PERFORMANCE AUDIT REPORT

HealthWave: Determining Whether the Program's Call Center Is Working As It Should

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
June 2008

08PA02

Legislative Post Audit Committee
Legislative Division of Post Audit

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June 12, 2008

To: Members, Legislative Post Audit Committee

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This report contains the findings, conclusions, and recommendations from our completed performance audit, *HealthWave: Determining Whether the Program's Call Center Is Working As It Should?*

The report includes several recommendations for the Kansas Health Policy Authority. We would be happy to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other State officials.

Barbara J. Hinton
Legislative Post Auditor

READER'S GUIDE

Get the Big Picture

Read the sections and features:

1. **Executive Summary** - an overview of the question we asked and the answers we found.

2. **Conclusion and Recommendations** - appear in boxes at the end of the report sections. They also are referenced in the Executive Summary.

3. **Agency Response** - is included as the last Appendix in the report.

Helpful tools for Getting to the Detail

- In many cases, an "**At a Glance**" description of the agency or program appears within the first few pages of the main report.
- **Side Headings** point out key issues and findings.
- **Charts and Tables** found throughout the report help tell the story of what we found.
- **Narrative text boxes** can highlight interesting information, or provide detailed examples.
- Appendices include additional supporting detail, along with the **Scope Statement** and **Agency Response (s)**.

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EXECUTIVE SUMMARY

LEGISLATIVE DIVISION OF POST AUDIT

Overview of the Kansas HealthWave Program

In 2001, the Legislature combined several medical insurance programs for low-income families into a program called HealthWave. *The HealthWave Program consists of the State's Children's Health Insurance Program (Title XXI) and several Medicaid insurance programs (Title XIX). The 2005 Legislature created the Kansas Health Policy Authority, which became responsible for overseeing HealthWave and other medical assistance programs in fiscal year 2007. The Authority contracts with MAXIMUS, a private contractor, to help determine eligibility and market the HealthWave Program. Under the contract, MAXIMUS also is required to operate a Call Center. In fiscal year 2007, about 340,000 people participated in the programs under the HealthWave umbrella.*

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Question 1: Is There a Problem With the HealthWave Program Returning Phone Calls Placed to Its Toll-Free Number, and If So, What's the Cause and What's Being Done To Fix It?

The HealthWave Call Center has a toll-free number accessible 24 hours, seven days a week. *Operated by MAXIMUS, a private contractor, the Call Center receives a monthly average of 27,000 phone calls and 1,300 voicemail messages from current and potential HealthWave Program participants. Generally, MAXIMUS staff are expected to attempt to return messages by the end of the next business day. The contract requires staff to attempt to return voicemail messages left after business hours by the end of the next business day. MAXIMUS also allows messages to be left during business hours (something not required by contract), and its goal is to attempt to return messages left during business hours by the end of the next business day as well.*

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The contractor doesn't have a system in place to ensure that all voicemail messages are captured so staff can return them. *Each day, Call Center staff transfer recorded messages on five voicemail boxes to paper message logs. MAXIMUS officials told us supervisors review the number of messages recorded on each of the voicemail boxes, which should match the number of messages staff record on the message logs. However, on 4 of the 11 days we reviewed for the month of February, those counts didn't match. In discussing these discrepancies with MAXIMUS officials, we learned that reconciling the two reports isn't always possible because of the continuous nature of voicemail messages being left throughout the day, and because supervisors don't record the number of voicemail messages consistently.*

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About one-third of the time we found problems with the Call Center's efforts to return calls, but most of those problems were fairly minor. *We found one or more problems with 28 of the 100 sample voicemail messages we reviewed. For 19 messages, returned calls weren't attempted before the end of the next business day, however; 13 of them were late by only one day. For nine messages, staff didn't fulfill MAXIMUS' internal goal of making three attempts to reach the caller (for two of these problem messages, staff also made their attempts late). For two other messages, there was no evidence MAXIMUS staff had attempted to return the call.*

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Several factors may have contributed to the problems we found. *MAXIMUS officials haven't clearly documented all the requirements their customer service representatives should meet. MAXIMUS officials also told us that, during the first few months of fiscal year 2008, they still were experiencing the residual effects from changes in federal requirements that caused a huge influx of calls in fiscal year 2007. These new provisions required clients to provide proof of identity and citizenship for Title XIX Medicaid programs, which resulted in the Call Center receiving an average of 10,000 more calls and 4,000 more voicemail messages per month.*

During that time, the Health Policy Authority didn't strictly enforce certain contract provisions because of circumstances brought on by those changes, and instead directed the contractor to shift resources to reduce the resulting backlogs in applications.

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We also noticed several weaknesses related to how MAXIMUS and the Kansas Health Policy Authority monitor or enforce the contract. *Based on records MAXIMUS maintains, it's difficult to track what actions its staff took to address any particular phone message. That's because the original messages are recorded on paper, while the actions staff took in response to the messages are contained in the contractor's computer system.*

For the Kansas Health Policy Authority, we found that its contract with MAXIMUS hasn't been updated to clearly spell out expectations related to handling phone messages from clients or potential clients. In addition, the weekly reports MAXIMUS provides to the Authority don't include all the information needed to monitor current contract provisions related to returning phone calls.

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Question 1 Conclusion

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Question 1 Recommendations for executive action

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Question 2: Does It Appear That Problems with Returning Phone Calls Could Be Having a Significant Negative Impact On Program Enrollment?

This audit was conducted by Katrin Osterhaus, Nathan Ensz and Brad Hoff. Leo Hafner was the audit manager. If you need any additional information about the audit's findings, please contact Katrin Osterhaus at the Division's offices. Our address is: Legislative Division of Post Audit, 800 SW Jackson Street, Suite 1200, Topeka, Kansas 66612. You also may call us at (785) 296-3792, or contact us via the Internet at LPA@lpa.state.ks.us.

HealthWave: Determining Whether the Program's Call Center Is Working As It Should

HealthWave is a program originally administered by the Department of Social and Rehabilitation Services to provide health insurance to uninsured children in Kansas. In 1998, the year the program started in Kansas, about 60,000 children were estimated to be uninsured.

The Department contracted with MAXIMUS, a private company, to provide information to people who may be eligible, determine their eligibility, and help them enroll in the Program. MAXIMUS maintains a customer service center with a toll-free number that current and potential program participants can call 24 hours a day 7 days a week.

In 2001, the Department expanded the HealthWave umbrella to include other Medicaid-related insurance programs for both children and adults. Currently, HealthWave covers children ages 0-19, living in households with incomes at or below 200% of the federal poverty level, and parents below 37% of the federal poverty level.

In 2006, the HealthWave Program became the responsibility of the Kansas Health Policy Authority. However, it continues to be administered by MAXIMUS. Recently, legislators have heard concerns from constituents who had called the toll-free number several times, left messages, and never had calls returned. Those legislators tried calling the center on behalf of their constituents, and experienced the same result. This has caused legislators to question whether there's a significant problem with calls not being returned, and whether this could be contributing to lower-than-anticipated enrollment in the Program.

To address these concerns, this performance audit answered the following questions:

1. **Is there a problem with the HealthWave Program returning calls placed to its toll-free number, and if so, what's the cause and what's being done to fix it?**

2. **Does it appear that problems with returning phone calls could be having a significant negative impact on program enrollment?**

To answer these questions, we interviewed Kansas Health Policy Authority and MAXIMUS officials, and we reviewed the Authority's contract with MAXIMUS. We also reviewed MAXIMUS' policies and procedures for how phone messages should be recorded and returned.

For a random sample of phone messages left with the Call Center, we determined whether MAXIMUS' staff responded according to policies and procedures. We analyzed information about the callers who left messages with the Call Center to determine whether they already were enrolled in HealthWave, or whether they were potential clients who might be eligible for the Program. We projected that information to the population of calls left during the first eight months of fiscal year 2008 to estimate the potential impact unreturned calls might be having on enrollment.

Finally, we reviewed general enrollment data from the Kansas Health Policy Authority, and talked to officials to get their input regarding program enrollment effects. A copy of the scope statement for this audit approved by the Legislative Post Audit Committee is included in Appendix A.

We conducted this performance audit in accordance with generally accepted government auditing standards with certain exceptions. Specifically, because of the way that records are maintained, we couldn't systematically test whether all phone messages received by the call center are being logged in daily voicemail logs. The voicemail logs were the only reasonable source for selecting the sample of calls we reviewed in this audit. As a result, the problems identified in the audit may be somewhat understated, because there is no way to know how the Call Center's staff handled calls that may not have been recorded in the voicemail logs.

We also didn't test the accuracy of the contractor's computer system where Call Center employees record the actions they take on the phone calls the Call Center receives. We used this information as a basis for determining what actions were taken to address caller inquiries. If Call Center staff didn't record actions they took to resolve caller inquiries, it could look like staff hadn't responded to a caller when in fact they had, therefore potentially overstating the problems identified in the report. We have no way of knowing how often this may have occurred, but given the Call Center's procedures, we think it is unlikely to be happening often enough to significantly affect our findings.

Finally, due to time constraints, we didn't fully test the Kansas Health Policy Authority's enrollment data, MAXIMUS' monthly reports of the number of calls and their average duration, and the number of messages its Call Center received. We used this information to evaluate the impact of unreturned calls and new federal requirements on enrollment trends. We think it's unlikely that any of these data are so grossly or systematically wrong as to affect our findings.

The standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusion based on our audit objectives. Except for the limitations described above, we believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Our findings begin on page 7 following a brief overview.

In 2001, the Legislature Combined Several Medical Insurance Programs For Low-Income Families Into a Program Called HealthWave

In 1998, the Kansas Legislature took advantage of a new joint federal and State program to help uninsured children from low-income working families get health insurance. The Legislature made the Department of Social and Rehabilitation Services (SRS) responsible for implementing this new State Children's Health Insurance Program. The Program was launched in Kansas in January 1999 under the name HealthWave.

Beginning in 2001, the Kansas Legislature blended the children's insurance program with several other Medicaid insurance programs under the HealthWave name. The State Children's Health Insurance Program is a Title XXI program. It's available to children between the ages of 0-19 living in homes with an income between 100-200% of the federal poverty level.

The other insurance programs (e.g. Poverty Level Eligible Children, Temporary Assistance to Families, and Medically Needy Families) fall within Title XIX of Medicaid. These programs cover children living in households with incomes between 0-150%, and also cover parents whose household income is below 37% of the federal poverty level. Blending the various programs together allowed individual families members who may have been eligible through different programs to have the same health plans and providers.

Throughout the remainder of this report, when we refer to the HealthWave Program we are referring to these low-income health insurance programs as a group, and not just the State Children's Health Insurance Program, originally named HealthWave.

