
- **KanCare Ombudsman Liaison Training Sessions**: (educational, networking, referrals, increase capacity)
    - RCIL, Emporia, KS (Lyon Co.) (October 25, 2017)
    - Catholic Charities, Kansas City (Wyandotte Co.) (October 30, 2017)
    - ECKAAA, Ottawa, KS (Franklin Co.) (November 29, 2017)

Publications: Outreach, posts and/or articles about the KanCare Ombudsman office services.

- Shepherd's Voice (Kansas City, KS) (October 2017)
- St. Paul's Catholic Church News Bulletin (Olathe, KS) (October 2017)
- The Communicator (Wyandotte/Leavenworth, KS) (November and December 2017)
- Golden Years Newspaper (Counties: Franklin, Osage, Anderson, Linn, Coffey) (Oct, Nov, Dec 2017)
- Mailed or emailed KanCare Ombudsman flyers to:
    - Atwater Neighborhood Resource Center, Wichita, October
    - Colvin Neighborhood Resource Center, Wichita, October
    - United Methodist Open Door, Wichita, October
    - St. Mark United Methodist Church, Wichita, October
    - Grasslands Estates, Wichita, October
    - Andover Senior Center, Andover, October
    - Northeast Senior Center, Wichita; November
    - Glenville Church, Wichita, November
    - First United Methodist Church, Wichita, November
    - St. Mark's Cathedral Church of God, Wichita, November
    - Fresh Hope, Wichita, November

Outreach through the KanCare Ombudsman Volunteer Program Update.

- The ***KanCare Ombudsman Johnson County Satellite Office*** has been providing assistance to KanCare members for almost a year and a half. The Johnson County Satellite office is answering the phone and meeting with individuals on Wednesdays (10-1), Thursdays (10-4), and Fridays (10-1). Two Education Resource and Information volunteers, through St. Mary's college, assist with developing resources for the Ombudsman's office.
- The ***KanCare Ombudsman Southern Kansas Satellite Office (Wichita)*** has been open two years, providing assistance to KanCare members. The Southern Kansas Satellite Office is answering the phone and meeting with individuals Monday (12-4), Tuesday (10-2), Thursday (10-12) and Friday (12-4). One intern through Wichita State University assists with community outreach, resources, and assisting beneficiaries.
- Both Satellite offices assist consumers with filling out applications on the phone and by appointment, in person.

Data by Ombudsman's Office

The Ombudsman on-line tracker has been updated to include the main Ombudsman office and the two Ombudsman satellite offices covered by volunteers.

The reason for the variance in the numbers in the satellite offices is when volunteers start or end their time with the Ombudsman's office. For example, in Johnson County there were two volunteers for some time, then there were four, then it dropped back to three. You can see the number of calls taken reflected in the number of volunteers available to take those calls. Something similar happened in Wichita between first, second and third quarters.

During fourth quarter we found that the 620 area code numbers, for some reason, had stopped going to the Wichita office. It's not clear when that happened, although if you look at the chart below, it may have been in second quarter. It was fixed by early November which accounts for the increase in numbers for Wichita for fourth quarter.

Contacts by Office	**Q4/16**	**Q1/17**	**Q2/17**	**Q3/17**	**Q4/17**
Main	432	648	639	759	718
Johnson County	21	28	81	51	62
Wichita	70	149	115	160	260
Total	**523**	**825**	**835**	**970**	**1,040**

Contact Method	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17	Q4/17
Email	291	192	175	125	125	127	143	122
Face-to-Face Meeting	0	8	3	3	11	5	6	8
Letter	2	3	1	0	2	0	0	0
ONLINE	0	0	0	0	0	0	0	0
Other	3	0	2	1	0	2	5	4
Telephone	866	647	507	393	689	701	816	906
Total	**1162**	**850**	**688**	**522**	**827**	**835**	**970**	**1040**

Note: NEW: Numbers may vary from prior reports due to continuing work on past quarters and pulling information from data reporting rather than adding information to chart each quarter.

Caller Type	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17	Q4/17
Consumer	876	601	544	351	631	661	773	862
MCO Employee	8	4	11	8	18	9	11	6
Other type	93	133	33	92	61	53	45	50
Provider	185	112	100	71	117	112	141	122
Total	**1162**	**850**	**688**	**522**	**827**	**835**	**970**	**1040**

Note: NEW: Numbers may vary from prior reports due to continuing work on past quarters and pulling information from data reporting rather than adding information to chart each quarter.

The most frequent calls regarding home and community-based services (HCBS) waivers during the fourth quarter of 2017 was regarding the intellectual developmental disability waiver, then the physical disability waiver, second, and the frail/elderly waiver was third.

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	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17	Q4/17
PD	48	22	13	9	40	37	32	45
I/DD	49	27	21	11	43	28	52	77
FE	23	19	10	7	30	27	33	38
AUTISM	1	2	2	1	3	2	2	0
SED	4	0	1	3	4	4	5	5
TBI	11	3	7	5	6	8	7	6
TA	13	10	4	4	8	10	2	7
WH	0	0	0	0	0	0	1	3
MFP	8	5	3	0	2	1	0	0
PACE	0	0	0	0	0	0	1	1
MENTAL HEALTH	11	7	3	2	5	5	2	5
SUB USE DIS	0	0	0	0	0	0	0	0
NURSING FACILITY	51	27	16	27	66	45	79	61
Total	**219**	**122**	**80**	**69**	**207**	**167**	**216**	**248**

Note: NEW: Numbers may vary from prior reports due to continuing work on past quarters and pulling information from data reporting rather than adding information to chart each quarter.

The Issue Categories listed below reflect the last two years in alphabetical order. The top six issues for each quarter are highlighted. The issues that carry across several quarters are Medicaid Eligibility Issues, Other and HCBS Eligibility Issues.

The highlighted issues on the left were added at the end of fourth quarter. There may be multiple issues for a member/contact.

Issues	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17	Q4/17
Access to Providers (usually Medical)	7	6	9	13	14	14	13	10
Abuse / neglect complaints	0	0	0	0	0	0	0	2
Affordable Care Act Calls	0	0	0	0	3	6	5	5
Appeals/Fair Hearing questions/issues	0	0	0	0	0	0	21	23
Background Checks	0	0	0	0	0	0	0	2
Billing	44	40	37	26	21	33	17	19
Care Coordinator Issues	8	3	6	4	5	11	6	12
Change MCO	15	3	0	6	3	1	2	6
Choice Info on MCO	0	0	0	0	0	0	0	0
Client Obligation	0	0	0	0	17	36	37	33
Coding Issues	0	0	0	0	3	0	8	18
Consumer said Notice not received	0	0	0	0	0	0	0	1
Cultural Competency	0	0	0	0	0	0	0	0
Data Requests	0	0	0	0	0	0	3	5
Dental	4	5	5	5	7	9	7	6
Division of Assets	0	0	0	0	2	2	5	5
Durable Medical Equipment	7	7	2	4	2	9	4	3
Estate Recovery	0	0	0	0	6	5	6	4
Grievances Questions/Issues	53	42	36	16	36	33	29	9
Guardianship	0	1	2	2	3	1	3	4
HCBS Eligibility issues	46	33	21	9	46	50	58	61
HCBS General Issues	70	32	16	15	33	34	21	49
HCBS Reduction in hours of service	13	4	3	3	7	2	4	6
HCBS Waiting List	18	2	2	4	6	9	8	4
Health Homes	8	2	0	2	0	3	0	0
Housing Issues	8	2	2	3	4	6	7	0
Medicaid Application Assistance	0	0	0	0	45	55	162	179
Medicaid Coding	0	0	0	0	0	0	0	0
Medicaid Eligibility Issues	529	247	173	173	237	177	237	299
Medicaid Fraud	0	0	0	0	0	0	0	0
Medicaid info (status) update	0	0	0	0	0	0	0	2
Medicaid Renewal	0	0	0	0	29	43	38	61
Medical Services	29	21	10	12	20	20	11	9
Medicare related Issues	0	0	0	0	0	0	15	22
Medicare Savings Plan Issues	0	0	0	0	0	0	9	21
Moving to / from Kansas	0	0	0	0	5	7	6	9
Nursing Facility Issues	42	26	22	22	40	26	23	21
Pharmacy	26	14	11	8	11	9	10	13
Questions for Conference Calls/Sessions	0	0	1	2	0	0	0	0
Respite	0	0	0	0	0	0	0	0
Social Security Issues	0	0	0	0	0	0	1	4
Spend Down Issues	19	19	17	16	18	32	29	28
Transportation	6	8	6	1	8	9	12	5

Working Healthy	0	0	0	0	0	0	2	3
X-Other	356	381	382	223	275	315	241	188
Z Thank you.	79	94	115	101	238	319	416	430
Z Unspecified	34	38	20	18	44	36	61	75
Total	**1421**	**1030**	**898**	**688**	**1188**	**1312**	**1537**	**1656**

Note: NEW: Numbers may vary from prior reports due to continuing work on past quarters and pulling information from data reporting rather than adding information to chart each quarter.

Issues by Managed Care Organization

Amerigroup

Note: NEW: Numbers may vary from prior reports due to continuing work on past quarters and pulling information from data reporting rather than adding information to chart each quarter.

Issue Category - Amerigroup	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17	Q4/17
Access to Providers (usually Medical)	1	1	2	2	3	7	2	2
Abuse / neglect complaints	0	0	0	0	0	0	0	0
Affordable Care Act Calls	0	0	0	0	0	0	0	0
Appeals/Fair Hearing questions/issues	0	0	0	0	0	0	2	3
Background Checks	0	0	0	0	0	0	0	1
Billing	11	6	7	2	1	5	3	2
Care Coordinator Issues	4	1	3	1	1	4	0	3
Change MCO	1	1	0	0	1	0	0	1
Choice Info on MCO	0	0	0	0	0	0	0	0
Client Obligation	0	0	0	0	1	7	4	3
Coding Issues	0	0	0	0	0	0	3	2
Consumer said Notice not received	0	0	0	0	0	0	0	1
Cultural Competency	0	0	0	0	0	0	0	0
Data Requests	0	0	0	0	0	0	0	0
Dental	0	0	1	1	0	0	1	0
Division of Assets	0	0	0	0	0	0	0	0
Durable Medical Equipment	2	2	1	1	0	1	1	0
Estate Recovery	0	0	0	0	0	1	0	1
Grievances Questions/Issues	9	5	1	0	10	4	4	0
Guardianship	0	0	0	0	1	0	0	0
HCBS Eligibility issues	8	5	4	0	6	7	7	10
HCBS General Issues	13	3	3	3	11	10	3	8
HCBS Reduction in hours of service	6	1	1	1	2	0	0	2
HCBS Waiting List	0	0	0	1	1	2	0	1
Health Homes	1	0	0	0	0	2	0	0
Housing Issues	1	1	0	1	0	1	1	0
Medicaid Application Assistance	0	0	0	0	0	0	0	1
Medicaid Coding	0	0	0	0	0	0	0	0
Medicaid Eligibility Issues	30	10	5	6	8	5	10	18
Medicaid Fraud	0	0	0	0	0	0	0	0
Medicaid info (status) update	0	0	0	0	0	0	0	0
Medicaid Renewal	0	0	0	0	4	7	3	8
Medical Services	7	2	3	1	5	7	1	0
Medicare related Issues	0	0	0	0	0	0	2	3
Medicare Savings Plan Issues	0	0	0	0	0	0	0	1
Moving to / from Kansas	0	0	0	0	1	0	0	1
Nursing Facility Issues	2	1	0	1	1	4	0	0

