KanCare Summary

Presented to the
Robert G. Bethell Joint Committee on Home and Community Based Services and KanCare Oversight

By the Kansas Department of Health and Environment

October 7, 2013

SUMMARY OF MONITORING ACTIVITIES

Routine and Ongoing Monitoring

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 work collaboratively in this role and have established the KanCare Interagency Monitoring Team (IMT) as an important component of comprehensive oversight and monitoring.

These sources of information guide the ongoing review of and updates to the KanCare Quality Improvement Strategy (QIS):

- Results of KanCare managed care organization (MCO) reporting (currently providing 98 reports on monthly or quarterly basis), quality monitoring and other KanCare contract requirements;
- External quality review findings and reports;
- The state's onsite review results;
- Feedback from governmental agencies, the KanCare MCOs, Medicaid providers, Medicaid members/consumers, and public health advocates; and
- The IMT's review of and feedback regarding the overall KanCare quality plan.

Some of the key quality assurance/monitoring activities for the KanCare program include:

- Ongoing and at least twice monthly business meetings regarding the KanCare State Quality Strategy.
- Extensive interagency and cross-agency collaboration, and coordination with MCOs, to develop and communicate to the MCOs 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 receipt, distribution, review and feedback regarding submitted reports.
- Development of the External Quality Review Organization (EQRO) work plan for calendar year 2013, and beginning of the associated deliverables detail. One of the business meetings with the MCOs each month is dedicated to discussing EQRO activities, MCO requirements related to those activities, and timeline/action items to move all EQRO deliverables and related MCO deliverables along apace with good mutual understanding and clarity.
- Continued management of the KanCare Key Management Activities Reporting (KKMAR) tool and related process, to capture multi-weekly then weekly snapshots of MCO performance in five key early-operation categories:
    - Customer Service Management
    - Call Center Management
    - Member & Provider Appeal/Member Grievance Management

- Claims Processing & Claims Denial Management
- Provider Network, LTSS Transition & Hot Spot Management

- Facilitation of multi-weekly then weekly KanCare Rapid Response Stakeholder Calls, to hear from providers, members, advocates and other stakeholders as to any issue of concern or question related to the launch and operation of the KanCare program.
- Identification of timetable to complete merger of HCBS waiver-based performance measures and practices within the comprehensive Kansas state quality strategy.
- Development and implementation of process to ensure LTSS-related ride alongs occurred between MCO staff and state quality monitoring staff; and process to receive and either approve or disapprove any MCO-initiated reduction in LTSS services Plans of Care.

Focused Review of MCO Performance

KDHE, in partnership with KDADS, conducted a focused review of the MCOs in July 2013. The review focused on core operational areas of the KanCare MCOs, to validate performance reports and to help ensure strong performance as the program shifted from the launch/initial implementation phase to the long-term/operational phase. Program management, contract monitoring and fiscal oversight staff from KDHE and KDADS obtained and assessed extensive documentation samples reflecting MCO performance and conducted related onsite reviews of these KanCare operational areas:

- Customer Service – for both members and providers
- Provider Credentialing – including timing and accuracy of related processes
- Grievances and Appeals – for both members and providers
- Prior Authorizations – including timing and accuracy of MCO and subcontractor decisions
- Third Party Liability, Spend Down and Client Obligation – evaluating program integrity

Annual Review of MCO Performance

KDHE and KDADS, in partnership with the State's EQRO, Kansas Foundation for Medical Care (KFMC), are preparing for the first annual review of KanCare MCO performance. The annual review will be a comprehensive assessment of each MCO as to performance and compliance. KFMC will focus on approximately 27 federal managed care regulatory requirements and how each MCO has implemented KanCare in compliance with those federal regulations. KDHE and KDADS staff will focus on approximately 105 state contractual/statutory/regulatory requirements and how well each MCO has implemented KanCare in compliance with those state standards. Those reviews will be conducted for three days at each MCO, in November, December and January. The results of these comprehensive reviews will be monitored over time to ensure that any identified areas for improvement are fully implemented.