Figure OV-1 shows enrollment levels for the three main populations enrolled in the programs under the HealthWave umbrella over the past three fiscal years and fiscal year 2008 through March. As the figure shows, almost 340,000 individuals participated in the HealthWave Program at some point during fiscal year 2007. On a monthly basis, the Program averaged about 190,000 beneficiaries in fiscal year 2007. This monthly average is much lower than the annual number because participants drift in and out of the Program for several reasons:

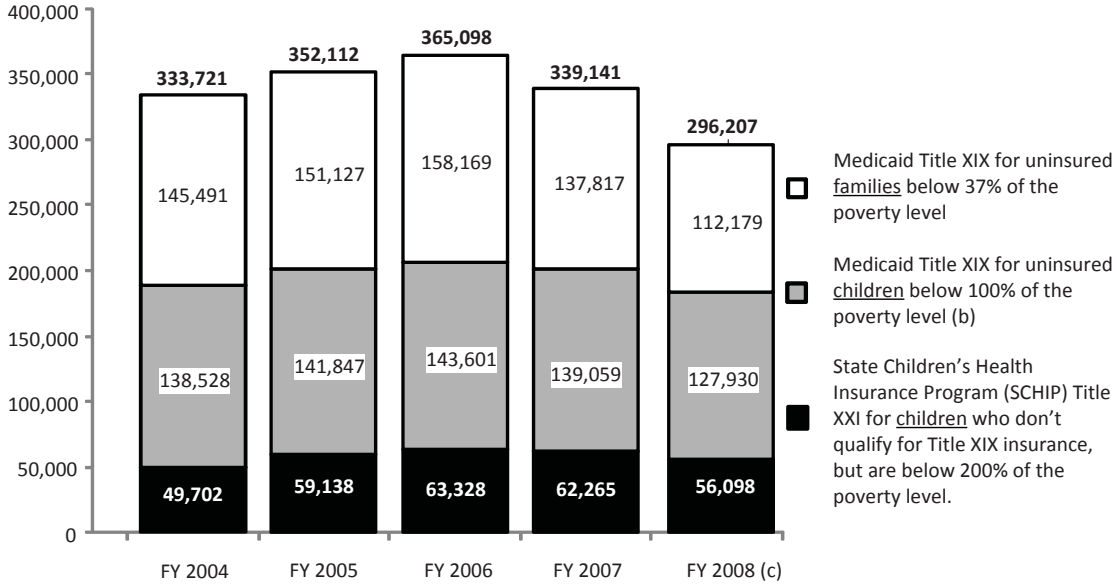
- **This population is mobile.** Consequently, when the time comes to complete their annual membership renewal, the renewal applications may not reach the family because they are no longer living at the address on file. Without the renewal paperwork being processed, the participants would lose their benefits until they reapply.

- **Individuals have unsteady incomes.** Depending on the jobs that family members have, a household's income can fluctuate above or below the income guidelines for eligibility. Such income fluctuations could make a family eligible during part of the year and ineligible during the remainder of the year.

- **Family composition sometimes changes**. Because eligibility is based on federal poverty levels for a certain household size, the birth of a new child, a child reaching adulthood, or a divorce could affect a household's eligibility status.

- **Program participants sometimes lose benefits because they are late in filing renewal applications**. Individuals may wait too long and only send in a renewal application once they learn they've lost their membership.

Figure OV-1
Number of People Enrolled In HealthWave Title XIX and Title XXI Programs (a)
Fiscal Years 2004 - 2008



Source: LPA summary of unaudited Kansas Medical Assistance Reports from Kansas Health Policy Authority
(a) The numbers shown above represent an unduplicated count of the people participating in HealthWave in any given year. Unduplicated means that a person who participated for two months early in a year and also participated again later in the year would be counted only once.
(b) Children in this category under one year of age are eligible up to 150% of the poverty level, children ages one to five are eligible up to 133% of the poverty level, and all other children are eligible at 100% of the poverty level.
(c) Fiscal year 2008 includes only the first nine months – July 1 through March 31, 2008.

As ***Figure OV-1*** shows, the annual Title XIX Medicaid enrollment declined in fiscal year 2007, while Title XXI enrollment (the Children's Health Insurance Program) stayed fairly stable. This decline likely is due to new federal citizenship and identification requirements that were imposed starting that year. Question 1 will discuss these changes in more detail.

The 2005 Legislature created the Kansas Health Policy Authority, which became responsible for overseeing HealthWave and other medical assistance programs in fiscal year 2007. The Authority took over several Medicaid programs and related health-care data

from SRS, along with several other public health programs. SRS still oversees other Medicaid programs that serve the elderly and physically disabled, and people still can apply for HealthWave Programs at SRS field offices.

The State contracts with MAXIMUS, a private contractor, to help determine eligibility and market the HealthWave Program. SRS entered into the initial 3-year contract with MAXIMUS in 2003. The Authority has renewed the contract several times, but the last extension will expire June 2009. The main responsibilities under the contract require MAXIMUS to market the HealthWave Program, provide customer service through a Call Center, and determine eligibility for applicants of the State Children's Health Insurance Program.

Under federal law, State employees must determine eligibility for Medicaid programs under the HealthWave umbrella. As a result, Kansas Health Policy Authority staff work alongside MAXIMUS staff to determine eligibility for certain HealthWave applications. For fiscal year 2008, MAXIMUS will receive a total of $8.3 million for its work under the current contract.

HealthWave
AT A GLANCE

Authority: HealthWave was created by K.S.A. 38-2001 and allowed the State to adopt a State Children's Health Insurance Program (SCHIP) as authorized under Title XXI of the Social Security Act. K.S.A. 75-7401 et seq. established the Kansas Health Policy Authority as an independent State agency with both operating and purchasing responsibility for Medicaid, SCHIP, and other programs.

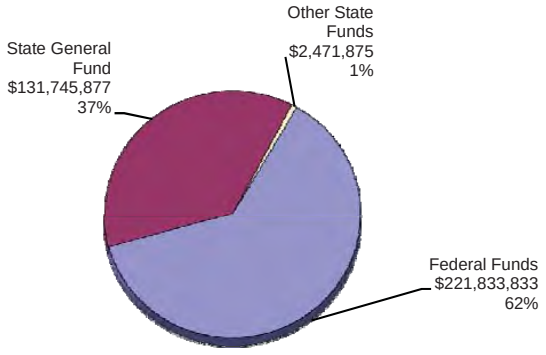
Staffing: The Kansas Health Policy Authority had 37.3 FTE employees working on the HealthWave Program in fiscal year 2007. Management of the HealthWave program is fully integrated with other Medicaid programs.

Budget: The HealthWave Program's funding sources come from a combination of federal allocations for Title XIX and Title XXI that are matched by State funds.

FY 2007 Expenditures

Type	Amount	% of Total
Payments to Managed Care Organizations	$290,830,824	81.7%
Other State Plan Services	$50,161,859	14.1%
Contractual Services	$13,268,805	3.7%
Salaries & Wages	$1,778,987	0.5%
Commodities	$7,338	0.0%
Capital Outlay	$3,772	0.0%
Total Expenses:	**$356,051,585**	**100%**

Sources for Funding for Expenditures



Total Funding: **$356,051,585**

Source: *Kansas Health Policy Authority*

Question 1: Is There a Problem With the HealthWave Program Returning Calls Placed to Its Toll-Free Number, and If So, What's the Cause and What's Being Done To Fix It?

ANSWER IN BRIEF: *MAXIMUS, the State's contractor for HealthWave, has a Call Center with a toll-free number accessible 24 hours, seven days a week. However, MAXIMUS doesn't have a system in place to ensure that all customer voicemail messages are captured so staff can return them. We also found that actions taken for almost one-third of the 100 messages we reviewed didn't meet all the Call Center's standards for returning phone messages. Most of the problems were minor timeliness issues—few calls were returned more than one day late.*

However, in some cases the efforts to return the calls were insufficient, and for two messages we couldn't find evidence that return calls were attempted. Factors contributing to such problems included the lingering effects from a high call volume the Call Center experienced in fiscal year 2007. Also, MAXIMUS doesn't have well-documented policies governing the level of effort its staff should expend, or how quickly they should return voicemail messages. We also noted several weaknesses in the way the Kansas Health Policy Authority and MAXIMUS monitor the Call Center. These and related findings are discussed in more detail in the sections that follow.

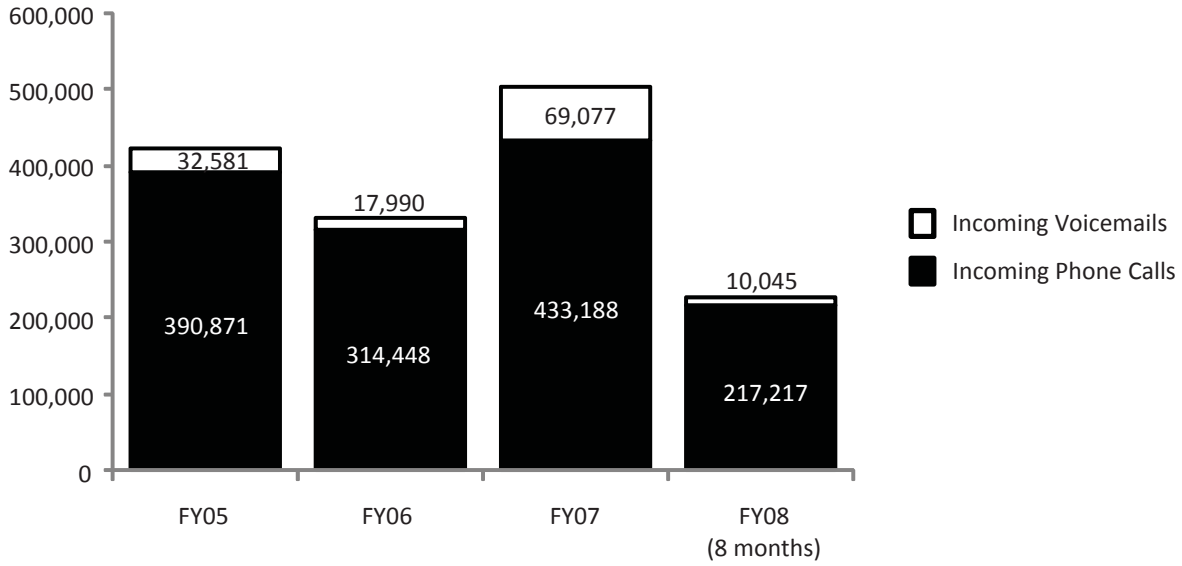
The HealthWave Call Center Has a Toll-Free Number Accessible 24 Hours, Seven Days a Week

Kansas Health Policy Authority contracts with MAXIMUS to administer the HealthWave Program. The contract requires MAXIMUS to market HealthWave, determine eligibility for certain applicants, provide customer service for walk-in clients, and operate a Call Center to assist current and potential Program participants.

The Call Center is staffed with 23 English- and Spanish-speaking customer service representatives who take phone calls from 7 a.m. to 6 p.m. Monday through Friday. In addition, the Call Center has a voicemail system that allows callers to leave messages 24 hours a day, seven days a week.

The Call Center receives an average of 27,000 phone calls and 1,300 voicemail messages a month. Because the Call Center is designed to serve all clients within the various insurance programs under the HealthWave umbrella, these calls represent questions from members of, or individuals interested in, various Medicaid insurance programs, or the State Children's Health Insurance Program. ***Figure 1-1*** shows a history of phone calls and voicemails received annually.