Pharmacy	4	1	0	2	1	2	2	1
Questions for Conference Calls/Sessions	0	0	0	0	0	0	0	0
Respite	0	0	0	0	0	0	0	0
Social Security Issues	0	0	0	0	0	0	0	0
Spend Down Issues	2	3	0	3	2	5	2	4
Transportation	2	1	1	0	1	1	3	0
Working Healthy	0	0	0	0	0	0	0	0
X-Other	20	16	20	9	14	19	11	6
Z Thank you.	6	4	9	5	23	31	13	26
Z Unspecified	2	0	0	2	1	1	1	0
Total	**132**	**64**	**61**	**42**	**99**	**133**	**79**	**109**

WAIVER - Amerigroup	**Q1/16**	**Q2/16**	**Q3/16**	**Q4/16**	**Q1/17**	**Q2/17**	**Q3/17**	**Q4/17**
PD	8	5	1	2	12	9	3	12
I/DD	10	8	3	3	9	2	6	8
FE	7	0	1	1	3	6	3	7
AUTISM	0	0	1	0	1	1	0	0
SED	2	0	0	1	1	3	2	1
TBI	5	1	2	2	2	2	3	1
TA	4	3	1	0	2	4	2	1
WH	0	0	0	0	0	0	1	0
MFP	0	0	0	0	0	0	0	0
PACE	0	0	0	0	0	0	0	0
MENTAL HEALTH	3	2	0	0	1	1	2	0
SUB USE DIS	0	0	0	0	0	0	0	0
NURSING FACILITY	1	1	1	0	2	3	2	0
Total	**40**	**20**	**10**	**9**	**33**	**31**	**24**	**30**

Sunflower

Note: NEW: Numbers may vary from prior reports due to continuing work on past quarters and pulling information from data reporting rather than adding information to chart each quarter.

Issue Category - Sunflower	**Q1/16**	**Q2/16**	**Q3/16**	**Q4/16**	**Q1/17**	**Q2/17**	**Q3/17**	**Q4/17**
Access to Providers (usually Medical)	1	1	2	0	4	3	2	3
Abuse / neglect complaints	0	0	0	0	0	0	0	0
Affordable Care Act Calls	0	0	0	0	0	1	0	0
Appeals/Fair Hearing questions/issues	0	0	0	0	0	0	1	1
Background Checks	0	0	0	0	0	0	0	0
Billing	6	8	9	7	3	6	5	9
Care Coordinator Issues	2	1	1	2	1	2	1	6
Change MCO	3	1	0	1	0	0	0	3
Choice Info on MCO	0	0	0	0	0	0	0	0
Client Obligation	0	0	0	0	3	5	4	5
Coding Issues	0	0	0	0	2	0	1	3
Consumer said Notice not received	0	0	0	0	0	0	0	0
Cultural Competency	0	0	0	0	0	0	0	0
Data Requests	0	0	0	0	0	0	0	0
Dental	1	2	0	0	0	1	1	1
Division of Assets	0	0	0	0	0	0	0	0

Durable Medical Equipment	5	2	0	2	0	2	1	2
Estate Recovery	0	0	0	0	0	0	1	0
Grievances Questions/Issues	14	11	8	2	5	8	1	3
Guardianship	0	0	0	0	0	0	1	0
HCBS Eligibility issues	3	7	3	2	3	10	10	6
HCBS General Issues	15	9	1	5	5	6	3	9
HCBS Reduction in hours of service	0	3	1	0	1	1	1	0
HCBS Waiting List	1	0	0	0	1	1	0	1
Health Homes	1	1	0	0	0	0	0	0
Housing Issues	0	0	0	0	1	1	1	0
Medicaid Application Assistance	0	0	0	0	1	0	3	2
Medicaid Coding	0	0	0	0	0	0	0	0
Medicaid Eligibility Issues	26	7	10	9	14	8	13	14
Medicaid Fraud	0	0	0	0	0	0	0	0
Medicaid info (status) update	0	0	0	0	0	0	0	0
Medicaid Renewal	0	0	0	0	6	5	8	6
Medical Services	4	8	0	3	5	3	5	1
Medicare related Issues	0	0	0	0	0	0	1	1
Medicare Savings Plan Issues	0	0	0	0	0	0	0	1
Moving to / from Kansas	0	0	0	0	0	1	0	0
Nursing Facility Issues	3	4	2	1	2	1	0	1
Pharmacy	4	1	4	4	4	3	1	0
Questions for Conference Calls/Sessions	0	0	0	0	0	0	0	0
Respite	0	0	0	0	0	0	0	0
Social Security Issues	0	0	0	0	0	0	0	1
Spend Down Issues	3	3	2	0	2	4	4	3
Transportation	1	2	4	1	4	3	1	1
Working Healthy	0	0	0	0	0	0	0	0
X-Other	23	12	24	16	18	19	11	15
Z Thank you.	7	6	8	11	20	25	31	32
Z Unspecified	1	0	0	0	1	0	1	2
Total	**124**	**89**	**79**	**66**	**106**	**119**	**113**	**132**

WAIVER - Sunflower	**Q1/16**	**Q2/16**	**Q3/16**	**Q4/16**	**Q1/17**	**Q2/17**	**Q3/17**	**Q4/17**
PD	16	6	2	3	7	8	8	8
I/DD	11	4	5	2	8	4	10	12
FE	1	6	1	1	4	5	3	6
AUTISM	0	1	0	0	1	0	1	0
SED	0	0	1	1	0	1	0	0
TBI	0	0	4	2	1	2	0	1
TA	3	2	2	2	2	2	0	1
WH	0	0	0	0	0	0	0	1
MFP	3	1	0	0	0	1	0	0
PACE	0	0	0	0	0	0	0	0
MENTAL HEALTH	2	2	2	0	1	1	0	0
SUB USE DIS	0	0	0	0	0	0	0	0
NURSING FACILITY	6	5	2	2	4	6	3	3
Total	**42**	**27**	**19**	**13**	**28**	**30**	**25**	**32**

UnitedHealthcare

Note: NEW: Numbers may vary from prior reports due to continuing work on past quarters and pulling information from data reporting rather than adding information to chart each quarter.

Issue Category - UnitedHealthcare	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17	Q4/17
Access to Providers (usually Medical)	2	1	0	2	4	2	0	2
Abuse / neglect complaints	0	0	0	0	0	0	0	1
Affordable Care Act Calls	0	0	0	0	0	0	0	0
Appeals/Fair Hearing questions/issues	0	0	0	0	0	0	3	2
Background Checks	0	0	0	0	0	0	0	0
Billing	3	5	2	3	3	7	3	0
Care Coordinator Issues	0	0	2	1	3	1	4	1
Change MCO	3	0	0	4	2	1	1	2
Choice Info on MCO	0	0	0	0	0	0	0	0
Client Obligation	0	0	0	0	2	2	3	5
Coding Issues	0	0	0	0	0	0	0	3
Consumer said Notice not received	0	0	0	0	0	0	0	0
Cultural Competency	0	0	0	0	0	0	0	0
Data Requests	0	0	0	0	0	0	0	0
Dental	1	3	2	0	1	3	2	0
Division of Assets	0	0	0	0	0	0	1	0
Durable Medical Equipment	0	1	0	0	2	2	1	0
Estate Recovery	0	0	0	0	0	1	0	0
Grievances Questions/Issues	6	4	5	1	3	3	4	0
Guardianship	0	0	0	1	0	0	1	0
HCBS Eligibility issues	6	4	2	0	9	6	3	7
HCBS General Issues	11	5	2	3	2	4	5	5
HCBS Reduction in hours of service	2	0	0	2	2	0	2	0
HCBS Waiting List	2	1	1	0	0	0	0	0
Health Homes	1	0	0	0	0	0	0	0
Housing Issues	0	0	0	0	0	0	1	0
Medicaid Application Assistance	0	0	0	0	0	1	1	2
Medicaid Coding	0	0	0	0	0	0	0	0
Medicaid Eligibility Issues	18	4	5	5	7	7	9	19
Medicaid Fraud	0	0	0	0	0	0	0	0
Medicaid info (status) update	0	0	0	0	0	0	0	0
Medicaid Renewal	0	0	0	0	1	1	6	6
Medical Services	4	1	4	0	3	3	0	2
Medicare related Issues	0	0	0	0	0	0	2	1
Medicare Savings Plan Issues	0	0	0	0	0	0	0	1
Moving to / from Kansas	0	0	0	0	0	0	0	0
Nursing Facility Issues	2	1	2	2	2	2	1	2
Pharmacy	8	2	4	0	0	1	0	3
Questions for Conference Calls/Sessions	0	0	0	0	0	0	0	0
Respite	0	0	0	0	0	0	0	0
Social Security Issues	0	0	0	0	0	0	0	0

Spend Down Issues	0	2	0	1	0	1	6	2
Transportation	1	0	0	0	2	2	2	1
Working Healthy	0	0	0	0	0	0	0	0
X-Other	14	20	21	12	15	17	13	12
Z Thank you.	5	10	7	9	11	22	30	33
Z Unspecified	2	0	0	0	2	0	4	4
Total	**91**	**64**	**59**	**46**	**76**	**89**	**108**	**116**

WAIVER - UnitedHealthcare	**Q1/16**	**Q2/16**	**Q3/16**	**Q4/16**	**Q1/17**	**Q2/17**	**Q3/17**	**Q4/17**
PD	7	4	1	1	8	3	5	4
I/DD	7	3	3	1	5	2	6	9
FE	7	4	1	2	7	3	5	6
AUTISM	0	0	1	0	0	1	0	0
SED	1	0	0	0	1	0	0	0
TBI	1	2	0	0	2	1	2	0
TA	2	0	0	0	0	1	0	2
WH	0	0	0	0	0	0	0	0
MFP	3	1	2	0	0	0	0	0
PACE	0	0	0	0	0	0	0	0
MENTAL HEALTH	2	0	0	0	0	1	0	2
SUB USE DIS	0	0	0	0	0	0	0	0
NURSING FACILITY	3	0	0	4	5	2	6	3
Total	**33**	**14**	**8**	**8**	**28**	**14**	**24**	**26**

Action Taken to Resolve Issues by Ombudsman's Office

The ***"Resolved"*** section explains how cases have been closed. If a call is returned and the person has already received an answer and does not need help from the Ombudsman's office or the person called to vent, then it is marked "Resolved" and closed. The ***"Used Contacts or Resources"*** shows when resources are provided; explaining KanCare processes, providing phone numbers, sending information by way of mail or email, or using contacts or resources that are listed in the blue or green categories below. Our offices will contact those offices themselves, with the member, or refer the member to the organization. Once it is resolved this is the section that is used. The **"Closed"** section is when a person contacts our offices and leaves a message and we are not able to get back in touch with them; either because the number left is a wrong number, there is no voice mail to leave a message and they don't call back, or messages are left and they don't return the call. After a month or so, the case is closed.