SUMMARY OF QUALITY MEASURES

The State Quality Strategy for the KanCare program identifies the key performance measures that will be required for KanCare MCOs and providers. A summary of those measures follows:

Service Type	Performance Measures	Pay-For-Performance Measures
Physical Health Services	• All applicable HEDIS measures • CAHPS Adult Survey • CAHPS Child Survey • CAHPS Children With Chronic Conditions	Year 2+ measures • Comprehensive diabetes care (HEDIS measure) • Well-child visits in first 15 months (HEDIS measure) • Preterm births (similar to Joint Commission National Quality Measure methodology) • Annual monitoring for patients on persistent medications (HEDIS measure) • Follow up after hospitalization for mental illness (HEDIS measure)
Behavioral Health Services	• Mental Health: 10 measures • Substance Use Disorders: 13 measures	Year 2+ measures • National Outcome Measures (NOMS): o NOMS for people with SPMI or SED receiving mental health services will meet or exceed the benchmark in at least 4 of these 5 areas: Adult Access to Services; Youth Access to Services; Homeless SPMI; Youth School Attendance; and Youth Living in a Family Home o NOMS for people receiving Substance Use Disorder services will meet or exceed the benchmark in at least 4 of these 5 areas: Living Arrangements; Number of Arrests; Drug and Alcohol Use; Attendance at Self-Help Meetings; and Employment Status • Decreased Utilization of Inpatient Services
HCBS Waivers and Disability-Related Services	• SED waiver: 31 measures • ID/DD waiver: 30 measures • PD waiver: 31 measures • TBI waiver: 31 measures • TA waiver: 31 measures • Autism waiver: 32 measures • FE waiver: 39 measures • ICF/MR: 7 measures • MFP services: 21 measures	*Included in hybrid measures below.
Nursing Facility Services	• 14 measures	Year 2+ measures • Nursing Facility Claim Denials • Fall Risk Management • Decreased Hospital Admission After Nursing Facility Discharge • Decreased Nursing Facility Days of Care • Increased Use of PEAK (Promoting Excellent Alternatives in Kansas)-Certified Days of Care

Hybrid Measures (for members using multiple service types) – Year 1		Year 1 – operational measures that touch all service types and members: • Timely claims processing • Encounter data submission • Credentialing process for providers • Grievances and appeals • Customer service

Hybrid Measures (for members using multiple service types) – Year 2		Year 2+ measures:
		• Integration of Care: The goal of this set of measures is to ensure an improved level of integration addressing physical, behavioral, long term care and HCBS. To be considered compliant, 8 of 8 integration indicators must meet or exceed the benchmarks.
		• Healthy Life Expectancy (positively impacting mortality rate/age of death): The goal of this set of proxy measures is to positively impact the mortality rate and age of death for KanCare members receiving PD or DD waiver services/on wait list, or diagnosed with SMI. To be considered compliant the MCOs must meet or exceed the benchmarks for the following:
		  • LE Proxy 1 – Health Literacy (4 indicators)
		  • LE Proxy 2 – Prevention (7 of 8 indicators)
		  o Mammograms
		  o Cervical Cancer Screening
		  o Chlamydia Screening
		  o Preventive Ambulatory Health Service (preventive care visit)
		  o Flu Shots for Adults
		  o Pneumonia Vaccination
		  o Hepatitis A Vaccination
		  o Hepatitis B Vaccination
		  • LE Proxy 3 – 9 – (Number to be proposed by MCO and approved by State)
		  3. Smoking Cessation (3 indicators)
		  4. Obesity (2 indicators)
		  5. AOD Treatment Initiation and Engagement (2 indicators)
		  6. Comprehensive Diabetes Care (10 indicators)
		  7. Cholesterol Management for Members with Cardiovascular conditions (2 indicators)
		  8. Beta-Blocker after AMI (1 indicator)
		  9. Controlled High Blood Pressure (1 indicator)

MEMBERSHIP AND CAPITATION PAYMENTS

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	Net Payment through September	Performance Withhold	9/30/13 Membership	%
Amerigroup	$427,186,764	$12,706,198	120,539	32.0%
United Healthcare Community Plan	$419,892,144	$12,332,774	118,699	31.6%
Sunflower State Health Plan	$466,649,509	$14,009,318	136,925	36.4%
	$1,313,728,417	$39,048,290	376,163	100.0%

Note: By contract, KanCare capitation is paid a month in arrears.