Figure 1–1
Incoming Calls and Voicemails to the MAXIMUS Call Center
Fiscal Years 2005 – 2008 (Through February 29, 2008)



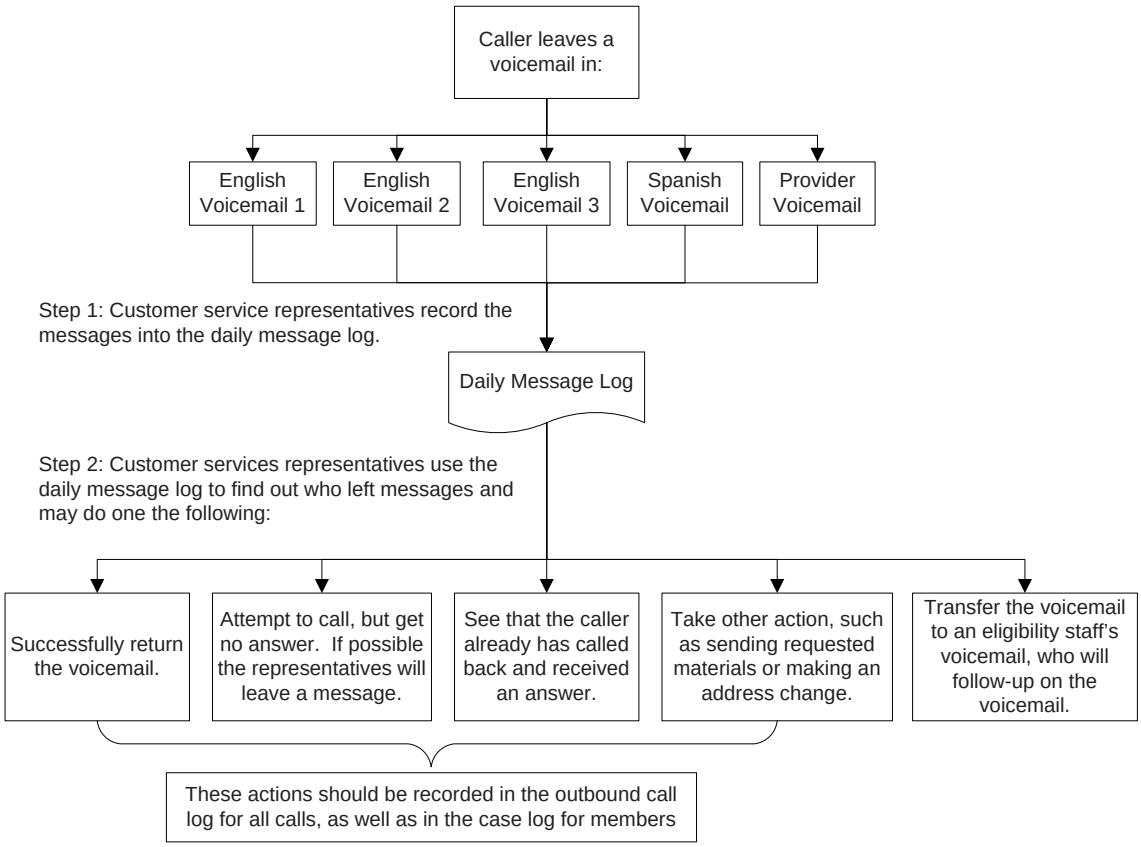
Source: LPA summary of unaudited monthly MAXIMUS call and voicemail reports

As the figure shows, the number of incoming phone calls and voicemails significantly increased in fiscal year 2007 due to new federal requirements, which will be discussed later. Call Center staff typically retrieve messages left on five voicemail boxes at the beginning of each workday.

On a paper message log, staff write down the date and time each message is left, as well as other information callers are prompted to leave, such as their name, phone number, case number, Social Security number, and their question or issue. If a caller indicates his or her message is urgent (e.g. the client is running out of his or her medication), that call will be shown as a priority call, and returned before all other voicemails left during the period.

After the Call Center's staff transfer all recorded messages to paper message logs, they attempt to return the calls as time permits between incoming calls. Staff are supposed to document efforts to return calls, and to include information about how the calls were resolved in MAXIMUS' computer system. The flowchart in ***Figure 1-2*** on the following page shows this process.

Figure 1-2
Process of Retrieving and Returning Voicemails at the MAXIMUS Call Center



Source: LPA summary of MAXIMUS' process of retrieving and returning voicemails.

Generally, MAXIMUS staff are expected to attempt to return messages by the end of the next business day. The contract between the Health Policy Authority and MAXIMUS requires the Call Center to have a voicemail system after hours, and requires MAXIMUS staff to try to return voicemail messages by the next working day. The contract also requires that—if a representative from the Call Center isn't able to contact the caller—a letter is to be sent acknowledging the caller's concern and responding appropriately. MAXIMUS officials told us they stopped sending those types of letters because of concerns about violating restrictions imposed by the Health Insurance and Portability and Accountability Act (HIPAA) in 2004.

As an enhancement to the after-hours voicemail system required by the contract, MAXIMUS' voicemail system also allows callers who can't get through to a customer service representative during normal business hours to leave messages. In reviewing the company's written policies and procedures for retrieving, recording,

and returning these messages, we noted that the procedures say MAXIMUS staff are required to return messages left after hours by the end of the next working day.

However, the procedures don't specifically address how quickly messages left during business hours are to be returned. MAXIMUS officials told us the goal is to attempt to return all voicemail messages by the end of the next working day. In addition, officials told us that one of their goals is for staff to attempt to reach a caller three times before the call is considered completed.

The Contractor Doesn't Have a System in Place To Ensure That All Voicemail Messages Are Captured So Staff Can Return Them

The first step in making sure the phone calls are returned is making sure that each message is recorded on the voicemail message logs. We asked MAXIMUS officials how they ensure that all voicemail messages are being recorded on those logs. They told us supervisors review the number of messages recorded on each of the five voicemail boxes and add them up to get a grand total of voicemail messages, which should match the number of messages staff record on the message logs.

We tested this process for messages left early February 2008. For the 11 workdays we reviewed, we found that the supervisor's report of the number of messages matched the number of messages staff recorded only seven times. On the four remaining days the numbers didn't match, which is shown in ***Figure 1-3***.

Figure 1-3
Differences Between Supervisor's Voice Message Counts and the Number of Messages on Daily Message Logs

Date	Supervisor's Count of Messages	Messages Copied to Daily Message Logs	Difference
2/1/2008	10	14	4
2/6/2008	25	10	-15
2/7/2008	24	21	-3
2/15/2008	7	0	-7

Source: LPA comparison of unaudited voicemail daily reports compiled by Call Center supervisors and the number of messages recorded on MAXIMUS' voicemail message logs.

In discussing these discrepancies with MAXIMUS officials, we learned that these inconsistencies can happen because the supervisor may not collect the number of messages to be retrieved right at the start of the day, and customers leave additional voicemails when the Call Center first opens and call volumes are high. In essence, because of the continuous nature of the messages flowing in, while the supervisor's report is a snapshot at one particular point in time, reconciling the two reports isn't always possible.

During our review, we also found two days on which it appeared not all voicemail messages were retrieved. On one day, no record existed that any messages were retrieved. On a second day, only

Spanish messages were recorded on the voicemail message logs. We confirmed with officials that it's unlikely for the Call Center not to receive any English-speaking messages. They stated that staffing shortages likely led to messages not being retrieved on those days.

Lastly, we found one instance where staff didn't write down the date on which messages were retrieved from the voicemail box. This adds to problems in trying to reconcile information to ensure that all messages are retrieved.

About One-Third of The Time We Found Problems With the Call Center's Efforts To Return Calls, but Most Of Those Problems Were Fairly Minor

During the first eight months of fiscal year 2008, reports from MAXIMUS show the Call Center logged slightly more than 10,000 voicemail messages. As mentioned in the previous section, there was no way for us to verify the total number of messages actually received during that time period, but we have no reason to believe that the reports significantly understate the number of messages the Call Center received.

After adjusting for callers who didn't leave enough information to return the call, we estimated that, during the time period we reviewed, the Call Center received approximately 9,300 voicemails that should have resulted in an attempt to return the phone call.

We randomly selected 100 returnable messages listed on the daily voicemail logs between July 1, 2007, and February 29, 2008. For each of those calls, we attempted to determine whether MAXIMUS staff responded according to the following policies, procedures, and goals officials told us they had established:

- Attempts to return calls should be made before the end of the next business day
- Three attempts should be made to contact the caller before considering follow-up on the call to be completed

We found 28 messages that weren't handled according to these criteria. Here's a breakdown of what we found (some calls had more than one problem, so the following list totals 30 problems):

- **For 19 messages, returned calls weren't attempted before the end of the next business day:** Of these, 13 messages were late by only one day. Four calls were two or three days late, one was six days late, and one was late by eight days.

- **For nine messages, staff didn't make three attempts to reach the caller:** In one case, staff documented two unsuccessful attempts to contact the caller, but for the other eight, return calls were attempted only once before the follow-up was considered to be completed (In addition, two of these attempts were made late – beyond the next

working day). MAXIMUS officials told us that when call volumes were high, they sometimes relaxed the self-imposed "three attempts" goal. In some cases, MAXIMUS officials indicated that while staff didn't reach the caller, they took actions to meet the caller's needs based on information the caller left in the message. Examples of such actions include initiating a review of an application that had been denied, or conducting a re-determination of benefits. However, without a return phone call, the caller wouldn't know that his or her concerns were being addressed.

- **For two messages, there was no evidence MAXIMUS staff attempted a return call:** One message came from a HealthWave client with a long case history. A return call should have been made and recorded in the individual's case log, but we found no entry in the case logs to show a return call had been attempted. We called this client, who told us MAXIMUS never called her back. The other message appears to have been left by a non-client, who didn't leave a name but left a phone number and a message. Even with the assistance of MAXIMUS officials, we couldn't find evidence an outbound call went to the phone number that person had provided. Because of Health Insurance and Portability and Accountability Act privacy rights, we couldn't contact this individual since we had no name to confirm we were talking with the right person.

Obviously not even attempting to return a phone call is the most serious of the problems we found. Based on our sample result, we estimated this occurred at least twice and possibly for as many as 442 of the roughly 9,300 returnable phone messages left during the first eight months of fiscal year 2008 (our sample period).

Three Problem Cases Where Messages Weren't Properly Returned

Of the 28 problem cases we identified, 19 weren't returned to callers on a timely basis. MAXIMUS Call Center customer service representatives are responsible for handling these messages or passing them on to eligibility staff.

The following are histories of three people who called the HealthWave Call Center whose voice messages didn't require eligibility staff and weren't returned timely by Call Center customer service representatives:

- An individual who had an ongoing case file left a voicemail message on August 29, 2007 (a Wednesday), checking if the application had been received, and indicating she had a medical need. We saw no evidence a call was returned to her. We called the individual, who confirmed she never did receive a call back from HealthWave staff.

- An individual left a voicemail message on August 8, 2007 (a Wednesday), checking on the status of her son's application. After four business days (Tuesday, August 14th), she hadn't received a response and called the Call Center back. This time, she talked to a customer service representative, and was told that her application had been received and was being processed.

- An individual left a voicemail message on October 1, 2007 (a Monday), wanting coverage for herself. She also indicated she had income questions. Two days later a Call Center staff returned the voicemail and left a message, as no one answered the phone.

Several Factors May Have Contributed to The Problems We Found

Through our discussions with MAXIMUS officials and our review of policies, procedures, and records for the Call Center, we identified several factors that can contribute to calls not being attempted timely or not at all.

MAXIMUS officials haven't clearly documented all of the requirements their customer service representatives should meet. Some specific weaknesses we identified were as follows:

- **No written policy exists governing deadlines for attempting to return phone messages left during "normal working hours."** As mentioned earlier, the contract with the Kansas Health Policy Authority and MAXIMUS' own policies require messages left after business hours to be returned by the end of the next business day, but policies governing messages left during the day aren't written. To ensure that everyone understands the expectations, officials should codify in a formal policy their verbal goal to return all messages the next working day.

- **No written policy exists spelling out the level of effort that needs to be made to return a call.** As mentioned earlier, MAXIMUS officials told us staff should make three attempts to contact the caller before the return call is considered to be completed. They described this as a project goal, and explained this goal may not be enforced during periods of high-call volume. Officials told us that staff are encouraged to take a break, or do something different in-between these attempts, but no written standards exist on how far apart staff should space their attempts. Without written guidelines, there's a higher risk that the customer-service representatives won't meet expectations for returning phone calls to customers.

Three Problem Cases Where Messages That Were Transferred to Eligibility Staff Were Returned Late

Of the 19 cases in our sample that weren't returned on a timely basis, the voicemail messages that took the longest to get returned tended to be messages that were transferred internally to eligibility staff. The following examples discuss what happened.

- An individual left a voicemail message on July 28, 2007 (a Saturday), asking why her application was denied. On Monday, July 30, the MAXIMUS customer service representative transferred the message to the voicemail of the MAXIMUS eligibility staff. On August 8—eight business days after the message was left in the Call Center—eligibility staff attempted a call, weren't able to reach the individual, and left a message. In this case, we also noticed that the application was received in the middle of April and wasn't processed for three months, until the end of July when it was denied.

- An individual left a voicemail message on September 21, 2007 (a Friday), asking how she could be over the maximum income allowed when the only income she received was public assistance. Her call was transferred to MAXIMUS' eligibility staff, who returned the call and spoke to her on Wednesday, September 26th— three business days from when the message was left.