Action Taken	**Q1/16**	**Q2/16**	**Q3/16**	**Q4/16**	**Q1/17**	**Q2/17**	**Q3/17**	**Q4/17**
QUESTION/ISSUE RESOLVED (NO RESOURCES)	161	249	306	213	163	81	73	100
USED CONTACT OR RESOURCES/ISSUE RESOLVED	472	395	314	175	504	601	685	704
CLOSED (NO CONTACT)	343	367	111	20	91	75	110	85

Note: NEW: Numbers may vary from prior reports due to continuing work on past quarters and pulling information from data reporting rather than adding information to chart each quarter.

"Resources" provided to members can be in many forms: a phone number for an agency, explaining the process for filing a grievance, answering a question about estate recovery, walking someone through the spenddown calculation, offering to mail the Medicaid application, or client obligation explanation, etc. These are just a few examples of the resources provided verbally, mailed and emailed to potential members, members, family, and providers assisting members.

Action Taken	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17	Q4/17
PROVIDED RESOURCES	367	239	116	93	238	307	346	439
MAILED/EMAIL RESOURCES	0	0	0	2	46	123	124	116

Note: NEW: Numbers may vary from prior reports due to continuing work on past quarters and pulling information from data reporting rather than adding information to chart each quarter.

The Resource Category below shows what action was taken and what contacts were made on behalf of a member, potential member, provider or other caller to resolve an issue and what resources where provided. A few new categories were created during first quarter of 2017. History is not available before then. Often multiple resources are provided to a member/contact.

The green lines are contacts that are typically made by the volunteers and staff of the Ombudsman's office to follow up on a call, email or visit. The blue lines show when contacts have been referred to agencies and/or organizations for further information.

Action Taken	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17	Q4/17
KDHE CONTACT	237	106	97	113	135	76	77	60
DCF CONTACT	6	2	1	4	1	4	8	1
MCO CONTACT	52	44	44	31	34	29	18	18
MCO REFERRAL	0	0	0	0	19	34	33	29
CLEARINGHOUSE CONTACT	0	0	0	0	75	130	201	165
CLEARINGHOUSE REFERRAL	0	0	0	2	26	104	142	142
HCBS TEAM CONTACT	30	21	12	5	30	23	24	28
HCBS TEAM REFERRAL	0	0	0	0	7	12	18	19
CSP MENTAL HEALTH CONTACT	1	1	0	0	2	0	1	0
OTHER KDADS CONTACT/REFERRAL	54	17	44	37	49	41	46	88
STATE OR COMMUNITY AGENCY REFERRAL	115	40	53	15	46	78	72	82
DISABILITY RIGHTS AND/OR KLS REFERRAL	13	7	4	3	8	2	1	6

Note: NEW: Numbers may vary from prior reports due to continuing work on past quarters and pulling information from data reporting rather than adding information to chart each quarter.

Next Steps for Ombudsman's Office

Ombudsman Bill in Legislature

The Ombudsman's office is involved with a bill that will move the office to the Department of Administration. If passed, the changes will take place the beginning of FY 2019.

1115 Waiver - Safety Net Care Pool Report
Demonstration Year 5 - Quarter 4
Health Care Access Improvement Pool
Paid date 12/07/2017

Provider Name	HCAIP DY/QTR: 2017/4	Provider Access Fund 2443	Federal Medicaid Fund 3414
Bob Wilson Memorial Hospital	34,539	15,125	19,414
Children's Mercy Hospital South	236,041	103,362	132,679
Coffeyville Regional Medical Center, Inc.	81,937	35,880	46,057
Doctors Hospital	2,436	1,067	1,369
Geary Community Hospital	73,205	32,056	41,149
Great Bend Regional Hospital	81,213	35,563	45,650
Hays Medical Center, Inc.	209,497	91,739	117,758
Hutchinson Regional Medical Center, Inc	139,340	61,017	78,323
Kansas Heart Hospital LLC	32,292	14,141	18,151
Kansas Rehabilitation Hospital	6,548	2,867	3,681
Kansas Surgery & Recovery Center	2,855	1,250	1,605
KVC Behavioral HC (Prairie Ridge)	3,305	1,447	1,858
Labette County Medical Center	55,560	24,330	31,230
Lawrence Memorial Hospital	224,420	98,274	126,146
McPherson Hospital, Inc	36,671	16,058	20,613
Menorah Medical Center	185,244	81,118	104,126
Mercy Health Center - Ft. Scott	49,841	21,825	28,016
Mercy Hospital, Inc.	6,788	2,972	3,816
Mercy Reg Health Ctr	212,631	93,111	119,520
Miami County Medical Center	44,870	19,649	25,221
Mid-America Rehabilitation Hospital	19,047	8,341	10,706
Morton County Health System	15,658	6,857	8,801
Newton Medical Center	126,984	55,606	71,378
Olathe Medical Center	231,620	101,426	130,194
Overland Park Regional Medical Ctr.	688,465	301,479	386,986
Prairie View, Inc.	12,254	5,366	6,888
Pratt Regional Medical Center	41,195	18,039	23,156
Providence Medical Center	382,369	167,439	214,930
Ransom Memorial Hospital	68,703	30,085	38,618
Saint Luke's South Hospital, Inc.	54,808	24,000	30,808
Salina Regional Health Center	184,943	80,987	103,956
Salina Surgical Hospital	6,646	2,910	3,736
Shawnee Mission Medical Center, Inc.	952,775	417,220	535,555
South Central KS Reg Medical Ctr	41,929	18,361	23,568
Southwest Medical Center	87,837	38,464	49,373
St. Catherine Hospital	255,807	112,018	143,789
St. Francis Health Center	489,117	214,184	274,933
St. John Hospital	76,907	33,678	43,229
St. Luke's Cushing Hospital	98,380	43,081	55,299
Stormont Vail Regional Health Center	1,036,373	453,828	582,545
Sumner Regional Medical Center	29,290	12,826	16,464
Susan B. Allen Memorial Hospital	125,052	54,760	70,292
Via Christi - St. Teresa	62,276	27,271	35,005
Via Christi Hospital Pittsburg	174,500	76,414	98,086
Via Christi Hospitals Wichita	1,822,620	798,125	1,024,495
Via Christi Rehabilitation Center	37,517	16,429	21,088
Wesley Medical Center	1,189,061	520,690	668,371
Wesley Rehabilitation Hospital	12,837	5,621	7,216
Western Plains Medical Complex	130,416	57,109	73,307
Total	**10,174,619**	**4,455,466**	**5,719,153**

Kansas Foundation for Medical Care, Inc

800 SW Jackson St., Suite 700
Topeka, Kansas 66612-1265
Phone 785-273-2552
kfmc.org

February 21, 2018

Becky Ross
Medicaid Initiatives Coordinator
Kansas Department of Health & Environment
Division of Health Care Finance
900 SW Jackson St.
Topeka, KS 66612

RE: 2017 KanCare Evaluation Quarterly Report
Year 5, Quarter 4, October - December

Dear Ms. Ross:

Enclosed is the 2017 Quarter 4 KanCare Evaluation Quarterly Report. If you have questions or corrections regarding this information, please contact me, jpanichello@kfmc.org or (785) 271-4138.

Sincerely,

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

Electronic Version: Shirley Norris, Senior Manager, MCO Operations, KDHE

Kansas Foundation for Medical Care, Inc.

ACCREDITED

2017 KanCare Evaluation

Quarterly Report

Year 5, Quarter 4, October - December

Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**February 21, 2018**
Review Team:	**Janice Panichello, PhD, MPA, Director of Quality Review & Epidemiologist**

Prepared for:

KanCare

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Year 5, Quarter 4, October - December

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KanCare Evaluation Quarterly Report
Year 5, Quarter 4, October – December 2017
February 21, 2018

Background/Objectives

The Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF), submitted the KanCare Evaluation Design to the Centers for Medicare & Medicaid Services (CMS) in August 2013; it was approved by CMS in September 2013 and updated in March 2015. The Kansas Foundation for Medical Care, 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 of the KanCare demonstration managed care Medicaid program. A subset of the annual performance measures was selected to be assessed and reported quarterly. The quarterly measures for the fourth quarter (Q4) Calendar Year (CY) 2017 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), Sunflower State Health Plan (Sunflower), and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare). For the KanCare Quarterly and Annual Evaluations, data from the three MCOs are combined wherever possible to better assess the overall impact of the KanCare program.

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

Timely Resolution of Customer Service Inquiries

Quarterly tracking 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 number and category 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.

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

Current Quarter and Trend over Time

In Q4 CY2017, 98.5% of the 77,997 customer service member inquiries reported by the MCOs and 99.7% of the 35,624 provider inquiries were resolved within two business days (see Table 1).

Q4 is the first quarter where resolutions of member inquiries within two days were below 99.0%. All of the 1,170 customer service inquiries from members not resolved within two business days in Q4 were reported by UnitedHealthcare, up from 704 (of 713) in Q3. Of the 110 provider inquiries not resolved within 2 business days, 95 were reported by Amerigroup and 15 by UnitedHealthcare.

In Q4 CY2017, Amerigroup and Sunflower MCOs met contractual requirements for resolving at least 98% of customer service inquiries within 5 business days. UnitedHealthcare reported 97.9% of member inquiries were resolved within 5 business days. All of the 609 customer service inquiries from members that were reported as not resolved within 5 business days in Q4 (and 374 of 375 in Q3) were reported by UnitedHealthcare. Since UnitedHealthcare categorized only the "primary inquiry" from each contact, the total number of inquiries received is most likely higher, and the number not resolved of all inquiries received is unclear.

Amerigroup and Sunflower met the contractual requirements to resolve 100% of inquiries within 15 business days. UnitedHealthcare reported 99.91% of member inquiries and 99.98% of provider inquiries were resolved within 15 days; 46 inquiries from members and six provider inquiries in Q4 CY2017 were reported as not resolved within 15 business days.

Table 1. Timeliness of Resolution of Member and Provider Customer Service Inquiries - Quarter 4, CY2015 to CY2017						
	Quarter 4					
	Member Inquiries			Provider Inquiries		
	CY2015	CY2016	CY2017	CY2015	CY2016	CY2017
Number of Inquiries Received	91,237	83,581	77,997	45,278	37,278	35,624
Number Resolved within 2 Business Days	91,213	83,237	76,827	45,278	37,274	35,513
Number Not Resolved within 2 Business Days	24	345	1,170	0	4	110
% Resolved Within 2 Business Days	99.97%	99.59%	98.50%	100%	99.99%	99.69%
Number Resolved within 5 Business Days	91,237	83,394	77,388	45,278	37,276	35,614
Number Not Resolved within 5 Business Days	0	188	609	0	2	10
% Resolved within 5 Business Days	100%	99.78%	99.22%	100%	99.99%	99.97%
Number Resolved within 15 Business Days	91,237	83,538	77,951	45,278	37,278	35,618
Number Not Resolved within 15 Business Days	0	43	46	0	0	6
% Resolved within 15 Business Days	100%	99.95%	99.94%	100%	100%	99.98%

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).