PERFORMANCE BY KANCARE MCOS – JANUARY-AUGUST 2013

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Customer Service-Member

Member Call Reasons	AMG		SUN		UHC
Find/change PCP	22%	PCP Change	16.3%	Benefits Inquiry	37%
Benefit Inquiry – regular or VAS	18%	Eligibility Inquiry	9.5%	Find / Change PCP	26%
Order ID card	9%	ID Card Request	7.4%	Order ID Card	9%
Claim or billing question	8%	Case Management	4.1%	Eligibility Inquiry	4%
Care management or health plan program	6%	Claims Status Inquiry	3.9%	Care Management or Health Plan Program	3%

Member Services Calls- YTD	AMG	SUN	UHC
Total Offered	140,216	144,775	102,047
Total Handled	139,830	143,832	101,168
Average seconds to answer	.05	9.4	3.5
Average length of call	4:34	5:27	5:15
Abandon Volume	386	1463	525
Abandon Rate	0.3%	1.0%	0.23%

Customer Service-Providers

Reasons for Call	AMG		SUN		UHC
Claim status inquiry	30.7%	Claims Status	59.50%	Claim Status Inquiry	76%
Authorization – new	21.1%	Adjustment	11.37%	Benefits Inquiry	17%
Claim denial inquiry	12.3%	Prior Authorization Status	3.10%	Claim Denial Inquiry	14%
Authorization – status	10.5%	Eligibility Inquiry	3.26%	Update Demographic Information	0%
Benefits inquiry	9.2%	Claims Submission Status	1.97%	Member Eligibility Inquiry	10%

Provider Services Calls- YTD	AMG	SUN	UHC
Total Offered	50,175	39,110	35,934
Total Handled	49,812	38,822	35,856
Average seconds to answer	0:15	8	2.255
Average length of call	6:06	6:25:15	07:31
Abandon Volume	363	273	83
Abandon Rate	0.7%	0.7%	0.22%

Pay for Performance - Reporting Protocol and Summary

Subject	P4P Metric	MCO	Measures Achieved During Reporting Period (Yes/No or Leave Blank Until Report Is Filed)												Year to Date Summary	
Monthly			**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total # Met**	**Total Standards**
Claims Processing	- 100% of clean claims are processed within 20 days - 99% of all non-clean claims are processed within 45 days - 100% of all claims are processed within 60 days	**AMG**	No	No	No	No	Yes	Yes							2	out of 12
		SUN	No	No	No	No	No	No							0	out of 12
		UHC	No	No	No	No	No	No							0	out of 12
Credentialing	- 90% providers completed in 20 days - 100% providers completed in 30 days	**AMG**	No	Yes	Yes	Yes	Yes	Yes	Yes						6	out of 12
		SUN	Yes	Yes	Yes	No	No	No	No						3	out of 12
		UHC	Yes	Yes	Yes	Yes	Yes	Yes	Yes						7	out of 12
Customer Service	- 98% of all inquiries are resolved within 2 business days from receipt date - 100% of all inquiries are resolved within 8 business days from receipt date	**AMG**	Yes	Yes	Yes	Yes	Yes	Yes	Yes						7	out of 12
		SUN	Yes	Yes	Yes	Yes	Yes	Yes	Yes						7	out of 12
		UHC	Yes	Yes	Yes	Yes	Yes	Yes	Yes						7	out of 12
Quarterly			**1Q**			**2Q**			**3Q**			**4Q**				
Grievances	- 98% of grievances are resolved within 20 days - 100% of grievances are resolved within 40 days	**AMG**	Yes			Yes									2	out of 4
		SUN	Yes			Yes									2	out of 4
		UHC	Yes			Yes									2	out of 4
Appeals	Contractor sends an acknowledgement letter within 3 business days of receipt of the appeal request	**AMG**	Yes			Yes									2	out of 4
		SUN	Yes			Yes									2	out of 4
		UHC	Yes			Yes									2	out of 4