- An individual left a voice message on August 8, 2007 (a Wednesday), asking what the guidelines are for pregnant women. The customer service representative transferred the message to the voicemail of the MAXIMUS eligibility staff on August 9, 2007. On August 16, 2007, six business days after the original message was left with the HealthWave Call Center, eligibility staff returned the voice message.

- **MAXIMUS lacks clear guidance on how its staff should handle voicemail messages forwarded to staff who determine whether clients are eligible for services.** When individuals leave messages on questions about eligibility criteria, the customer service representatives can transfer those inquiries to the voicemail box for the eligibility section, without notifying the caller. MAXIMUS doesn't have written policies on when eligibility staff need to attempt to return those transferred messages, but MAXIMUS officials told us they expect eligibility staff to attempt to return calls within one business day. However, when messages are forwarded to the eligibility section, the messages get a new "date received" stamp, leading to additional delays from the time a client originally left the message. In our sample, we found that four messages were forwarded to the eligibility voicemail box. Eligibility staff returned all of them late – two were two to three days late, one was six days late, and one was eight days late.

MAXIMUS officials also told us that, during the first few months of fiscal year 2008, they still were experiencing the residual effects from changes in federal requirements that caused a huge influx of calls in fiscal year 2007. Provisions in the Federal Deficit Reduction Act of 2005 required clients to provide proof of identity and citizenship for Title XIX Medicaid programs, starting in fiscal year 2007 (July 2006). The box below provides more information about that change. Although these requirements didn't apply to the Title XXI Children's Health Insurance Program of HealthWave, the Health Policy Authority initially enforced these new rules on all the

New Federal Requirements Caused a Huge Influx of Calls For the HealthWave Contractor in Fiscal Year 2007

As a result of the 2005 Federal Deficit Reduction Act, beneficiaries of all Title XIX Medicaid programs were required to provide proof of identity and citizenship. The Kansas Health Policy Authority was responsible for ensuring that the new requirements were implemented starting July 1, 2006. To provide consistent and simplified policies for all HealthWave medical assistance programs, the Authority also adopted these new requirements for the Title XXI State Children's Health Insurance Program. As a result of the new citizenship and identity requirements, the contractor's Call Center experienced dramatic increases in calls and voicemail messages.

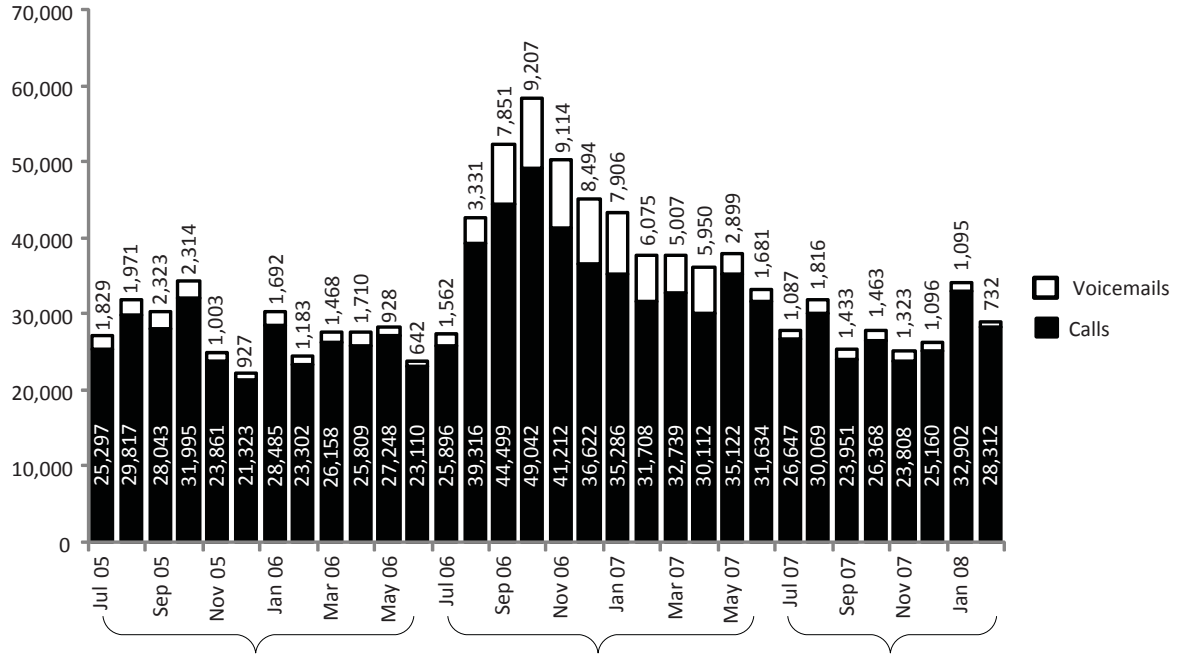
In November 2006, Authority staff lifted the self-imposed citizenship and identity requirement for the State Children's Health Insurance Program to curb the decline in the number of children enrolled in HealthWave. As a result, while applicants typically must first be screened for Medicaid Title XIX eligibility, children whose family household income clearly is too high for that Program can become eligible for the Children's Health Insurance Program without having to comply with the citizenship and identity requirements.

In addition to the increased call and voicemail volume the contractor was responsible for, applications and new paperwork that individuals submitted also caused a backlog. To deal with these problems, Authority officials went before the 2007 Legislature to request additional funding. The Legislature approved about $700,000 to pay for 15 additional staff to process application materials, secure citizenship and identity verification, and answer phone calls. At the start of fiscal year 2008, MAXIMUS hired these staff, five of whom are dedicated to the Call Center.

With the last extension of the contract, Authority staff also amended the contract requiring MAXIMUS to cooperate with other State agencies, such as the Departments of Education and Health and Environment to locate possible birth, school, and immunization records to serve as proof of citizenship and identity for applicants. By the beginning of fiscal year 2008, the incoming call and voicemail volumes had decreased to levels experienced before the federal requirements took effect.

Programs under the HealthWave umbrella for consistency purposes. These changes significantly increased the number of people calling to find out what they had to do to meet the new requirements, and how those requirements might affect their benefits. As data compiled by MAXIMUS shows, this created a spike in the number of messages individuals left when they couldn't reach a customer service representative. This is shown in ***Figure 1-4***.

Figure 1-4
Incoming Phone Calls and Voicemails by Month



Fiscal Year 2006
- Average Calls/Month: 26,204
- Average Voicemails/Month: 1,499
- Average Call Time/Call: 3 min 43 sec

Fiscal Year 2007
- Average Calls/Month: 36,099
- Average Voicemails/Month: 5,756
- Average Call Time/Call: 4 min 32 sec

Fiscal Year 2008 (partial)
- Average Calls/Month: 27,152
- Average Voicemails/Month: 1,256
- Average Call Time/Call: 3 min 49 sec

Source: LPA summary of unaudited MAXIMUS monthly reports of incoming calls, incoming voicemails, and average call time.

As shown in the bottom of the figure, the Call Center received an average of 36,099 calls and 5,756 voicemails per month during fiscal year 2007, about 10,000 more calls and 4,000 more voicemails per month than in fiscal years 2006 or 2008. The average call received in fiscal year 2007 also lasted almost a minute longer than in fiscal year 2006 or 2008. As discussed on page 2, we did not audit this data.

In response to the increased call volume, the 2007 Legislature provided additional funding for the contract that allowed MAXIMUS to hire five additional customer service representatives for the Call Center at the beginning of fiscal year 2008.

By the start of 2008, the volume of calls and messages had returned to more normal levels, but MAXIMUS officials told us they were still in the process of getting the new staff trained. Because training these new staff took away from the time MAXIMUS' more senior staff had to answer and return phone calls, officials told us it negatively impacted the Call Center's ability to return calls during those early months of fiscal year 2008.

During that time, the Health Policy Authority didn't strictly enforce certain contract provisions because of circumstances brought on by changes in federal requirements. As discussed in the Overview, the Health Policy Authority became the oversight agency for HealthWave at the start of fiscal year 2007, which coincided with the new federal requirements related to proof of citizenship and identity.

Because MAXIMUS faced major issues as a result of these requirements, the Health Policy Authority waived clauses in the contract allowing fines to be imposed when contract requirements weren't met. In addition, the Authority directed MAXIMUS to shift resources as needed to reduce delays in determining eligibility so that applicants could receive coverage and providers could receive payments for services.

During the audit, we also noted that officials from the Health Policy Authority were aware that MAXIMUS wasn't always meeting the contract standard for attempting to return calls by the end of the next business day—especially on Mondays, when high call volumes require staff to address incoming calls rather than return phone messages left over the weekend. Officials told us that's one of the reasons why the two parties meet in the middle of the week to review call performance, rather than the start of the week.

Health Policy Authority officials also told us that it's difficult to hold MAXIMUS to original contract requirements when the assumptions going into the contract have changed, and the workload significantly increases. It's anticipated that the request for proposal for the new contract to go into effect July 2009 will include significant changes in the contract terms.

We Also Noticed Several Weaknesses Related to How MAXIMUS and The Kansas Health Policy Authority Monitor or Enforce The Contract

As part of this audit, we also looked at what steps MAXIMUS and the Health Policy Authority have taken to ensure that voicemails left with the Call Center are returned in a timely manner. We identified several issues, as follows.

Findings Related to the MAXIMUS Call Center

Information about what happened in response to a particular message is difficult to assemble, especially when the original message was incomplete or inaccurate. MAXIMUS' system of retrieving the messages on paper logs, but capturing what staff do in response to these messages in its computer system, makes it difficult to determine quickly how well messages are returned. This gets particularly difficult when the original message:

- was left by someone other than the person listed as the head of the case file, because that's where the outcome would be recorded
- doesn't include the case number, which would make it easier to look up the outcome in the computer system
- was left by non-clients, because responses to them are logged in the computer system, but can't be easily searched

Essentially, without periodically sampling messages like we did, it's impossible to evaluate how quickly staff attempted to return a call, whether staff connected with the client and answered the questions, or whether even multiple attempts didn't resolve the issue because the client couldn't be reached.

Findings Related to the Health Policy Authority

The Health Policy Authority's contract with MAXIMUS hasn't been updated to clearly spell out expectations related to handling phone messages from clients or potential clients. The current contract the Health Policy Authority has with MAXIMUS began in 2003, when SRS still had responsibility for HealthWave. Although The Health Policy Authority has exercised the option to amend the contract twice, the language hasn't been modified to reflect the expectations in two areas:

- **The contract still requires MAXIMUS to send out a letter when its staff can't reach a caller who has left a message within two working days**. MAXIMUS officials told us they can no longer send out these letters because of restrictions placed on them by the Health Insurance and Portability and Accountability Act. Since staff no longer send letters, callers who aren't contacted by MAXIMUS don't know their voicemail message was received and their issue is being looked at.

- **The contract doesn't address response times for phone messages left during normal business hours**. As discussed earlier, the current contract addresses only phone messages left outside of normal business hours. MAXIMUS officials have implemented a voicemail system to take overflow calls during normal business hours when all the customer service representatives are busy serving other customers.

However, the contract hasn't been modified to address expectations for returning those phone calls.

The weekly reports the Health Policy Authority receives don't contain the information needed to monitor the current contract provisions related to returning customer phone calls. Every Wednesday, Health Policy Authority and MAXIMUS officials meet to discuss contract performance and other issues. We examined the report that is discussed in those meetings to determine what types of information the Authority receives about MAXIMUS' performance in returning customer phone calls. We identified two weaknesses with the information provided:

- **The Health Policy Authority hasn't required MAXIMUS to provide an "aged" list of calls waiting to be returned**. An aged list would show each date that still has calls needing to be returned, and how many calls are left over from those days. The weekly report MAXIMUS provides doesn't give a full picture of how far behind the contractor may be in returning phone calls. Although the report shows the date of the oldest message needing to be returned, it doesn't show the number of messages from that date. Consequently, Health Policy Authority officials wouldn't know from the information contained in the report whether there are 2 calls or 20 calls needing to be returned from any given date.