- The number of inquiries from members in Q4 was the lowest number since MCOs began reporting in Q2 2014.
- *Benefit inquiries* in Q4, as in previous quarters, had the highest percentage (21%) of member inquiries.
- Of the 77,997 customer service inquiries from members in Q4 CY2017, 42% were reported by Sunflower, 37% by UnitedHealthcare, and 21% by Amerigroup.
- As in previous quarters, there are categories where two-thirds or more of the inquiries in the quarter were reported by one MCO. This seems likely to be due to differing interpretations of the criteria for several of the categories in the reporting template. The categories where two-thirds or more of the reported inquiries were from one MCO include:
  - *Update demographic information*: 77% of 10,347 inquiries in Q4 CY2017 were reported by Sunflower (71%–82% for last 13 quarters);
  - *Enrollment information*: 66% of 3,021 inquiries were reported in Q4 CY2017 by Amerigroup (66%–81% for the last 13 quarters);
  - *Care management or health plan program*: 73% of 962 inquiries in Q4 CY2017 were reported by Amerigroup (73%–86% in the last seven quarters);
  - *Member emergent or crisis call*: 99% of 286 inquiries in Q4 CY2017 were reported by Sunflower (98%–99.8% in the last 13 quarters); and
  - *Need transportation*: 74% of 1,700 inquiries were reported in Q4 CY2017 by Amerigroup (66%–77% in the last five quarters).
- Sunflower continued to add a category for *Health Homes*; the 50 customer service inquiries reported in Q4 CY2017 as related to *Health Homes* (which were discontinued in July 2016) were added to the *Other* category for consistency in reporting aggregated counts for the three MCOs.

Table 2. Customer Service Inquiries from Members, Q1 to Q4 CY2017 and Annual Comparison CY2015 to CY2017							
Member Inquiries	CY2017				CY2015	CY2016	CY2017
	Q1	Q2	Q3	Q4			
1. Benefit Inquiry – regular or VAS	17,675	17,216	16,143	**16,913**	77,119	84,047	**67,947**
2. Concern with access to service or care; or concern with service or care disruption	1,889	1,978	1,827	**2,016**	7,101	7,815	**7,710**
3. Care management or health plan program	1,010	1,001	1,140	**962**	11,175	5,711	**4,113**
4. Claim or billing question	5,764	5,398	4,830	**4,277**	27,869	23,192	**20,269**
5. Coordination of benefits	3,075	3,280	3,098	**2,708**	12,444	12,435	**12,161**
6. Disenrollment request	463	524	424	**344**	2,371	2,299	**1,755**
7. Eligibility inquiry	15,475	14,420	13,077	**13,064**	55,717	57,041	**56,036**
8. Enrollment information	3,900	3,234	3,086	**3,021**	9,560	10,789	**13,241**
9. Find/change PCP	10,519	9,554	9,413	**9,875**	53,581	46,873	**39,361**
10. Find a specialist	2,794	3,043	3,043	**2,819**	15,249	12,994	**11,699**
11. Assistance with scheduling an appointment	58	88	119	**113**	148	191	**378**
12. Need transportation	1,353	1,594	1,821	**1,700**	6,223	4,972	**6,468**
13. Order ID card	6,894	6,190	4,521	**3,537**	26,038	25,992	**21,142**
14. Question about letter or outbound call	1,134	2,253	1,045	**1,617**	4,405	5,764	**6,049**
15. Request member materials	732	751	661	**667**	4,759	4,098	**2,811**
16. Update demographic information	13,821	12,568	10,572	**10,347**	51,491	52,628	**47,308**
17. Member emergent or crisis call	655	371	321	**286**	3,150	2,659	**1,633**
18. Other	5,162	5,085	4,332	**3,731**	22,598	20,479	**18,310**
Total	**92,373**	**88,548**	**79,473**	**77,997**	**390,998**	**379,989**	**338,391**

The 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 quarterly GAR reports. To address this, KDHE has revised the Customer Services Inquiries report template to remove this category in monthly reports beginning in Q2 2018.

Provider Customer Service Inquiries

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

- Of the 35,364 provider inquiries in Q4 CY2017, Amerigroup reported 42%, Sunflower 47%, and UnitedHealthcare 11%. The total number and percentages of provider inquiries from each MCO, however, may be inaccurate due to UnitedHealthcare reporting only one primary inquiry from each contact.
- Claim status inquiries were again the highest percentage (51%) of the 39,586 provider inquiries.
- Two provider inquiries reported by Sunflower in Q4 CY2017 as related *Health Homes* were added to the *Other* category for consistency in reporting aggregated counts and percentages for the three MCOs.

As noted in previous quarterly reports, there are several 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*: 99% of 1,333 inquiries in Q4 CY2017 were reported by Amerigroup (98%–99% for the last 13 quarters);
- *Authorization—Status*: 69% of 1,988 inquiries in Q4 CY2017 were reported by Amerigroup (69%–74% in the previous three quarters);
- *Update demographic information*: 96% of 448 inquiries were reported in Q4 CY2017 by Sunflower (91%–99.5% in the last 13 quarters); and
- *Benefits inquiry*: 76% of 1,801 inquiries were reported in Q4 CY2017 by Amerigroup (73% in Q3).

Table 3. Customer Service Inquiries from Providers, Q1 to Q4 CY2017 and Annual Comparison CY2015 to CY2017

Provider Inquiries	CY2017				CY2015	CY2016	CY2017
	Q1	Q2	Q3	Q4			
1. Authorization – New	1,707	1,561	1,332	**1,333**	8,359	7,359	**5,933**
2. Authorization – Status	2,497	2,351	2,360	**1,988**	9,790	10,355	**9,196**
3. Benefits inquiry	2,811	2,730	1,980	**1,801**	16,587	11,868	**9,322**
4. Claim denial inquiry	5,127	5,245	4,876	**4,503**	19,081	19,488	**19,751**
5. Claim status inquiry	17,519	20,320	20,718	**18,585**	83,068	83,422	**77,142**
6. Claim payment question/dispute	3,537	3,910	4,095	**3,210**	22,975	16,390	**14,752**
7. Billing inquiry	367	337	330	**263**	1,958	1,709	**1,297**
8. Coordination of benefits	348	283	202	**167**	3,675	1,530	**1,000**
9. Member eligibility inquiry	1,695	1,634	1,490	**1,626**	7,169	6,819	**6,445**
10. Recoupment or negative balance	83	40	53	**64**	852	267	**240**
11. Pharmacy/prescription inquiry	535	499	496	**542**	2,113	2,185	**2,072**
12. Request provider materials	52	42	33	**32**	189	180	**159**
13. Update demographic information	684	655	426	**448**	2,215	2,557	**2,213**
14. Verify/change participation status	293	243	186	**168**	1,268	1,095	**890**
15. Web support	139	101	99	**83**	852	506	**422**
16. Credentialing issues	160	147	153	**127**	805	669	**587**
17. Other	974	940	757	**684**	5,679	6,924	**3,355**
Total	**38,528**	**41,038**	**39,586**	**35,624**	**186,635**	**173,323**	**154,776**

Of the 17 provider inquiry categories, seven are claims-related: *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, but consistently, by MCO. For the last 12 quarters, for example, Amerigroup has reported over 98% of the provider inquiries categorized as *Authorization—New,* and Sunflower has reported 0% of the *Claim Denial* provider inquiries.

Table 4. Maximum and Minimum Numbers of Claim-Related Provider Inquiries by MCO - Q1 to Q4 CY2017

	CY2017							
	Q1		Q2		Q3		Q4	
	Max	Min	Max	Min	Max	Min	Max	Min
Authorization - New	1,695	0	1,546	1	1,323	1	1,324	0
Authorization - Status	1,816	134	1,741	172	1,615	267	1,367	266
Benefits Inquiry	1,550	431	1,762	441	1,441	181	1,376	107
Claim Denial Inquiry	3,070	0	3,646	0	3,114	0	2,811	0
Claim Status Inquiry	10,011	1	12,903	670	12,779	466	11,267	569
Claim Payment Question/Dispute	1,971	127	2,688	74	3,010	34	2,092	28
Billing Inquiry	241	1	217	0	182	0	146	0

Amerigroup | UnitedHealthcare | Sunflower

Combining the seven claims-related inquiries may allow a better comparison over time overall and by MCO (see Table 5).

- UnitedHealthcare again reported less than one-third as many provider inquiries than Amerigroup and Sunflower, which may be due to differences in provider inquiry tracking and reporting.
- The overall number of claims-related provider inquiries were lower in Q1–Q4 CY2017 compared to Q1–Q4 CY2016.

Table 5. Combined Totals of the Seven Claims-Related Provider Inquiry Categories by MCO, Q1 CY2016 to Q4 CY2017

	CY2016				CY2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Amerigroup	16,373	14,967	14,479	14,354	15,015	14,663	14,663	13,715
Sunflower	18,706	16,182	15,255	13,544	13,213	16,787	16,787	14,187
UnitedHealthcare	7,284	6,796	8,362	4,289	5,337	5,004	5,004	3,781
Total	42,363	37,945	38,096	32,187	33,565	36,454	36,454	31,683

KDHE staff reported the revised customer service inquiry template will include detailed criteria for categorizing claims and that criteria will be reviewed with MCO staff in conference calls related to the updated template.

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

- *The State should implement the revised Customer Service Inquiries reporting template (that excludes the "Concern with access to service or care; or concern with service or care disruption" reporting option) by Q1 CY2018, if possible.*

Follow-up response: KDHE has revised the template and plans to implement it in March 2018 for April MCO report submissions.

- *The State should consider reviewing a sample of inquiries categorized to date as "Concern with access to service or care; or concern with service or care disruption" to ensure those that have met grievance or appeal criteria have had appropriate follow-up.*
  Follow-up response: KDHE reported that "*the program manager is working to sit in on the MCO call quality reviews to improve conformity of the call categorization as well as overall call quality*."
- *The State should consider requiring MCOs to report the monthly number of contacts in addition to the monthly number of issues addressed during each contact to better ensure consistency in reporting and to better analyze the numbers and types of member and provider inquiries over time.*
  Follow-up response: KDHE reported this has been addressed in the contract standard tab of the new customer service template to be implemented in March.

Recommendations (Timely Resolution of Customer Service Inquiries)

1. MCOs should report all inquiries from each contact and not limit reporting and categorization of inquiries to one primary inquiry.
2. After implementation of the revised customer service inquiry template, the State should monitor to ensure comparable categorization of inquiries by each of the MCOs.
3. The State should consider requiring the MCOs to track the number of customer service inquiries that are forwarded for review as grievances or appeals.
4. As the Health Homes program ended in July 2016, Sunflower should evaluate reasons for continuing to receive inquiries each month related to Health Homes or should determine if these are misclassified (potentially questions related to home health care).