VALUE ADDED SERVICES PROVIDED BY KANCARE MCOS – JANUARY-AUGUST 2013

2013 VAS Type

Amerigroup	Total Units YTD	Total Value YTD	Sunflower	Total Units YTD	Total Value YTD	United	Total Units YTD	Total Value YTD
Adult Dental Care	1689	$211,233.12	CentAccount debit card	55298	$1,107,815.00	Additional vision services	17905	$765,259.70
Member Incentive Program	5363	$174,735.00	Dental Visits for adults	23669	$749,450.04	Adult dental services	3483	$452,790.00
Mail Order OTC	4629	$74,586.28	SafeLink®/Connections Plus cell phones	8567	$409,759.61	Incentive payments for KAN Be Healthy Screening	36157	$361,570.00
Grand Total - all VAS this MCO - YTD Aug 2013	28,177	$670,219.09	Grand Total - all VAS this MCO - YTD Aug 2013	665,555	$2,714,550.59	Grand Total - all VAS this MCO - YTD Aug 2013	71,067	$1,900,378.70

All KanCare MCOs Combined

2013 VAS	Total Units YTD	Total Value YTD
Grand Total - all VAS all MCO - YTD Aug 2013	764,799	5,285,148.38

Provider Payment Comparison

Type of Service	Jan through September 2012	Jan through September 2013
HCBS	$423,493,362	$422,947,769
Behavioral Health	$175,850,203	$152,346,802
Pharmacy	$202,957,882	$222,122,087
Dental	$37,702,353	$42,319,406
Nursing Facility	$356,166,088	$351,017,671
Medical/All Other	$704,999,079	$666,057,784
Total	**$1,901,168,968**	**$1,856,811,520**

Payer	Jan through September 2012	Jan through September 2013
KMAP	$1,436,309,978	$494,045,510
Prior MCOs	$464,858,989	$51,396,985
Amerigroup	$0	$423,658,557
Sunflower	$0	$470,124,312
United Healthcare Community Plan	$0	$417,586,156
Total	**$1,901,168,968**	**$1,856,811,520**

Footnotes:

KMAP expenditures are from the MMIS/DSS ClaimsReporting system.
KMAP expenditure data is based on date of payment.
The MCO expenditure data is received from the MCOs.
Coventry amounts for February/March 2013 do not include Rx.
Vision and Transportation included in Medical/All Other

Revised: October 4, 2013

NON-CLAIM PROVIDER PAYMENT COMPARISON

Type of Payment	Jan through September 2012	Jan through September 2013
Critical Access Hospital Settlement	$4,928,359	$10,099,444
Nursing Facility Pass Through Payments	$8,874,900	$2,605,074
Childrens Mercy Outlier Method Adjustment	$4,923,173	$2,897,219
Cash Refund	$10,767	$70,703
FQHC-RHC Monthly Settlement	$8,897,597	$1,613,134
DSH Regular	$47,803,541	$49,353,519
Graduate Medical Education	$9,724,032	$4,294,024
Health Care Access Improvement Program Pool	$0	$30,631,548
HIPP Payment	$587,344	$601,104
KU Outpatient Hospital Settlement	$6,169,955	$2,721,062
LEA Cost Settlement	$7,957,849	$2,167,697
Large Public Teaching Border City Children Hosp	$0	$29,892,411
Lump Sum Delivery Payments	$0	$10,443
Miscellaneous	$563	$192,615
Nursing Facility Payback	$1,977	$0
Provider Assessment	$68,562	$20,500,005
Professional Supplemental Teaching Adjustment	$12,312,667	$11,602,728
Recoupment error	$600	$0
FQHC-RHC Yearly Settlement	$2,612,724	$3,249,803
TXXI Retro Eligibility	$13,229	$13,698
Tuberculosis	$3,848	$1,072
WORK	$4,018,522	$4,048,152
Grand Total	**$118,910,211**	**$176,565,453**