- **The weekly report the Health Policy Authority gets from MAXIMUS doesn't differentiate between messages left during business hours and messages received after business hours.** MAXIMUS officials repeatedly emphasized that they are only responsible for meeting the contract terms in place for after-hour messages.

Conclusion:

The Call Center apparently experienced a significant increase in call volumes in fiscal year 2007 when changes to federal requirements caused many HealthWave participants to call in about the new requirements. However, since that time, call volumes have returned to a normal level and additional staff have been provided to the Call Center to help handle calls. Nonetheless, 28 percent of the phone messages we reviewed weren't returned according to contract requirements or internal performance goals. While most of those problems weren't severe – many were returned only one day late—about 10% of all messages had more significant problems. This suggests that better efforts must be made on the part of MAXIMUS and the Health Policy Authority to ensure that staff know what is expected, and that appropriate monitoring occurs to ensure that standards are being followed.

Recommendations for Executive Action:

1. To help ensure that its contract with MAXIMUS reflects current expectations for returning phone calls and isn't in conflict with the Health Insurance Portability and Accountability Act (HIPAA), the Health Policy Authority should revise the contract to do the following:

    a. specify its expectations for timeliness and level of effort in returning messages left during the day as well as after hours

    b. establish actions the Call Center will take when callers can't be reached by phone that don't conflict with HIPAA

2. To help ensure that MAXIMUS staff take appropriate steps to address phone messages left with the company's call center, the Health Policy Authority should direct MAXIMUS to do the following:

    a. develop a system that allows MAXIMUS to document that all voice messages left on voice mail machines on any given day are transcribed to daily call logs or other acceptable media

    b. develop additional written policies and procedures that clearly spell out such things as how many attempts Call Center or eligibility staff should make to contact callers, how often those attempts should be made, and what further steps should be taken if staff are unable to contact the caller by phone

    c. train staff on those revised policies and procedures

    d. capture additional information for each call that would allow MAXIMUS management to readily ascertain what actions were taken in response to a voice mail message, when those actions were taken, and what the outcome was.

    e. revise the reports it provides to the Health Policy Authority to show more details on the number of messages that remain to be returned on each date

    f. periodically review a sample of messages and how staff handled them in order to determine whether established policies and contract requirements are being followed

3. To help ensure that MAXIMUS is meeting the Authority's expectations for returning phone messages left with the Call Center, the Authority should do the following:

a. review MAXIMUS' written procedures for handling phone messages to ensure that they are in accordance with contract terms and Health Policy Authority expectations

b. review the periodic reports MAXIMUS submits to assess whether contract terms and expectations are being met. If the Authority needs additional information to make that assessment, it should ensure that MAXIMUS provides that information in future reports.

Question 2: Does It Appear that Problems with Returning Phone Calls Could Be Having a Significant Negative Impact on Program Enrollment?

ANSWER INBRIEF: *Decreases in HealthWave Program enrollments in fiscal year 2007—especially in the Title XIX programs—likely were the result of new federal requirements that took effect at the beginning of that year. For fiscal year 2008, the year from which our sample voicemail messages were drawn, we think it's not likely that unreturned messages for non-HealthWave clients had a significant negative impact on HealthWave enrollments. The number of such messages was very small, many people whose calls weren't returned previously had been determined to be ineligible, and people had numerous other ways in which to get HealthWave information, including phoning the Call Center again, or getting enrollment information from local agencies like hospitals or SRS offices. These and related findings are discussed in more detail in the sections that follow.*

The Fiscal Year 2007 Drop In HealthWave Enrollments Likely Was the Result of New Federal Citizenship and Identity Requirements

As mentioned in Question One, starting in July 2006, the federal government began requiring proof of identity and citizenship for HealthWave Program participants covered under Title XIX. For consistency purposes, the Health Policy Authority initially decided to apply those same requirements to the State Children's Health Insurance program participants.

This new requirement resulted in big increases in the amount of new paperwork MAXIMUS' staff had to handle, and also caused an influx of calls to the Call Center in fiscal year 2007. On average, the Call Center received:

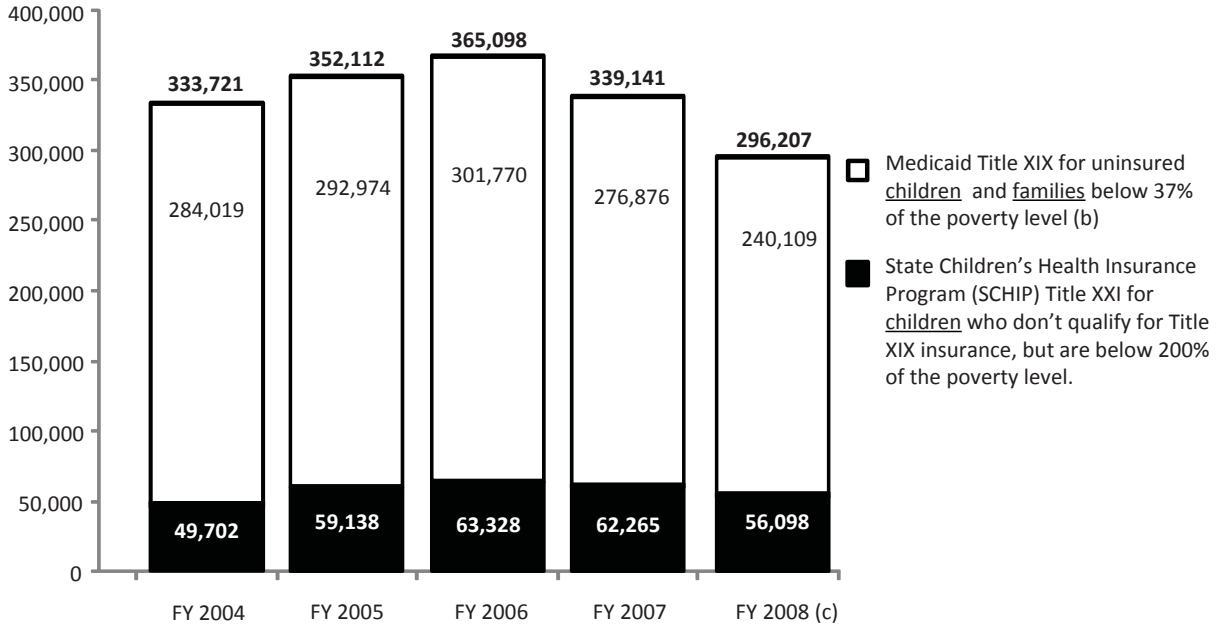
- 10,000 more calls per month than in the previous year
- about 4,000 more voicemails per month than in the previous year

In November 2006, Health Policy Authority officials lifted the self-imposed requirements for citizenship and identity documentation for the State's Children's Health Insurance Program applicants. The memo lifting the requirement cited a concern that the additional requirements resulted in decreased enrollment in this Program.

As discussed in the Overview of this report, total enrollment in Title XIX and Title XXI programs included under the HealthWave umbrella dropped by about 7% between fiscal years 2006 and 2007, from 365,098 participants to 339,141. Fiscal year 2008 isn't yet complete, so we can't know whether enrollments for that year will be up or down compared to 2007. As mentioned on page 2 of this report we didn't audit the enrollment data.

As ***Figure 2-1 shows***, enrollment in the State Children's Health Insurance Program portion of Healthwave—which didn't have the new federal documentation requirements in effect for the full year—was down only by about 1.7%. On the other hand, enrollment in the Title XIX portions of the HealthWave Program—which did have the documentation requirements in place for the entire year—was down by more than 8%.

Figure 2-1
Number of People Enrolled In HealthWave Title XIX and Title XXI Programs (a)
Fiscal Years 2004 - 2008



Source: LPA summary of unaudited Kansas Medical Assistance Reports from the Kansas Health Policy Authority
(a) The numbers shown above represent an unduplicated count of the people participating in HealthWave in any given year. Unduplicated means that a person who participated for two months early in a year and also participated again later in the year would be counted only once.
(b) Children in this category under one year of age are eligible up to 150% of the poverty level, children ages one to five are eligible up to 133% of the poverty level, and all other children are eligible at 100% of the poverty level.
(c) Fiscal year 2008 includes only the first nine months – July 1 through March 31, 2008.

This suggests the federal documentation requirements had a significant effect on HealthWave Program enrollments. Possible reasons: potential participants may not have had the necessary documents, had problems obtaining the needed documents from other states where their children were born, or were unwilling to go through the additional work involved.

In addition, Health Policy Authority officials told us that MAXIMUS had accumulated a tremendous backlog of applications because the administrative burden of the new federal documentation requirements overwhelmed the contractor's limited resources. Officials estimated that during that time period, nearly 20,000 people had been disenrolled from the programs as a result of not providing the necessary documentation.

For Fiscal Year 2008, We Think Unreturned Phone Messages Likely Had No Significant Negative Impact On Program Enrollments

As described in Question One, we reviewed a random sample of 100 recorded phone messages left with the HealthWave Call Center between July 1, 2007, and February 29, 2008. In all, 11 of those phone messages weren't returned. We conducted a more detailed review of those 11 calls to determine whether it was likely the callers who weren't called back may have wanted to enroll in HealthWave and were unable to because their calls weren't returned.

As part of our review, we looked at information recorded in the HealthWave computer system as well as in the Kansas Automated Eligibility Child Support Enforcement System (KAECSES) computer system. KAECSES contains information about individuals enrolled in several State/federal assistance programs, such as health insurance, food stamps, and cash assistance. Here's what we found out about the 11 individuals whose messages weren't returned:

- **Six callers already were enrolled in HealthWave**. We found that in all six cases, callers either wanted to add family members, inquire about the status of the paperwork they submitted, or had questions on renewing their membership. While staff didn't call them back, we found their membership requests had been granted. As a result, we determined that not returning these six calls likely didn't affect enrollment levels in the Program.

- **Three callers previously had been determined to be ineligible for HealthWave**. In all three cases, the individuals hadn't provided the necessary documentation for eligibility determination, and called because they had questions about their denials. If these people had subsequently gotten the information together that they needed to prove they were eligible, it's possible that not returning calls to them could have impacted enrollment in the Program.

- **Two callers couldn't be found in either the HealthWave or the KAECSES computer system**. One caller wanted information about transportation services; the caller left a phone number, but didn't leave a name. The other caller requested an application for HealthWave but didn't supply her full phone number and the city she lived in. Although the information about these callers is sketchy, there is a possibility that not calling them back may have either delayed their enrollment or caused them not to enroll in the program.

Many factors about these calls and callers can't be known, making a reliable projection of our sample results impossible. Originally, we had planned to use our sample results to project our findings to the whole population of messages to answer this question, but we encountered several limitations. As described above, our sample included five callers who weren't already members and who weren't called back (three callers who had previously been denied eligibility, and two who weren't in the computer system). For

enrollments to have been negatively affected by not returning phone calls, we would have to assume the following:

- That the three callers who had previously been determined ineligible based on lack of documentation would have turned in the necessary paperwork could show that they were now eligible

- That the caller wanting transportation actually wanted to join HealthWave and would be eligible had he applied

- That the caller requesting an application would have submitted it and would have met all the eligibility requirements

- That none of the five callers called back at a later time and talked to a customer service representative (MAXIMUS officials told us this happens quite often)

- That none of the five callers picked up applications elsewhere (e.g., through county health agencies and libraries) or gotten help through local SRS offices (Authority officials told us SRS area offices process an estimated 15% of all HealthWave applications directly)

If all these assumptions held true for these five callers and our results were projected to the population, the maximum number of people who would not have been enrolled in HealthWave because of unreturned phone calls is about 2,000. This represents only .7% of the total HealthWave Program enrollment. If these assumptions were true for only one caller with an unreturned call, that estimate drops to 633, or only .2% of the Program enrollment.

Because of all the uncertainties involved with these callers, their eligibility status, and the other enrollment avenues open to them, we don't feel we can reliably project our sample results to the entire population. However, we think it's unlikely that unreturned phone calls had a significant negative impact on HealthWave enrollments in fiscal year 2008.