Timeliness of Claims Processing

Claims, including those of MCO vendors, are to be processed within 30 days if "clean" and within 60 days if "non-clean"; all claims, except those meeting specific exclusion criteria, are to be processed within 90 days. Claims excluded from the measures include "*claims submitted by providers placed on prepayment review or any other type of payment suspension or delay for potential enforcement issues*" and "*any claim which cannot be processed due to outstanding questions submitted to KDHE*."

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

Claims received in the middle or end of a month may be processed in that month or the following month(s). Since a non-clean claim may take up to 60 days to process, a claim received in mid-March, for example, may be processed in March or may not be processed until early May and still meet contractual requirements. To allow for claims lag, the KanCare Evaluation Report for Q4 CY2017 assesses timeliness of processing clean, non-clean, and all claims reports received through Q3 CY2017 (see Table 6).

Table 6. Timeliness of Claims Processing, Q1 CY2016 to Q3 CY2017							
	CY2016				CY2017		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Clean Claims							
Clean claims received in quarter	4,380,378	4,248,060	4,052,640	4,242,248	4,332,165	4,192,588	4,199,760
Number of claims excluded	263	88	61	709	445	720	307
Number of clean claims not excluded	4,380,115	4,247,972	4,052,579	4,241,539	4,331,720	4,191,868	4,199,453
Clean claims received within quarter processed within 30 days	4,378,159	4,246,507	4,050,603	4,239,788	4,329,950	4,190,829	4,197,414
Clean claims received within quarter not processed within 30 days	1,956	1,465	1,976	1,751	1,770	1,039	2,039
Percent of clean claims processed within 30 days	99.96%	99.97%	99.95%	99.96%	99.96%	99.98%	99.95%
Non-Clean Claims							
Non-clean claims received in quarter	198,558	157,210	182,401	217,957	238,370	152,537	174,050
Number of claims excluded	2,974	1,434	1,344	1,372	1,617	1,193	2,003
Number of non-clean claims not excluded	195,584	155,776	181,057	216,585	236,753	151,344	172,047
Non-clean claims received within quarter processed within 60 days	195,335	155,608	180,909	211,621	235,719	150,733	170,736
Non-clean claims received within quarter not processed within 60 days	249	168	148	4,964	1,034	611	1,311
Percent of non-clean claims processed within 60 days	99.87%	99.89%	99.92%	97.71%	99.56%	99.60%	99.24%
All Claims							
All claims received in quarter	4,578,936	4,405,270	4,235,041	4,460,205	4,570,535	4,345,125	4,373,810
Number of claims excluded	3,237	1,522	1,405	2,081	2,062	1,913	2,310
Number of claims not excluded	4,575,699	4,403,748	4,233,636	4,458,124	4,568,473	4,343,212	4,371,500
Number of all claims received within quarter processed within 90 days	4,575,552	4,403,630	4,233,492	4,457,945	4,568,285	4,343,082	4,371,401
Number of all claims received within quarter not processed within 90 days	147	118	144	179	188	130	99
Percent of all claims processed within 90 days	99.997%	99.997%	99.997%	99.996%	99.996%	99.997%	99.998%

Data Sources

In monthly Claims Overview reports, MCOs report the monthly number of claims received and processed, including whether these claims were processed in a timely manner as defined by the type of claim and State-specified timelines. The report also includes average turnaround times (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.

For claims received in Q3 CY2017:

- **Clean claims**:
  - None of the MCOs met the contractual requirement to process 100% of clean claims within 30 days.
  - 99.95% of 4,199,453 clean claims received in Q3 CY2017 were reported by the MCOs as processed within 30 days.
  - Of the 2,039 clean claims not processed within 30 days – 291 (14%) were claims received by Amerigroup; 397 (20%) by Sunflower; and 1,351 (66%) by UnitedHealthcare.
- **Non-clean claims**:
  - 99.2% of 172,047 non-clean claims received in Q3 CY2017 were reported by the MCOs as processed within 60 days.
  - In Q3 CY2017, Amerigroup and Sunflower met the contractual requirement of processing at least 99% of the non-clean claims within 60 days. UnitedHealthcare met the requirement in July, but reported they processed only 95.6% of non-clean claims in August and 98.9% in September (97.4% for Q3).
  - Of the 1,311 non-clean claims not processed within 60 days – 113 were claims received by Amerigroup; 23 were claims received by Sunflower; and 1,175 were claims received by UnitedHealthcare.
- **All claims**:
  - 99.998% of 4,371,401 "all claims" received in Q3 CY2017 were reported by the MCOs as processed within 90 days.
  - Of the 99 claims not processed within 90 days – 16 were claims received by Amerigroup, 14 were claims received by Sunflower, and 69 were claims received by UnitedHealthcare.

Due to the high volume and same-day processing of pharmacy claims, questions were raised at a February 2018 KanCare legislative public meeting about the impact of pharmacy claims on the reported 99.99% claims processing rate within 90 days. In 2017, KFMC validated MCO claims processing timeliness related to the State's pay-for-performance program that included incentives in 2016 for MCOs to process 99.5% of clean claims within 20 days (instead of the contractually required 30 days) and to process 99% of all claims within 40 days (instead of the contractually-required 90 days). KFMC validated that the 40-day processing by claim type in 2016 ranged from 99.90%–99.98% for Medical claims; 99.83%–>99.99% for Vision claims; >99.99%– 100% for Dental claims; 96.54%–100% for non-emergency medical transportation (NEMT) claims; and 99.85%–99.99% for all claims. Pharmacy claims, however, did comprise 39.8% of the clean claims and 37.9% of all claims. If pharmacy claims had not been included in the 40-day processing period, the rates would have been slightly lower, 99.78%–99.98% compared to 99.85%–99.99% with pharmacy claims included.

Follow-up on Previous Recommendations (Timeliness of Claims Processing by Claim Type and Date Received)

- *MCOs should update their monthly claims processing reports for 2017 and annual totals for 2016 to reflect the criteria used by all three MCOs (and their vendors) as revised during the validation of P4P claims metrics, adapted to meet contractual timeliness standards for clean claims (30 days), non-clean claims (60 days), and all claims (90 days). The State should provide guidance to the MCOs as to the time periods for which claims data should be updated.*
  Follow-up response: KDHE reported this is planned to be implemented in Q2 and will include updating of annual rates for 2016 and 2017.
- *The State should provide additional direction to the MCOs as to appropriate reporting of processing times newborn claims. If newborn claims are not to be excluded from the 90-day processing*

requirement for "all claims," additional direction should be provided as to which monthly reports should be updated to include processing of newborn claims previously excluded from the 90-day processing requirement.

Follow-up response: KDHE reported this has been addressed through guidance to the MCOs and that Sunflower has agreed to report newborn claims within the non-clean and all claims tables as recommended.

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

1. To address concerns about the impact of pharmacy claims (which are high volume and processed same-day) on claims processing timeliness, the State should consider requiring the MCOs to report the number of pharmacy claims included in the clean claims and all claims rates (reported on the Claims Contract Standard tab of the monthly Claims Overview Report).

Average Turnaround Time for Processing Clean Claims

As indicated in Table 7, the MCOs reported 4,126,949 clean claims were processed in Q4 CY2017 (includes claims received prior to Q4). Excluding 1,456,248 pharmacy claims (which are processed same-day), there were 2,670,701 clean claims processed in Q4.

Table 7. Average Monthly Turnaround Time Ranges for Processing Clean Claims, by Service Category - Comparison of Current and Previous Quarter and Annual Monthly Ranges*

Service Category	Current and Previous Quarter		Annual Monthly Ranges			
	Q3 CY2017	Q4 CY2017	CY2014	CY2015	CY2016	CY2017
Hospital Inpatient	10.3 to 12.9	**9.7 to 13.0**	5.0 to 19.2	6.4 to 15.9	7.1 to 18.4	**6.0 to 15.6**
Hospital Outpatient	5.4 to 9.8	**5.8 to 10.1**	3.6 to 12.8	3.5 to 10.8	4.0 to 12.9	**4.5 to 10.1**
Pharmacy	same day	**same day**	same day	same day	same day	**same day**
Dental	7.0 to 13.0	**6.0 to 8.0**	2.0 to 21.0	4.0 to 13.1	6.0 to 13.0	**6.0 to 13.0**
Vision	6.0 to 12.7	**5.0 to 15.1**	7.0 to 12.5	9.0 to 12.5	7.0 to 12.7	**5.0 to 15.1**
Non-Emergency Transportation	11.0 to 13.4	**10.9 to 13.0**	10.9 to 18	10.4 to 16	9.0 to 14.4	**10.9 to 14.0**
Medical (Physical health not otherwise specified)	6.0 to 8.8	**6.5 to 9.4**	3.3 to 10.6	3.4 to 10.5	4.2 to 10.7	**4.7 to 9.8**
Nursing Facilities	4.8 to 10.0	**5.2 to 9.3**	4.3 to 11.5	4.1 to 9.7	4.6 to 9.0	**4.3 to 10.5**
HCBS	6.8 to 9.3	**6.4 to 12.2**	3.2 to 15.6	4.1 to 10.2	5.7 to 10.8	**5.7 to 12.2**
Behavioral Health	4.6 to 9.4	**5.4 to 9.7**	3.4 to 8.6	2.7 to 10.5	4.1 to 11.7	**3.8 to 9.9**
Total Claims (Including Pharmacy)	4,090,819	**4,126,949**	16,763,501	17,820,402	17,820,402	**17,302,422**
Total Claims (Excluding Pharmacy)	2,645,108	**2,670,701**	10,370,998	10,999,807	10,999,807	**10,887,328**
Average TAT (Excluding Pharmacy)^	**6.4 to 9.0**	**6.7 to 9.5**	**4.3 to 11.5**	**4.3 to 10.3**	**5.0 to 10.6**	**5.3 to 9.9**

*The average TAT monthly ranges reported in Table 7 only include clean claims processed by the MCOs and do not include clean claims received but not yet processed.
^Average TATs are weighted averages calculated after excluding pharmacy claims.

The average TAT for Total Services (excluding pharmacy claims) was 6.7–9.5 days in Q4 CY2017. In CY2017, the average monthly TAT for Total Services ranged from 5.3 to 9.9 days. Amerigroup's overall TAT in Q4 was 6.7–8.5 days, Sunflower's was 8.3–9.5 days, and UnitedHealthcare's was 8.2–8.5 days.

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

- **Hospital Inpatient** –TATs in Q4 CY2017 ranged from 9.7 to 13.0 days (compared to 10.3–12.9 days in Q3 and 6.0–15.6 days in Q2).
- **Medical** – TATs in Q4 ranged from 6.5–9.4 days.
- **Nursing Facilities** – TATs ranged from 5.2–9.3 days in Q4.
- **Dental** – TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 6.0– 8.0 days in Q4, down from 7.0–13.0 days in Q3 CY2017.
- **Behavioral Health** – TATs ranged from 5.4– 9.7 days in Q4 CY2017.
- **Vision** – The average monthly TATs for Vision in Q4 ranged from 5.0 to 15.1 days, the widest range of the service types.