DENIALS SUMMARY

	Jan-Sept 2013	Jan-Sept 2012		
	KanCare MCOs	Healthwave MCOs	KMAP	BH Contractors
Inpatient	15.3%	15.1%	34.4%	
Outpatient	12.1%	11.0%	19.7%	
Medical	14.5%	11.5%	22.7%	
Pharmacy	23.1%	21.4%	38.3%	
Nursing Facilities	16.2%		9.8%	
Behavioral Health	9.6%			12.4%
Dental	8.3%		9.0%	
HCBS*	9.2%			
*HCBS included in "Medical" in 2012 KMAP stats				

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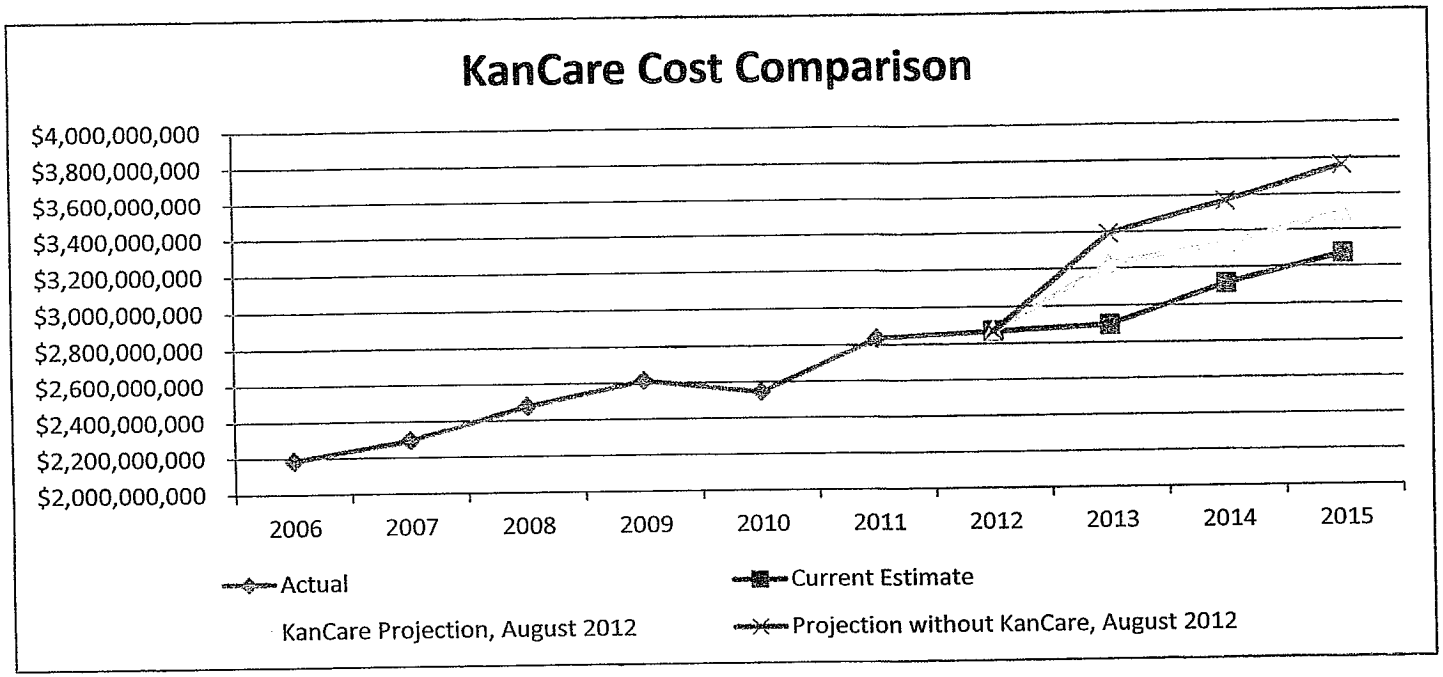
KANCARE COST VS. PROJECTIONS