Other factors related to customer service could have some impact in delaying enrollments in HealthWave. Although determining how well MAXIMUS processes applications wasn't part of this audit, we noted two cases in which staff delayed actions on applications.

- In the first case, MAXIMUS received an application April 17, 2007, and didn't evaluate it until three months later. On July 26, staff denied the application based on the fact that the applicant and her child were both adults, something that could have been determined right away. On July 28, the woman left a message to inquire about the denial. On August 8, eligibility staff left a message in response, which was the last entry in the case log.

- In the second case, MAXIMUS received an application on August 1, 2007. The case log indicated that the applicant had called in twice, August 14 and August 27, to check on the status of the application. Both times, the applicant was told the application was being processed and a letter would be sent as soon as a decision was made. On August 29, staff requested current employment income from the applicant. The missing income information was received on September 11, and the caller's application reached final status on September 12. The applicant's child was deemed to be eligible for HealthWave benefits retroactively to August 2007.

While the delay in processing these applications didn't cause the denial of membership, instances such as these could certainly delay the services that are intended to be provided to eligible Kansans, or make people be reluctant to visit a doctor or get medication when they don't know whether the cost is covered.

Conclusion:	Many of the thousands of messages the MAXIMUS Call Center receives annually come from individuals who are—or at some point were—part of the HealthWave Program. In addition, not returning a single call to a possible applicant doesn't necessarily mean the person won't call back, or won't get access to HealthWave through another source. We found only a negligible proportion of problem calls that could deter a person's enrollment in the Program, and concluded unreturned phone messages likely didn't negatively impact enrollment. However, improving the contractor's system for retrieving messages as discussed in Question One, as well as processing applications timely, will further ensure that the HealthWave Program is as accessible as it should be.

APPENDIX A

Scope Statement

This appendix contains the scope statement approved by the Legislative Post Audit Committee for this audit on September 24, 2007. The audit was requested by Representative Doug Gatewood.

HealthWave: Determining Whether the Program's Call Center is Working As It Should

HealthWave is a program designed to provide health insurance to uninsured children in Kansas, which in 1998 were estimated to total about 60,000. It is part of a larger federal/state program.

HealthWave covers children ages 0-19, living in households with income levels at or below 200% of the federal poverty level. Within the first year, HealthWave enrolled 15,500 of those children and teens in Kansas. By 2004 more than 32,000 children were covered under the Program. Also, through HealthWave outreach efforts, an additional 17,000 previously uninsured children were found to be eligible for Kansas Medicaid. The Program maintains a toll-free number for its customer service center.

Recently, legislators have heard concerns from constituents who had called the toll-free number several times, left messages, and never had their calls returned. Those legislators tried calling the center on behalf of their constituents' and experienced the same result. This has caused legislators to question whether there is a significant problem with the calls not being returned, and whether this could be contributing to lower-than-anticipated enrollment in the Program.

A performance audit of this topic would address the following questions.

1. **Is there a problem with the HealthWave Program returning calls placed to its toll-free number, and if so, what's the cause and what's being done to fix it?** To answer this question, we would determine what records are made when someone calls into the toll-free number and is directed to leave a message because no one is available to take the call. We would review those records for several recent months to determine whether those calls were ever returned, and how long it took for them to be returned. If possible from the information recorded in the record, we also would determine how many people made repeated calls to the toll-free number without a returned call. We would compare the number of "problem" calls to the total call volume for the period to assess how big the problem is. We would discuss the causes of any problems with Program officials, and find out whether they have taken any steps to address those problems.

2. **Does it appear that problems with returning phone calls could be having a significant negative impact on program enrollment?** To answer this question, we would identify people who have called the toll-free number and never had their calls

returned. We would contact a sample of those individuals to determine whether they were inquiring about benefits and, if so, whether they would qualify for the program. We would relate the results of that work to the number of people signed up for the program during the period we were looking at to determine what impact that might be having on Program enrollment levels.

Estimated time to complete: 3-4 weeks

APPENDIX B

Agency Responses

On May 14, we provided copies of the draft audit report to the Kansas Health Policy Authority and to MAXIMUS, the contractor that operates the Call Center and handles certain other functions related to the HealthWave Program. Both responses are included in this Appendix. The response from MAXIMUS included 23 pages of attachments which are not included here because of space considerations. Copies of those attachments are available from our office upon request. Based on the responses, we clarified several sections of the report. The changes we made didn't affect our overall findings and conclusions.

The Health Policy Authority's response raised several issues that warrant further discussion. Each of those is addressed below:

1. *In its response (pages 4 and 5), the Health Policy Authority indicates that a disproportionate share of messages from our sample of phone messages (44%) were drawn from the first three months of fiscal year 2008, and states that the results of our sample are not reflective of what was occurring at the <u>end</u> of the sample time period. The Authority questioned the small size of our sample, and also indicated that it had provided feedback regarding the disruptions to the workflow at the call center during the first few months of our sample period, "but those concerns were not reflected in any adjustment nor temporing of the audit's findings and conclusions."*

We randomly selected 100 voicemail messages from the <u>entire</u> population of returnable phone messages left during the eight-month period between July 1, 2007 and February 29, 2008. As shown in Figure 1-4 on page 15 of the report, during that period 10,045 phone messages were left, and 4,336 of those (just over 43%) were in the first three months of the fiscal year. Hence, our sample was proportionate to the number of messages left during those months. Our sample size was based on statistical sampling techniques and was sufficient to allow us to estimate of the number of voicemails with problems within a range of plus or minus 10%. Finally, before sending our draft report to the Health Policy Authority for its review, we added language at the bottom of page 15 and the top of page 16 to explain the issues the Call Center was facing during the early months of fiscal year 2008.

2. *The Authority's response (pages 5 and 6) raises the issue that the audit question doesn't define what constitutes a problem, and that we held MAXIMUS to a higher standard in the audit than the State paid for.*

In making our assessment of the nature and level of problems that may have occurred, we needed to identify standards to measure the contractor's performance. Typically, auditors look for an established standard such as a statutory requirement, a contractual requirement, or a written policy established by the entity being reviewed. When written standards don't exist, it's common and acceptable practice to use whatever the entity has established as its expected level of performance, written or unwritten. Page 11 of our report defines the standards we used to identify problems with handling phone messages, based on our review of the contracts and

our discussions with MAXIMUS officials about their operating practices. Those standards were either in the contract or MAXIMUS officials had established them as a targeted goal. The fact that some standards were self-imposed by the company and not explicitly contained in the contract does not make them less useful for measuring performance.

3. *Finally, on page 8 of its response, the Authority refers to unpublished results as showing that message outcomes were significantly improved in January and February of 2008 following the successful resolution of the enrollment backlog at the beginning of fiscal year 2008.*

Authority officials are referring to information we shared with them during the audit that showed which phone messages were problematic and when those problems occurred. Authority officials noted that fewer problem calls appeared in the months of January and February than in earlier months of our sample period. While it's possible that the number of problems lessened by January and February 2008, our sample wasn't drawn in a way that would allow valid conclusions to be made about that, which is why we didn't report those results in the audit. We would caution against drawing that type of conclusion from the data.

In general, the Kansas Health Policy Authority and MAXIMUS agreed with our recommendations. The Authority acknowledged the potential value of recommendations 2b and 2c, but indicated it wouldn't be implementing them because it viewed them as establishing more restrictive and explicit contractual performance targets. Those recommendations call for the Authority and MAXIMUS to agree on an acceptable level of effort for MAXIMUS' staff to make when returning phone messages, to clearly describe that level of effort in MAXIMUS' standard operating procedures, and to train staff on those procedures. Implementing these recommendations wouldn't necessarily require a change to contract terms, but if a contract change is necessary, the Health Policy Authority will soon be modifying the contract to address other issues.

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KHPA™

KANSAS HEALTH POLICY AUTHORITY

June 2, 2008

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LEGISLATIVE DIVISION OF POST AUDIT

Ms. Barbara J. Hinton
Legislative Post Auditor
Legislative Division of Post Audit
800 Southwest Jackson Street, Suite 1200
Topeka, Kansas 66612

RE: HealthWave Audit: Determining Whether the Program's Call Center is Working As It Should

Dear Ms. Hinton:

Attached you will find our response to the audit including actions that KHPA has taken or is planning on taking regarding the recommendations.

If you have any questions regarding this information, please contact Christiane Swartz at (785) 368-6296. Thank you for the opportunity to respond.

Sincerely,

Andy Allison

Dr. Andrew Allison, Deputy Director
Medicaid Director

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Medicaid and HealthWave:
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Summary

The Kansas Health Policy Authority (KHPA) has received the Legislative Division of Post Audit's (LPA) report regarding its audit of voice mail management at the family medical eligibility clearinghouse (i.e., the "Clearinghouse"), and appreciates the opportunity to respond to the report. KHPA is pleased with the information generated by the audit, which indicates that KHPA, along with its contractor, MAXIMUS, made wise and effective decisions in response to the overwhelming demands placed on the Clearinghouse by the implementation of the citizenship and identity documentation (i.e., "CitDoc") provisions of the Deficit Reduction Act (DRA) of 2005. These program decisions were aimed at prioritizing client services by focusing on the overriding goal of enrolling eligible children and families as quickly as possible to ensure timely access to needed care.

According to Appendix A of the report, the audit was requested after legislators received calls from concerned constituents that messages they had left at the Clearinghouse's voice mail system were not being returned. The legislators left similar voice mails but had no record of receiving a returned call from the Clearinghouse. KHPA agrees that based on this anecdotal information, an audit was warranted. We are pleased to find that the audit revealed no systemic problems warranting significant and immediate action, but instead found that:

- the vast majority of voice mail messages were returned – often more than once;
- the percentage of successfully returned calls rose to nearly 100% (compared to various standards) in the months after KHPA addressed the widely publicized work backlog caused by the federal CitDoc requirements; and
- unreturned calls by the Clearinghouse had no measureable impact on the timing and number of enrollees entering the HealthWave program.

KHPA recognizes the value of auditing individual processes, which can be an extremely important tool in evaluating the integrity and success of that process and identifying areas of needed or potential improvement. This is especially true in the financial arena, where process level controls are so crucial. Narrow process audits, however, need to be viewed in a broader context in order to avoid a pre-occupation with a narrow set of outcomes when drawing conclusions and making recommendations. While KHPA agrees to a large extent with many of LPA's findings we believe the audit would have benefited from an examination of the broader purpose of the Clearinghouse operation. Indeed, the audit did not describe the Clearinghouse's

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State Self
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overall operation and overriding purpose. This omission makes it difficult for policymakers to understand the relationship between the evidence obtained in the audit and the conclusions drawn from that evidence, in particular the conclusion that additional contract and agency resources should be (and should have been) dedicated to the management of voice messages.

Background

The LPA report on voice mails left at the Clearinghouse included a brief history of the Clearinghouse, the HealthWave brand, and the interaction of different funding streams (Title XIX and Title XXI) and delivery systems (managed care). Some elaboration would be helpful.

The Clearinghouse

The Clearinghouse was established in September 1998 in order to begin determining eligibility for Title XIX (Medicaid) and Title XXI (SCHIP) children's health programs and providing Title XXI managed care enrollment. Over the years, some of the ancillary functions performed at the Clearinghouse have changed (e.g., all managed care enrollment is now done by KHPA's largest sub-contractor Electronic Data Systems (EDS) in its operation of the Medicaid program's payment management system). Nevertheless, the primary functions of the Clearinghouse have remained the same: to determine eligibility for family medical programs and to provide customer service to people enrolled in those programs.

In order to support these primary functions, a number of supporting processes have been developed. File storage and imaging is part of those support functions, along with receiving and answering telephone calls, returning messages, making changes to beneficiaries' enrollment status in medical programs, conducting fair hearings, providing general information to the public, printing and distributing applications, providing internal mail receipt and distribution services and many others. The state has chosen to outsource these functions through the competitive bidding process. The RFPs that have been released in the past (there have been two) have included requirements related to all of these functions. MAXIMUS has been the winning bidder on both of the Clearinghouse RFPs released, and will continue to provide these services during the third recontracting phase, which begins with the release of an RFP in the next few months and culminates with the implementation of a new contract on June 30, 2009.