Grievances

Data Sources

Grievances are reported and tracked on a quarterly basis by MCOs in the Grievance and Appeal (GAR) report. The report tracks the number of grievances received in the quarter, the number of grievances closed in the quarter, the number of grievances resolved within 30 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 descriptions and resolution, category type, date received, Medicaid ID, waiver type, and number of business days to resolve.

Track Timely Resolution of Grievances

Quarterly tracking and reporting of timely resolution of grievances in the KanCare Evaluation are 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 (and is not expected to) equal the number of grievances "resolved" during the quarter (see Table 8).

Table 8. Timeliness of Resolution of Grievances - Q1 to Q4 CY2017 and CY2013 to CY2017

	CY2017				CY2013 to CY2017				
	Q1	Q2	Q3	Q4	2013	2014	2015	2016	2017
Grievances received in quarter	412	458	541	506	1,786	2,287	2,021	1,767	1,917
Grievances resolved in quarter*	412	447	546	507	1,723	2,307	2,046	1,743	1,912
Grievances resolved within 30 business days*	410	441	543	498	1,723	2,283	2006	1,667	1,892
Percent resolved within 30 business days	99.5%	98.7%	99.5%	98.2%	100%	99.0%	98.0%	95.6%	99.0%
Grievances not resolved within 30 business days	2	6	3	9	0	24	40	76	20
Grievances resolved within 60 business days*	412	446	546	505	1,723	2,299	2,035	1,742	1,909
Percent resolved within 60 business days*	100%	99.8%	100.0%	99.6%	100%	99.7%	99.5%	99.9%	99.8%
Grievances closed in quarter not resolved in 60 business days*	0	1	0	2	0	8	11	1	3

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

In Q4 CY2017, 98.2% (498) of the 507 grievances reported by the MCOs as resolved in Q4 were reported as resolved within 30 business days. Sunflower and UnitedHealthcare reported 100% of the grievances were resolved within 30 days; Amerigroup reported 94% were resolved within 30 days and 99% within 60 days, both below the contractual requirements of 98% and 100%, respectively.

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

All Grievances

In September 2017, KDHE staff provided follow-up training to MCO staff to clarify criteria for each grievance and appeal category and increased staff review and response to MCOs related to apparent misclassifications. In Q4, with the increased KDHE staff review and input, there has been noticeable progress in reporting of grievances and appeals. While in past quarters, 30% or more of the grievances appeared to be categorized incorrectly (based on grievance descriptions and resolution details), in Q4 only 6% (32) of the grievances appeared to be misclassified (see Table 9). An additional 22 grievances were also identified where members noted more than one grievance during their contact to the MCO, and three of the 507 were recategorized as appeals, bringing the total number of grievances to 526 for the quarter.

Of the 22 grievances potentially categorized incorrectly by the MCOs:

- 14 were categorized as *Customer Services* that, based on grievance details, would be more correctly categorized as *Access to Service or Care* (3); *Quality of Care–non-HCBS* (5); *Quality of Care–HCBS* (2); *Other* (3); and *Billing and Financial Issues* (1);
- Two were categorized as *Transportation–Other* that met criteria for *Transportation–No Show* and *Transportation–Safety;*
- One *Transportation–Safety* was better categorized as *Transportation–Other;*
- One *Quality of Care–non-HCBS* met criteria for *Transportation–Other;*
- One *Billing and Financial Issues* and one *Member Rights and Dignity* met criteria for *Quality of Care – non-HCBS*; and
- Three were determined to meet criteria to be categorized as appeals.

A number of issues have been encountered when categorizing grievances each quarter*:*

- Some grievances clearly fit the definition of more than one category. For example, grievances referred to the quality of care (QOC) staff are to be categorized as *Quality of Care non-HCBS* or *Quality of Care-HCBS,* while those related to the lock in program are to be categorized *as Access to Service or Care*. How then, should the MCO categorize a grievance related to lock in that has been referred to the QOC staff?
- The *Customer Services* category, not only in this quarter, has often had many categorization errors. *Customer Services* is defined as "*Complaints about cleanliness, responsiveness, attitude of staff (either the MCO or provider staff),*" which may better describe "customer service" (not individual "customer service**s**").
- Questions have also been raised as to whether the categorization should be based on only the initial description of the grievance or whether it should include details on the resolution. A grievance described as a *Transportation–No-Show* based on the member description may in the resolution description meet the criteria of *Transportation –No Driver Available*.

Table 9. Comparison of Grievances as Categorized by MCOs and Based on Grievance Descriptions Q4 CY2017*

	As categorized by MCOs		Based on Grievance Descriptions	
	# grievances	# members	# grievances	# members
Billing and Financial Issues	112	106	118	113
Access to Service or Care	27	27	31	29
Quality of Care (non-HCBS)	44	44	57	56
Quality of Care - HCBS	14	13	18	17
Quality of Care^	6	6		
Customer Services	60	56	46	43
Pharmacy Issues	12	11	9	8
Member's Rights/Dignity	7	7	7	7
Value-Added Benefit	15	13	15	13
Transportation - Other	42	40	48	45
Transportation - Reimbursement	18	18	20	18
Transportation Safety	21	20	19	19
Transportation No Show	53	52	57	54
Transportation Late	70	68	72	69
Transportation No Driver Available	3	3	3	3
Other	3	3	6	6
Appeals #			*3*	*3*
Total	507	487	526	500

*Includes grievances received in Quarter 3 CY2017 resolved in Quarter 4 CY2017
^UnitedHealthcare-added category instead of the State-specified categories.
Appeals are not included in total counts.

To address these issues and to provide additional instruction, examples, and guidance to further improve MCO comparability in categorizing grievances and appeals, KDHE has scheduled follow-up training to MCO staff.

Of the 526 grievances resolved in Q4 CY2017, 147 (28%) were reported by Amerigroup, 173 (34%) by Sunflower, and 207 (39%) by UnitedHealthcare.

Transportation-related grievances continued to be the most frequently reported grievances, ranging from 182 to 232 in 2017, 219 in Q4. Of the 219 transportation-related grievances, 57 (26%) were reported by Amerigroup, 85 (39%) were reported by Sunflower, and 77 (35%) were reported by UnitedHealthcare. The number of *Transportation - No Show* and *Transportation* - Late grievances continued to be high, with 57 "*No Show*" grievances and 72 "*Late*" grievances in Q4. Of concern, too, is the number of *Transportation – Safety* grievances (19 in Q4). In follow-up response, the State is now requiring the MCOs to send monthly NEMT reports, in addition to quarterly reports, to promote quicker follow-up and resolution of transportation-related issues.

Of 526 grievances in Q4 (based on grievance descriptions), 192 (36%) were from 182 members receiving waiver services (see Table 10).

Table 10. Grievances Reported by Waiver Members Resolved in Q4 CY2017*

	FE	I/DD	PD	SED	TA	TBI	Autism	Total	Members
Billing and Financial Issues	3	8	11	6	2	2		32	31
Access to Service or Care	3	3	5			1	1	13	11
Quality of Care (non-HCBS)	2	3	7	2				14	14
Quality of Care - HCBS	2	2	9		2	3		18	17
Customer Service	3	1	7	2				13	13
Pharmacy Issues			1					1	1
Member's Rights/Dignity		1	1	1		1		4	4
Value-Added Benefit		1	2					3	3
Transportation - Other	3		14	1		1		19	17
Transportation - Reimbursement		1	1	3		2		7	5
Transportation Safety	2	1	2					5	5
Transportation No Show	5	1	19	3				28	26
Transportation No Driver Available					1			1	1
Transportation Late	5	3	23					31	31
Other	1	1	1					3	3
Total	29	26	103	18	5	10	1	192	182

*Counts are based on grievances as described by MCOs.

As shown in Table 11, the percentage of transportation-related grievances was higher among waiver members in each quarter of CY2017 (47%–50%) compared to members not receiving waiver services (38%–42%).

Table 11. Transportation-Related Grievances Resolved in Q1 to Q4 CY2017, by Waiver

	# Grievances					% Transportation Related				
	Q1	Q2	Q3	Q4	2017	Q1	Q2	Q3	Q4	2017
Physical Disability (PD)	71	90	114	103	378	58%	57%	52%	57%	56%
Frail Elderly (FE)	31	27	33	29	121	55%	52%	58%	50%	54%
Intellectual/Developmental Disability (I/DD)	11	28	26	26	91	36%	25%	31%	23%	27%
Traumatic Brain Injury (TBI)	13	6	10	10	39	38%	67%	60%	30%	46%
Serious Emotional Disturbance (SED)	8	9	10	18	45	25%	11%	10%	39%	24%
Technology Assisted (TA)	5	3	6	5	19	20%	67%	17%	20%	26%
Autism	0	1	0	1	2	NA	0%	NA	NA	NA
Waiver Member Grievances	139	164	199	192	695	50%	48%	47%	47%	48%
Non- Waiver Member Grievances	265	291	352	336	1,244	42%	41%	39%	38%	40%
All Member Grievances	404	455	552	529	1,940	45%	44%	42%	41%	43%

Of 192 grievances received from 182 waiver members in Q4, 91 (47%) were transportation-related.

- Physical Disability (PD) Waiver members had the most grievances in Q4, with 100 members reporting 103 grievances, 59 transportation-related (comparable to Q3 – 114 grievances, 59 transportation-related).
- Frail Elderly (FE) Waiver members (28) reported 29 grievances in Q4, 15 transportation-related.
- Intellectual/Developmental Disability (I/DD) Waiver members (26) in Q4 reported 26 grievances, six transportation-related.
- Serious Emotional Disturbance (SED) Waiver members (13) reported 18 grievances in Q4, seven transportation-related.
- Traumatic Brain Injury (TBI) Waiver members (10) reported 10 grievances in Q4, three transportation-related.
- Technology Assistance (TA) Waiver members (5) reported five grievances in Q4; one transportation-related.

Access-Related Grievances

Definitions and examples in the GAR report of grievances meeting *Access to Service or Care* criteria are those where "*Appointment availability, no providers available within distance standards, timeliness to get appointment, complaints about non-covered services (other than pharmacy), MCO system issue error – (eligibility not updated, TPL not current, processing error) difficulty finding HCBS provider*."

Of 526 grievances, as categorized by MCOs in the Q4 GAR report, 27 were categorized as *Access to Service or Care.* Only one grievance categorized as *Access to Service or Care* was identified this quarter as more appropriately being categorized as *Quality of Care–HCBS*, as the grievance was referred to the QOC staff for resolution.

There were also five grievances that may more appropriately meet the criteria for the *Access to Service or Care* category. Four of the five were categorized by the MCOs as *Customer Services*. The fifth grievance was categorized correctly as *Quality of Care–HCBS* but also met criteria for a second grievance related to *Access to Service or Care.*

Quality-Related Grievances

Definitions and examples in the GAR report of grievances meeting *Quality of Care (non-HCBS, non-Transportation)* criteria are those where "*Provider/Staff error or neglect in delivery of any health care services, e.g., someone is hurt, or it is determined necessary to forward to the QOC department for investigation. Additional examples: someone is dropped during transfer, doctor operates on wrong site, wrong medication administered, neglect*."