Calendar Year	Actual	Current Estimate*	KanCare Projection, August 2012	Projection without KanCare, August 2012
2006	$ 2,182,856,667			
2007	$ 2,292,775,940			
2008	$ 2,477,025,146			
2009	$ 2,612,166,086			
2010	$ 2,544,388,869			
2011	$ 2,832,385,267			
2012	$ 2,862,154,049			
2013		**$ 2,891,323,853**	**$ 3,221,220,283**	**$ 3,388,650,296**
2014		**$ 3,109,434,618**	**$ 3,327,626,978**	**$ 3,566,432,256**
2015		**$ 3,266,939,994**	**$ 3,491,455,543**	**$ 3,760,308,271**

* Current Estimates reflect Appropriations and Spring Caseloads



COMMON CONSUMER ISSUES AND RESOLUTION

Issue	Resolution	Action Taken to Prevent Further Occurrences
Member's eligibility cannot be confirmed by pharmacy through MCO's system, so prescriptions cannot be filled (often within a day or two of eligibility being established).	When referred to the State, eligibility was confirmed, the MCO called pharmacy and prescriptions filled.	Assurance that eligibility file is loaded in timely fashion by MCOs and their vendors. Providers can confirm eligibility by directly accessing KMAP or calling customer service.
Some members found, after their 90 day "choice period" expired, that their preferred providers were not contracted with their assigned MCO, or that needed/desired services were not available through that MCO. Thus, members requested reassignment.	MCOs worked to assure needed services were available within the State's geographic access standards, either with in-network providers or single case agreements with out-of-network providers. If those conditions were not met, members were granted their request for re-assignment to a different health plan. May-September, 35 such requests were approved.	MCOs' contracting efforts are ongoing, to close gaps in their provider networks.
Prescriptions and other services were delayed or denied for lack of a prior authorization.	Some PA requirements were relaxed, upon guidance from State Program Managers and Pharmacist. Providers advised of necessary documentation needed to obtain PA, and allowed to resubmit. MCO's PA processes were improved to provide more rapid decisions.	For Rx, the State's Pharmacist is monitoring MCOs' PA lists to assure that they aren't incorrectly requiring PAs.
Incorrect information was given to members and providers by customer service representatives.	Instruction/correction of individual staff when issues were called to MCO's attention. On occasion, MCO has covered services which were provided on the basis of incorrect information.	Ongoing education of CSRs to understand the eligibility information available to them, the services which are covered by KanCare, and correct routing of calls.
Incorrect application of spenddown, client obligation, and patient liability	MCO education to providers on how to properly apply claims to patient responsibility (spenddown).	State held a training session for MCO staff targeting these issues.

GRIEVANCES AND APPEALS

State of Kansas Office of Administrative Fair Hearings: January 1, 2013 – October 1, 2013

Members:

Services were rendered	No adverse action	Member did not appear	Pending Schedule	Total
1	40	1	20	62

Providers:

Dismissed	Withdrawn	MCO Affirmed	Pending Schedule	Total
57	71	2	35	165

All Member Grievances ***Calendar Q1:*** **January 1, 2013 – March 31, 2013**

Total Received	Resolved in Quarter
454	407

KDHE Grievance Data Base **– Members** ***Calendar Q2*****: April 1, 2013 – June 30, 2013**

MCO	Access	Dental Access	Pharmacy	Benefits and Billing	Quality of Care	Rights and Dignity	Total
Amerigroup	23	5	26	69	4	0	127
Sunflower	20	6	41	73	3	1	144
United	23	0	17	44	2	0	86

KDHE Grievance Data Base **- Providers** ***Calendar Q2*****: April 1, 2013 – June 30, 2013**

MCO	Access	Enrollment	Dental Access	Pharmacy	Benefits and Billing	Total
Amerigroup	3	11	9	13	161	197
Sunflower	1	1	16	18	51	87
United	2	3	0	14	95	114