In its report, LPA mistakenly identifies an entity they refer to as the MAXIMUS "Call Center," their capitalization indicating an independently operated stand-alone entity. It is important to note that the customer service representatives at the Clearinghouse are part of a larger, integrated eligibility process. As with most going concerns, processes within the organization are often modified or permanently changed as demands require. Employees and other resources (e.g., managers' time and priorities) are often shifted internally to meet the most pressing needs as determined by the agency. This is generally considered good management as it results in a fluid, agile organization that is able to adapt to unforeseen changes within the resources allocated. Indeed, history has proven the necessity of this type of agility with regard to the Clearinghouse when frequently changing rules, regulations, laws, and marketplace dynamics have occurred in the midst of a long-term contract. KHPA has worked in close partnership with its contractor to make necessary changes in order to maximize the efficiency of the Clearinghouse and reduce

pressure on parts of the organization experiencing increased stress, while still providing the best customer service possible and making the most of the resources committed to the organization.

The Backlog

As described in the LPA report and many other documents prepared by KHPA in the past two years, implementing the "CitDoc" provisions created a tremendous hardship for beneficiaries and their families, and placed significant unanticipated administrative burdens on all parts of the Clearinghouse. KHPA and MAXIMUS were given very little time to implement the provisions and, due to the timing of federal regulations implementing the provisions, KHPA was unable to identify and secure additional resources before the end of the preceding legislative session. Consistent with the new federal law, KHPA implemented CitDoc July 1, 2006. The LPA report accurately notes that KHPA initially applied the requirements to Title XXI children as well, even though the federal law did not require it. Enrollment relationships between the two programs have always been strong. A single application form serves for both programs. All applications are screened for Medicaid eligibility first. Most children enrolled in SCHIP have already been in Medicaid at some point in the past. One quarter of SCHIP families also have a child in Medicaid. Early in July 2006, it seemed that in the long run, it would be easier to gather the information for everyone in the household rather than just for the Medicaid children.

Nevertheless, the administrative burden of the CitDoc requirements was worse than feared, and too great to sustain for those children enrolling in SCHIP. In November 2006, the Clearinghouse had accumulated a tremendous backlog of applications and nearly 20,000 people had been disenrolled from the programs as a result of applicants and recipients having to provide the additional documentation. It turned out that people were not prepared to have to provide original copies of their birth certificates and identification. Identification is especially hard for children who typically do not have a picture ID. Many adults living in poverty do not keep or have never obtained birth certificates for themselves or their children, making it difficult to prove citizenship. Many applicants and recipients were born out of state, so obtaining this documentation usually requires access to the Internet or telephone services. Most states charge for official copies of birth certificates. Kansas charges $13 per document. A family of five, then, living at a fraction of poverty, would have to pay $65 to obtain these birth records, and that is if they were all born in Kansas. Some states charge as much as $30 per document. Apparently, little thought was given to this barrier when the law was passed or when the regulations were promulgated. CMS staff subsequently acknowledged that they thought most people obtained and kept these documents.

Almost every application and renewal form came into the Clearinghouse without this documentation and; therefore, KHPA had to request the information from the applicants. According to federal requirements, if people called and indicated they were making a good faith effort to obtain the information, their applications had to remain in pending status indefinitely. This required eligibility staff to pend almost every application and renewal form and to periodically check to verify that the family was still making a good faith effort to obtain and provide the information. The result was an increase in the number of calls coming into and going out of the Clearinghouse (an increase from approximately 25,000 incoming calls per month to 44,000 calls in September 2006), and the duration of each call nearly tripled. Application

processing in the first few months nearly ground to a standstill while the first of these applications remained in pending status. Enrollment wait times increased rapidly from a matter or weeks to months.

By September 2006, KHPA and MAXIMUS were looking at any way possible to try to keep up with the volume of work coming in, let alone to deal with the mounting backlog. One of KHPA's responses was to remove the CitDoc requirements from the Title XXI kids. Processes had to be adjusted to accommodate this change which took effect in November 2006. As was shared with the legislature during testimony this year, contract resources dedicated to marketing purposes were diverted in October 2006 in order to allow MAXIMUS to hire some additional staff. Other efficiencies were implemented and human capital was re-purposed as necessary. In May 2007, the legislature approved additional funding for the Clearinghouse operations. Additional staff was added at the beginning of fiscal year 2008, which began on July 1, 2007. The backlog of pending enrollment cases peaked in February 2007 and gradually fell until it was resolved in January2008.

During this crisis, everyone involved with the Clearinghouse went to extraordinary efforts to minimize the impact of CitDoc on enrolling beneficiaries. MAXIMUS and KHPA eligibility staff worked many hours of overtime per week for many months. Central office staff went to the Clearinghouse after work and on weekends to provide support. Temp staff retrieved and logged voice mails. Everyone from the mailroom staff to the executive staff contributed in some significant way to helping to sustain business continuity and provide customer service. As the LPA audit suggests, customer service was not ideal during these days. Many people had to wait long periods to be informed of their eligibility. In-bound phone lines were clogged with calls. Local SRS offices were receiving additional contacts from consumers. E-mails skyrocketed. FAX machines would run all weekend (MAXIMUS staff came in every few hours on the weekend to add paper).

After the additional staff was hired at the Clearinghouse, the number of calls and their duration returned to a more normal level almost immediately, although the nature of the calls remains more complex than prior to CitDoc implementation. By January 2008, the backlog of pending applications was retired. The Clearinghouse still struggles with helping people to obtain the necessary documentation, but applications are being processed on a timely basis, and are largely being adjudicated within the timeliness guidelines required by CMS. KHPA is proud of these efforts and the accompmlishments of state and contractor staff during this extended time of crisis. Although customer service was less than ideal during this time, as LPA's empirical findings illustrate, KHPA did everything in its power to accomplish the pre-eminent public policy goal of timely enrollment in Medicaid and SCHIP.

The Timing of the Audit

The sample of messages the LPA pulled began in July 2007, the same month that additional resources were added to the Clearinghouse to begin eliminating the backlog (see Figure 1). In fact, 23% of the messages sampled occurred in August 2007 alone, 37% within the first two months after the additional resources were added, and 44% within the first three months. This would suggest that the months immediately following the addition of resources are

disproportionately represented in LPA's small sample of 100 voice messages. The statistical variation reflected in LPA's findings as a result of this small sample – a rate of unreturned calls of between 0.02% and 4.75% for the entire sample period – does not in itself account for the potential that the audit period overlay by at least half the tail end of an historically large period of increased demand and disruptive workflow in Clearinghouse services that is not comparable to the present timeframe. This fact does not undermine the audit's results, but significantly limits their applicability to the present management of Clearinghouse activities. KHPA provided this feedback to LPA in informal responses prior to finalization of the audit, but these concerns were not reflected in any adjustment nor temporing of the audits findings and conclusions.

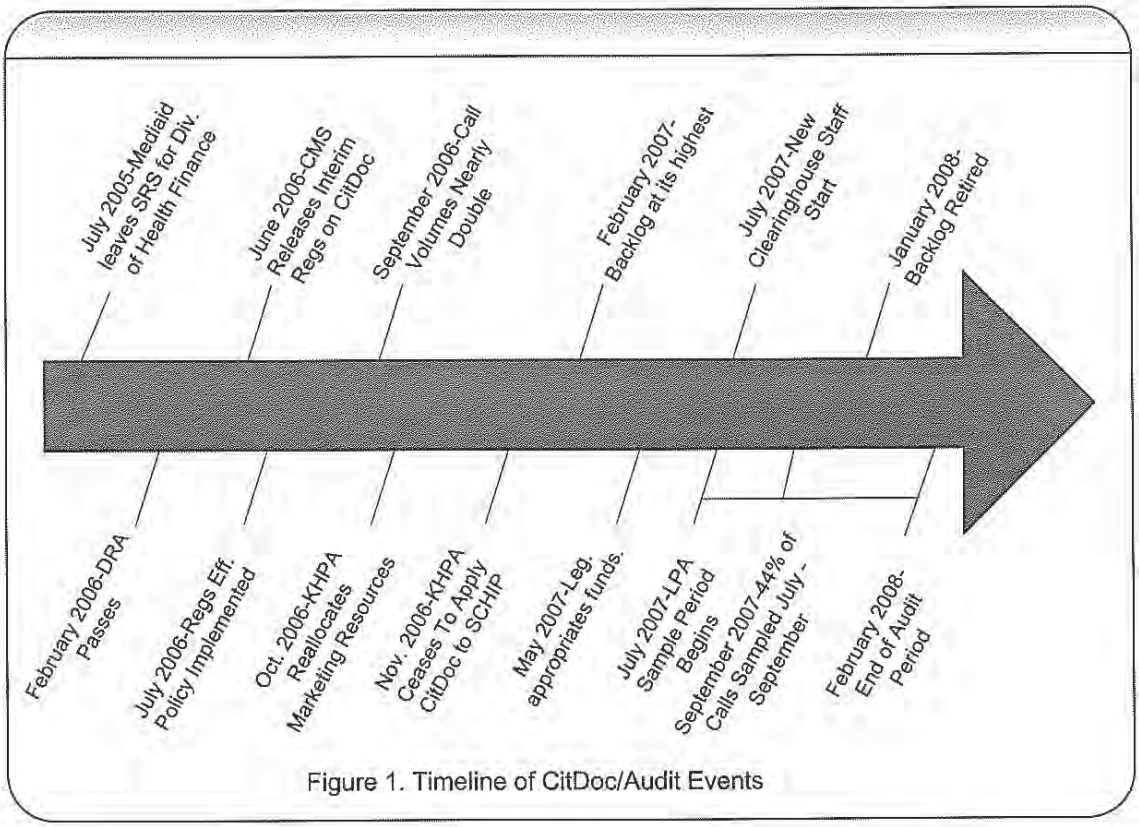


Figure 1. Timeline of CitDoc/Audit Events

KHPA Comments on LPA Conclusions and Recommendations

Question 1: Is there a problem with the HealthWave Program returning calls placed to its toll-free number, and if so, what's the cause and what's being done to fix it?

Some legislators were concerned that their may be a problem with the Clearinghouse not returning voice mails left at the Clearinghouse. The audit question does not presume to define what might constitute a "problem." The LPA report also does not attempt to explicitly define what might constitute a "problem" level of message return service at the Clearinghouse, instead relying variously on contract and self-imposed internal requirements. Instead, its in analysis and in its findings and conclusions, LPA relies on an implicit definition of problem as consisting of

any deviation from either contractual standards *or* internal performance targets that go above and beyond contractual obligations. In effect, LPA holds the contractor to a higher standard than the state paid for. As importantly, KHPA found it necessary to redirect resources to handle the CitDoc backlog, and explicitly waived some performance standards during the backlog crisis in order to focus on the agency's priority goal of reducing enrollment wait times. At the height of the backlog, KHPA made a decision that some calls would not be returned because it would detract from time spent processing eligibility. This decision reflects KHPA's judgement that providing timely eligibility to people who need health care coverage must take precedence over returning their calls when doing both is not possible. During July through September 2007, there was still a significant backlog of pending applications and reviews in addition to the applications and reviews coming in every day. Resources were still shifted within the Clearinghouse to handle significant volumes of work and to accomplish the seemingly impossible task of processing thousands of backlogged applications and reviews.

LPA notes the redirection of resources in their report, but does not acknowledge it in establishing an operating definition of a "problem" for the purpose of addressing question one. As a result, while their conclusion to question one seems to imply the presence of a problem in Clearinghouse performance, it does not clarify that the "problem" was a matter of resources intentionally diverted to a more important component of Clearinghouse operations.