Definitions and examples in the GAR report of grievances meeting *Quality of Care - HCBS* criteria are those where "*Provider/Staff error or neglect in delivery of any HCBS services, e.g., mistreatment of member, not providing service as specified in support plan or plan of care."*

Of 526 grievances categorized in the Q4 GAR report, 44 were categorized by the MCOs as *Quality of Care (non-HCBS, non-Transportation);* six were categorized by UnitedHealthcare only as *Quality of Care; and* 15 were categorized as *Quality of Care – HCBS*. As described in the GAR report, 57 meet the criteria for *Quality of Care (non-HCBS, non-Transportation)* and 18 as *Quality of Care – HCBS.* This is the first quarter where there has been agreement with all grievances categorized as Quality of Care meeting QOC category criteria.

Again this quarter, however, there were grievances that, based on the MCO descriptions, meet criteria to be categorized as *Quality of Care–non-HCBS* or *Quality of Care–HCBS*:

- Nine grievances categorized as *Customer Services* would more accurately be categorized as *Quality of Care–non-HCBS, non-Transportation* (7) and or Quality of Care-HCBS (2);
- One grievance categorized as *Billing and Financial Issues* and one categorized as Member Rights Dignity may more appropriately be categorized as *Quality of Care–non-HCBS; and*
- One grievance categorized as *Access to Service or Care* may be better categorized as *Quality of Car – HCBS.*

Follow-up on Previous Recommendations (Grievances)

- *MCOs should make it a higher priority to ensure transportation is available timely and consistently for members.*
  Follow-up response: The number of *Transportation – Late* and *Transportation – No Shows* has continued to be high. The State, however is now requiring the MCOs to send monthly NEMT (non-emergency medical transportation) reports, in addition to quarterly NEMT, to allow for quicker follow-up and resolution of issues.
- *The State should review the grievance categories to determine if additional examples should be included and to determine if additional categories may be needed.*
  Follow-up response: KDHE reviewed the categories and added a transportation category this quarter (*Transportation Issues – Reimbursement*). Staff are monitoring the grievances each quarter. Training to MCO staff on grievance categorization was held in September 2017, with a second training planned for March or April 2018.
- *UnitedHealthcare should categorize grievances using only the State-specified categories.*
  Follow-up response: UnitedHealthcare again categorized six grievances as *Quality of Care* without clarifying if these were or were not HCBS-related.

Recommendations (Grievances)

1. KFMC recommends categorizing grievances based on consideration of both the initial description and the resolution.
2. The State should consider renaming *Customer Services* as *Customer Service*.
3. UnitedHealthcare should categorize grievances using only the State-specified categories, including specifying whether a Quality of Care grievance is or is not HCBS-related.
4. MCOs should continue to make it a high priority to ensure transportation is available timely and consistently for members.

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 sources in Q4 CY2017 are the quarterly KanCare Ombudsman Quarterly and Annual Reports.

Current Quarter and Trend over Time

Ombudsman Office assistance is provided by the Ombudsman (Kerrie Bacon), a Volunteer Coordinator, a Project Coordinator, and trained volunteers at satellite offices. Information (as well as volunteer applications) is also available on the Ombudsman's Office website, www.KanCare.ks.gov/kancare-ombudsman-office and is provided to members by mail and email as-needed.

The Ombudsman's Office is located in Topeka, with satellite offices in Wichita and Olathe (Johnson County). Assistance is provided by phone and in person, by appointment, including assistance completing Medicaid applications.

Volunteer assistance has been a critical factor in helping meet the high demand for assistance. In Q4, KanCare Ombudsman Liaison Training Sessions were held in Emporia, Ottawa, and Kansas City. A new volunteer position, Education and Resource Information volunteer, was created which engages students from the St. Mary's College Health Information Management Program that requires 120 hours of volunteer work. After background checks and completion of the 30-hour volunteer training, three students in Q4 began providing assistance, including development of resources for beneficiaries.

As delineated in the CMS Kansas Special Terms and Conditions (STC), revised in January 2014, the Ombudsman's Office data to be tracked include date of incoming requests (and date of any change in status); 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, by specific issues and by location (main office or satellite office). Notes and email history from previous contacts were added in 2017, which has improved the level of assistance provided. In Q4 CY2017, the Ombudsman's Office tracked 1,040 contacts, approximately twice as many as in Q4 CY2016.

Since some contacts include more than one issue, the Ombudsman's Office tracks the number of certain issues addressed during contacts, including the number of issues that are MCO-related (see Table 12). In Q4, 264 (22%) of 1,204 issues addressed in 1,040 contacts to the Ombudsman's Office were MCO-related. The most frequently reported MCO-related issues quarterly to date have been *Medicaid Eligibility Issues* and HCBS-related issues.

The number of contacts has increased each quarter of 2017.

Table 12. Issues tracked by Ombudsman's Office - All and Percentage MCO-Related, CY2017 by Quarter and Compared to CY2016

	CY2017								2016		2017	
	Q1		Q2		Q3		Q4					
	All	% MCO Related	All	% MCO Related	All	% MCO Related	All	% MCO Related	All	% MCO Related	All	% MCO Related
Medicaid Eligibility Issues	237	**12%**	177	**11%**	237	**14%**	299	**14%**	1,122	**12%**	950	**14%**
Medicaid Renewal	29	**38%**	43	**30%**	38	**45%**	61	**33%**	^	^	171	**36%**
Medicaid Application Assistance	45	**2%**	55	**2%**	162	**2%**	179	**3%**	^	^	441	**2%**
HCBS - Total	92	**47%**	95	**49%**	91	**37%**	120	**41%**	291	**48%**	398	**43%**
HCBS General Issues	*33*	*55%*	*34*	*59%*	*21*	*52%*	*49*	*45%*	*133*	*55%*	*137*	*52%*
HCBS Eligibility Issues	*46*	*39%*	*50*	*46%*	*58*	*34%*	*61*	*38%*	*109*	*40%*	*215*	*39%*
HCBS Reduction in Hours of Service	*7*	*71%*	*2*	*50%*	*4*	*75%*	*6*	*33%*	*23*	*74%*	*19*	*58%*
HCBS Waiting List	*6*	*33%*	*9*	*33%*	*8*	*0%*	*4*	*50%*	*26*	*23%*	*27*	*26%*
Appeals, Grievances												
Appeal/Fair Hearing questions/issues	^	^	^	^	21	**29%**	23	**26%**	^	^	44	**27%**
Grievances Questions/Issues	36	**50%**	33	**45%**	29	**31%**	9	**33%**	147	**45%**	107	**42%**
Medical Services	20	**65%**	20	**65%**	11	**55%**	9	**33%**	72	**51%**	60	**58%**
Billing	21	**33%**	33	**55%**	17	**65%**	19	**58%**	147	**47%**	90	**52%**
Durable Medical Equipment	2	**100%**	9	**56%**	4	**75%**	3	**67%**	20	**80%**	18	**67%**
Pharmacy	11	**45%**	9	**67%**	10	**30%**	13	**31%**	59	**58%**	43	**42%**
Care Coordinator Issues	5	**100%**	11	**64%**	6	**83%**	12	**83%**	21	**86%**	34	**79%**
Transportation	8	**88%**	9	**67%**	12	**50%**	5	**40%**	21	**62%**	34	**62%**
Nursing Facility Issues	40	**13%**	26	**27%**	23	**4%**	21	**14%**	112	**19%**	110	**15%**
Housing Issues	4	**25%**	6	**33%**	7	**43%**	0	**0%**	15	**20%**	17	**35%**
Access to Providers	14	**79%**	14	**86%**	13	**31%**	10	**70%**	35	**43%**	51	**67%**
Change MCO	3	**100%**	1	**100%**	2	**50%**	6	**100%**	24	**58%**	12	**92%**
Dental	7	**14%**	9	**44%**	7	**57%**	6	**17%**	19	**58%**	29	**34%**
Client Obligation	17	**35%**	36	**39%**	37	**30%**	33	**39%**	^	^	123	**36%**
Spenddown Issues	18	**22%**	32	**31%**	29	**41%**	28	**32%**	71	**27%**	107	**33%**
Medicare-related issues	^	^	^	^	15	**33%**	43	**19%**	^	^	67	**19%**
Notice not received	^	^	^	^	^	^	1	**100%**	^	^	1	**100%**
Abuse/neglect complaints	^	^	^	^	^	^	2	**50%**	^	^	2	**50%**
Coding Issues	3	**67%**	0	**0%**	8	**50%**	18	**44%**	^	^	29	**48%**
Moving to/from Kansas	5	**20%**	7	**14%**	6	**0%**	9	**11%**	^	^	27	**11%**
Other*	331	**16%**	366	**17%**	321	**14%**	278	**15%**	1,469	**15%**	1,310	**15%**
Total Issues - All & MCO-Related	**948**	**24%**	**991**	**27%**	**1,106**	**20%**	**1,204**	**22%**	**3,645**	**23%**	**4,275**	**23%**

^Category added in 2017; not reported for 2016

* Includes issues categorized as Other, Affordable Care Act, Estate Recovery, Health Homes, Guardianship, Division of Assets, Social Security Issues, and Unspecified

The Ombudsman's Office also reports contact issues by waiver-related type. As shown in Table 13, there were 178 waiver-related contacts in Q4, over four times as many as in Q4 CY2016. The most frequent waiver-related issues in Q4 were related to the I/DD Waiver (77), PD Waiver (45), and FE Waiver (38). Approximately half of the waiver-related inquiries have been MCO-related.

Table 13. Waiver-Related Inquiries to Ombudsman - Comparison of Q4 and Annual Increases from CY2016 to CY2017 and Percentage MCO-Related

Waiver	Q4					Annual				
	2016		2017		% change	2016		2017		% change
	all	MCO-related	all	MCO-related	all	all	MCO-related	all	MCO-related	all
Intellectual/Developmental Disability (I/DD)	11	55%	77	38%	**600%**	108	56%	200	41%	**85%**
Physical Disability (PD)	9	67%	45	53%	**378%**	92	61%	154	56%	**67%**
Technology Assisted (TA)	4	50%	7	57%	**75%**	31	61%	27	63%	**-13%**
Frail Elderly (FE)	7	57%	38	50%	**443%**	59	54%	128	45%	**117%**
Traumatic Brain Injury (TBI)	5	80%	6	33%	**20%**	26	73%	27	63%	**4%**
Serious Emotional Disturbance (SED)	3	67%	5	20%	**67%**	8	75%	18	50%	**125%**
Autism	1	0%	0	0%	**-100%**	6	50%	7	71%	**17%**
Total	**40**	**60%**	**178**	**44%**	**345%**	**330**	**62%**	**561**	**49%**	**70%**

Follow-up on Previous Recommendations (Ombudsman's office)

1. *The State should consider making the quarterly GAR reports 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.*
   Follow-up response: KDHE reported that in 2017 an Action Log for grievances and appeals was implemented that allows for follow-up and communication with each MCO related to these issues. For NEMT grievances, the MCOs are reporting monthly, which allows quicker follow-up. KDHE staff advised that adding the Ombudsman could increase the role confusion by both the Ombudsman's Office and KDHE-DHCF trying to follow up on issues.
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, where applicable.*
   Follow-up response: Regional tracking is not conducted by member residence. The Ombudsman's Office does, however, report the number of contacts by whether they were received and/or addressed at the main office or one of the satellite locations.

Conclusions Summary

Timely Resolution of Customer Service Inquiries

- In Q4 CY2017, 98.5% of the 77,997 customer service member inquiries received by the MCOs and 99.7% of the 35,624 provider inquiries were resolved within two business days All the 1,170 customer service inquiries from members not resolved within two business days in Q4 were reported by UnitedHealthcare.

- UnitedHealthcare staff confirmed that UHC categorizes only one primary inquiry for each contact. Amerigroup and Sunflower report multiple inquiries per contact, as per State reporting guidelines.
- In Q4 CY2017, Amerigroup and Sunflower MCOs met contractual requirements for resolving at least 98% of customer service inquiries within 5 business days. UnitedHealthcare reported 97.9% of member inquiries were resolved within 5 business days.
- Amerigroup and Sunflower met the contractual requirements to resolve 100% of inquiries within 15 business days. UnitedHealthcare reported 99.91% of member inquiries and 99.98% of provider inquiries were resolved within 15 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
  - The number of inquiries from members in Q4 was the lowest number since MCOs began reporting in Q2 2014.
  - Of the 77,997 customer service inquiries from members in Q4 CY2017, 42% were reported by Sunflower, 37% by UnitedHealthcare, and 21% by Amerigroup.
  - Benefit inquiries were the highest percentage (21%) of member inquiries in Q4.
  - As in previous quarters, there were categories where two thirds or more of the inquiries in the quarter were reported by one MCO. This seems likely to be due to differing interpretations of the criteria for several of the categories in the reporting template.
- Provider customer service inquiries
  - Of the 35,364 provider inquiries received by MCOs in Q4 CY2017, Amerigroup reported 42%, Sunflower 47%, and UnitedHealthcare 11%.
  - Claim status inquiries were again the highest percentage (51%) of provider inquiries.
  - 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.
- 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.
- The customer service reporting template is being updated by KDHE. Additional guidance will be provided to the MCO staff within the reporting template and through conference calls and MCO staff training.

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 Q3 CY2017, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days. Of 4,199,453 clean claims received in Q3 CY2017, 99.95% were processed within 30 days. Of the 2,039 clean claims not processed within 30 days – 291 (14%) were claims received by Amerigroup; 397 (20%) were claims received by Sunflower; and 1,351 (66%) were claims received by UnitedHealthcare.
- In Q3 CY2017, Amerigroup and Sunflower met the contractual requirement of processing at least 99% of the non-clean claims within 60 days UnitedHealthcare met the requirement in July, but reported they processed only 95.6% of non-clean claims in August and 98.9% in September (97.4% for Q3).
- Of 4,371,401“all claims” received in Q3 CY2017, 99.998% were processed within 90 days.

- Questions were raised by legislators on the impact of pharmacy claims on the processing rates of clean claims and all claims, as pharmacy claims are high volume and processed same-day. In validating a 2016 pay-for-performance claims processing measure (that provided incentives for MCOs to process all claims within 40 days instead of the contractually-required 90 days), KFMC found 39.8% of the clean claims and 37.9% of all claims processed were pharmacy claims. If pharmacy claims had been excluded from the p4p measure, processing rates of all claims would have been slightly lower, 99.78% to 99.98% compared to 99.85% to 99.99%.

Turnaround time (TAT) ranges for processing clean claims

- In Q4 CY2017, the MCOs reported 4,126,949 clean claims were processed (including 1,456,248 pharmacy claims).
- The average TAT for Total Services (excluding pharmacy claims) was 6.7 to 9.5 days in Q4 CY2017. In CY2017, the average monthly TAT for Total Services ranged from 5.3 to 9.9 days.
- The average TAT for processing clean claims for individual service types again varied by service type and by MCO.

Grievances

- In Q4 CY2017, 98.2% of the grievances reported by the MCOs as resolved in Q4 were reported as resolved within 30 business days. Sunflower and UnitedHealthcare reported 100% of the grievances were resolved within 30 days; Amerigroup reported 94% were resolved within 30 days and 99% within 60 days, both below the contractual requirements of 98% and 100%, respectively.
- KDHE is continuing to monitor grievance reporting and is scheduling follow-up training for MCO staff in March or April to promote more accurate and consistent reporting.
- Of 526 grievances resolved in Q4 CY2017, 147 (28%) were reported by Amerigroup, 173 (34%) by Sunflower, and 207 (39%) by UnitedHealthcare.
- In Q4 there were 31 *Access to service or care* grievances, 57 *Quality of Care (non-HCBS)* grievances, and 18 *Quality of Care- HCBS* grievances.
- MCOs categorized 60 grievances as Customer Services, but only 46 grievances met criteria for this category
- Transportation-related grievances continued to be the most frequently reported grievances.
  - MCOs reported resolution of 219 transportation-related grievances, which ranged from 164 to 232 in 2017.
  - The number of *Transportation No Show, Transportation - Late,* and *Transportation – Safety* grievances continued to be high, with 57 *Transportation – No Show* grievances (plus 3 no-show due to no driver available), 72 *Transportation – Late* grievances, and 19 *Transportation – Safety* grievances in Q4.
  - The State is now requiring the MCOs to send monthly NEMT (non-emergency medical transportation reports to promote quicker follow-up and resolution of issues.
- In Q4, 192 (36%) grievances were from 182 members receiving waiver services; 47% of the grievances reported by waiver members were transportation-related (compared to 38% of those not receiving waiver services).

Ombudsman's Office

- Ombudsman's Office assistance is available at the main office in Topeka, two satellite offices (Wichita and Olathe), and on the Ombudsman's Office website.

- Beginning in Q4, students from St. Mary's College, after completing Ombudsman volunteer training, began providing volunteer assistance, including development of resources for beneficiaries.
- KanCare Liaison Training Sessions were held in Emporia, Ottawa, and Kansas City in Q4.
- In Q4 CY2017, the Ombudsman's Office tracked 1,040 contacts, about twice as many as in Q4 CY2016.
- In Q4, 264 (22%) of 1,204 issues addressed in 1,040 contacts to the Ombudsman's Office were MCO-related.
- The most frequently reported MCO-related issues quarterly to date have been *Medicaid Eligibility Issues* and HCBS-related issues.
- The most frequent waiver-related issues in Q4 were related to the I/DD Waiver (77), PD Waiver (45), and FE Waiver (38).

Recommendations Summary

Timely Resolution of Customer Service Inquiries

1. MCOs should report all inquiries from each contact and not limit reporting and categorization of inquiries to one primary inquiry.
2. After implementation of the revised customer service inquiry template, the State should monitor to ensure comparable categorization of inquiries by each of the MCOs
3. The State should consider requiring the MCOs to track the number of customer service inquiries that are forwarded for review as grievances or appeals.
4. As the Health Homes program ended in July 2016, Sunflower should evaluate reasons for continuing to receive inquiries each month related to Health Homes or should determine if these are misclassified (potentially questions related to home health care).

Timeliness of Claims Processing by Claim Type and Date Received

1. To address concerns about the impact of pharmacy claims (which are high volume and processed same-day) on claims processing timeliness, the State should consider requiring the MCOs to report the number of pharmacy claims included in the clean claims and all claims rates (reported in the Claims Contract Standard section of the monthly Claims Overview Report).

Grievances

1. KFMC recommends categorizing grievances based on consideration of both the initial description and the resolution.
2. The State should consider renaming *Customer Services* as *Customer Service*.
3. UnitedHealthcare should categorize grievances using only the State-specified categories, including specifying whether a Quality of Care grievance is or is not HCBS-related.
4. MCOs should continue to make it a high priority to ensure transportation is available timely and consistently for members.

KDHE Summary of Claims Adjudication Statistics –

January through December 2017 – 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	36,670	$1,725,207,211	5,520	$342,927,372	15.05%
Hospital Outpatient	331,748	$912,233,956	40,675	$101,821,377	12.26%
Pharmacy	1,878,570	$152,439,611	494,162	Not Applicable	26.31%
Dental	133,764	$37,339,313	9,510	$2,777,015	7.11%
Vision	79,515	$21,541,779	12,549	$3,816,861	15.78%
NEMT	105,202	$4,502,476	451	$22,488	0.42%
Medical (physical health not otherwise specified)	1,893,380	$1,093,081,017	227,237	$155,153,721	12.00%
Nursing Facilities-Total	92,779	$231,016,565	6,685	$20,664,899	7.21%
HCBS	186,187	$121,735,038	9,726	$8,132,747	5.22%
Behavioral Health	651,227	$89,044,149	55,414	$7,390,379	8.51%
Total All Services	5,389,042	$4,388,141,119	861,929	$642,706,863	15.99%

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	37,644	$1,529,483,287	8,813	$443,138,028	23.41%
Hospital Outpatient	337,343	$868,417,612	50,461	$143,812,265	14.96%
Pharmacy	2,426,007	$300,968,613	985,566	$174,746,667.01	40.63%
Dental	150,975	$39,397,144	14,313	$2,900,168.95	9.48%
Vision	92,671	$21,854,324	11,637	$2,731,135.84	12.56%
	163,902	$4,561,360	2,701	$73,178.24	1.65%
NEMT	1,703,392	$878,573,465	204,276	$172,707,900	11.99%
Medical (physical health not otherwise specified)	132,748	$296,274,174	11,025	$35,562,449	8.31%
Nursing Facilities-Total	571,743	$294,226,873	23,176	$12,246,589	4.05%
HCBS	728,944	$111,722,783	61,304	$10,689,494	8.41%
Behavioral Health	6,345,369	$4,345,479,636	1,373,272	$998,607,875	21.64%
Total All Services	37,644	$1,529,483,287	8,813	$443,138,028	23.41%

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	27,858	$1,020,273,7728	6,225	$273,665,387	22.35%
Hospital Outpatient	316,843	$859,388,615	61,567	$192,790,508	19.43%
Pharmacy	1,786,061	$236,705,655	418,358	$110,367,973	23.42%
Dental	143,200	$39,690,303	11,824	$3,535,214	8.26%
Vision	81,551	16,895,808	14,071	3,003,802	17.3%
NEMT	180,836	$4,815,490	3,029	$78,286	1.67%
Medical (physical health not otherwise specified)	1,820,014	$923,863,405	259,464	$208,533,773	14.26%
Nursing Facilities-Total	95,014	$254,406,659	13,709	$40,039,704	14.43%
HCBS	341,829	$94,543,131	16,655	$7,992,807	4.87%
Behavioral Health	466,996	$131,114,177	32,701	$17,218,722	7.00%
Total All Services	5,260,202	3,581,697,018	837,603	857,226,180	15.9%