The data show that for 98% of the voicemails recorded, MAXIMUS documented an attempt to return the calls (see Figure 2). In fact the vast majority of voice mails were returned within one business day, which is the requirement in the contract. The rest were returned within a few more business days. Five of the six anecdotes listed on page 11 and 12 depicting "problem" voice mails were all pulled from within 90 days of adding the additional Clearinghouse staff, a period already established as potentially having significantly elevated problems. It is worth noting that even with the oversampling of this period, a significant problem did not emerge.

Type	Number	Percent of Sample
Messages returned within one business day	79	79%
Message returned within two business days	13	13%
Messages returned within four business days	4	4%
Messages returned within seven business days	1	1%
Messages returned within nine business days	1	1%
Total messages returned	**98**	**98%**
Messages not returned	2	2%

Figure 1. LPA sample for Question 1.

Ninety-two percent of the messages sampled were returned within two business days. The audit notes that in some cases—nine messages of the 100 sampled—MAXIMUS staff did not attempt to return the call three times. MAXIMUS customer service staff may have only documented one or two attempts to return the call. The contract does not specify how many times MAXIMUS

must attempt to return a call, which implies that one attempt is enough. MAXIMUS, nonetheless, set this internal standard for itself. When production levels permit, MAXIMUS strives to make three attempts, even though they are not required to by the contract. LPA's strongest conclusions in response to Question Number 1 involve primarily the 9 out of 100 voice messages that were not returned a second and third time when unsuccessful. Clearly, the strength of the LPA audit hinges on the question of whether the periodic failure to meet internal performance standards that exceed contractual requirements is a problem that requires fixing.

The LPA audit also draws attention to voice mails left during the day. There are contractual requirements for voice mails left during the day because it was KHPA's intent to have every call answered by a real person, even if having to be on hold for a little while. However, when call volumes are half-again-as-much as what the vendor had projected based on data the state provided and there were no additional financial resources available to meet the requirement, MAXIMUS improvised by providing voice mail service during the day so that people were not on hold inordinate amounts of time and phone lines could be freed up. This is an example of adapting and adjusting to provide the highest level of customer service possible within the available resources, which in this case have not necessarily been adequate at all times during the day to answer every call.

Response to Recommendations to Question 1

LPA makes three recommendations to KHPA in its oversight of the Clearinghouse. First, they recommend that KHPA clarify contractual obligations with regard to phone calls that cannot be returned either because of restrictions due to the Health Insurance Portability and Accountability Act (HIPAA), or because return attempts were unsuccessful (1a, 1b, and 3a). KHPA notes the ambiguity present in the existing contract with regard to un-returnable calls, and concurs in the recommendation to clarify these requirements with MAXIMUS. KHPA will amend its current contract and will also include these requirements in the next contract to be put in place in July 2009. Recommendation 2e calls on KHPA to require MAXIMUS to enhance the weekly reports it provides in order to better assess and more closely manage the voice message response process. The suggested reports are a good idea and KHPA appreciates the suggestion. These reports have now been developed and a sample report is included in MAXIMUS' response. We are also in agreement with recommendations 2a, 2d, and 2f. MAXIMUS and KHPA began collaborating on a voice mail tracking mechanism some months ago and implemented the new tracking system the end of May 2008. KHPA will be monitoring its effectiveness and sampling individual voice messages beginning in the month of June.

The remainder of LPA's second recommendation calls for KHPA to introduce more restrictive and explicit contractual performance targets for the management of voice messages (2b, 2c). To meet this recommendation would require re-opening contract terms with our existing contractor, and would ultimately require that additional resources be devoted to the voice mail operation within the Clearinghouse. KHPA acknowledges the potential value of each of these recommendations in improving the voice message return process. Nevertheless, KHPA is committed first and foremost to the efficient and timely processing of applications for enrollment in Medicaid and SCHIP. Given that the audit's findings demonstrate that any problems with unreturned voice messages were largely resolved by January and February 2008, KHPA does not

plan to implement these recommendations at this time. KHPA will solicit feedback from the Health Policy Oversight Committee, the KHPA Board, and other stakeholders for guidance in the forthcoming re-contracting process. Together with these policymakers, KHPA will continue to strike an appropriate balance between the needs of our consumers seeking services from the Clearinghouse, and the scarce public resources that are put towards those services.

The final recommendation (3b) is for KHPA to regularly review the reports that it receives from its contractor and to assess whether contract terms and expectations are being met. By longstanding practice, KHPA staff meet at least weekly with the contractor to review a variety of Clearinghouse reports and to provide ongoing direction to the contractor in the management of its operations, including the voice message return function. KHPA will continue this practice.

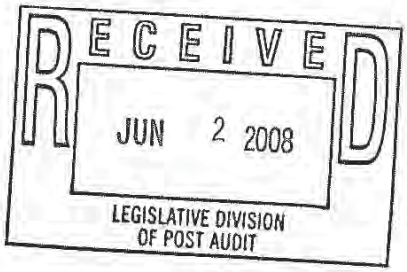
Question 2: Does it appear that problems with returning phone calls could be having a significant negative impact on program enrollment?

KHPA welcomes LPA's conclusion that they "found only a negligible proportion of problem calls that could deter a person's enrollment." Together with the low rate of problems identified in the LPA audit results for Question 1, this is confirmation of KHPA's successful management, and MAXIMUS' successful execution, of their overriding programmatic and contractual priorities during the resolution phase of its experience with the new federal CitDoc requirements. In implementing the CitDoc requirements, KHPA sought to minimize the impact on beneficiary access to care by processing applications as quickly as possible. Unfortunately, the lack of resources and federal planning during the initial implementation of CitDoc requirements led to a large backlog and long delays in enrollments. KHPA both redirected resources and sought new resources during calendar year 2007 to address these delays. The nature of the CitDoc administrative crisis and the demands of its resolution put stress and strain on secondary Clearinghouse processes, including the voice message response functions. In their audit of the Clearinghouse, LPA appropriately documents some of the impacts of KHPA's prioritization, but also finds (in unpublished results) that voice message outcomes were significantly improved in January and February 2008, following the successful resolution of the enrollment backlog at the beginning of 2008. We point out the often emotional and consistently demanding burden placed on both state and contract staff at the Clearinghouse during 2006 and 2007, and applaud their efforts in achieving the results acknowledged by LPA in this audit.

MAXIMUS
HELPING GOVERNMENT SERVE THE PEOPLE

June 2, 2008

MAX: 08-0027



Barbara J. Hinton
Legislative Post Auditor
Legislative Division of Post Audit
800 Southwest Jackson Street, Suite 1200
Topeka, KS 66612-2212

RE: Performance Audit HealthWave: Determining Whether the Program's Call Center is Working As It Should

Dear Ms. Hinton:

MAXIMUS appreciates the thorough review of our Project's Call Center. Attached you will find our response to this audit including actions MAXIMUS has taken and plans to take regarding your recommendations.

If you have any questions or concerns regarding this information, please contact me at 785-431-7020.

Sincerely,

Carla H. Deckert
Project Manager

c: Michael Lemberg
Chris Swartz
Teresa Graber

LEGISLATIVE DIVISION OF POST AUDIT
HEALTHWAVE:
DETERMINING WHETHER THE PROGRAM'S CALL CENTER IS WORKING AS IT SHOULD

MAXIMUS PROJECT MANAGER:
CARLA H. DECKERT

LEGISLATIVE POST AUDITOR:
BARBARA J. HINTON

JUNE 2, 2008

A. THE LEGISLATIVE POST AUDIT SUMMARY

B. GENERAL OPINION

MAXIMUS appreciates the thoroughness and comprehensive nature of this audit. We take very seriously any evaluation of our performance and look forward to using the auditor's recommendations to further improve our processes.

As the auditor's were fully aware, MAXIMUS is co-located with the Kansas Health Policy Authority (KHPA) the Kansas HealthWave Clearinghouse. Our office is address is 545 S. Kansas Avenue in the Bank IV Tower. Work tasks at this location include applications and reviews received, imaged, registered and processed: case maintenance actions for ongoing cases received and processed: calls received by the toll free phone lines; walk-in customers; and voice mails received and returned.

MAXIMUS strives to work in close partnership with KHPA in all facets of the contract. Because of our close proximity, KHPA's monitoring of the contract is continual and ever present. Rather than depend only on reports for oversight, KHPA staff are located just a few feet away from MAXIMUS staff members. This unfettered access is important to understand as the Committee reviews this Report.

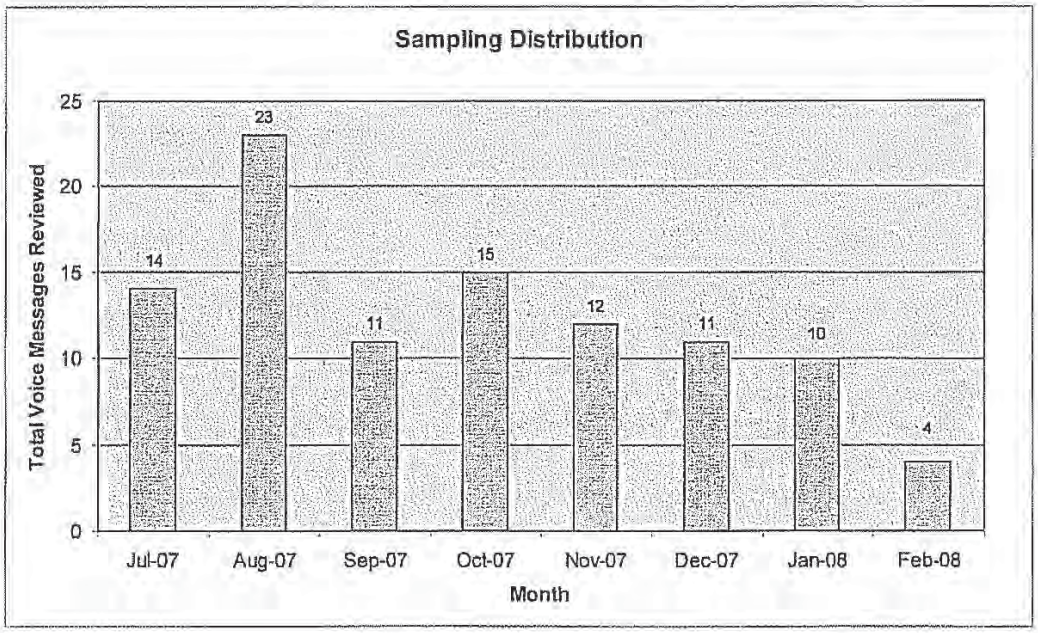
The Customer Service Center's hours of operations are 7:00 a.m. until 6:00 p.m. There is also a voice message system available after hours. According to the contract, voice messages left after working hours should be responded to within one working day. If additional research is needed, the answer should be provided within five working days at least 95% of the time. In addition to these contractual requirements, we have set additional customer service internal goals that exceed the contractual standards. While MAXIMUS makes every effort to meet these internal goals each month, they serve as stretch goals to improve customer service performance and cannot always be achieved when call volume spike.

Our current voice mail process is a typical two step process. First, voice messages are played and listened to by one of our Customer Service Representatives (CSRs); second they are responded to by taking whatever action was required by the caller. In most cases this means to call back the caller at the number provided. Specific staff are assigned to each step of this process. In order to provide the best customer service possible, MAXIMUS staff listen to the voice message, record information that the caller left, and attempt to locate the case (if appropriate) before the call is returned. Therefore, when the return call is made, the CSR has the information available to provide to the caller. Sometimes, after they have spoken with the caller, the call center will transfer the voice message information to eligibility either via an e-mail or a voice mail asking them to do further research and respond to the caller.

As we indicated in our testimony to the Joint Committee on Children's Issues in November 2006 and again in October 2007, the federal requirement to establish citizenship and verify identity for all of Medicaid recipients had a negative impact on nearly every operational area at the Clearinghouse. A year following the implementation of C/I, additional staff was added to the Clearinghouse to help clear up the C/I backlog and help with the ongoing work

loads. While the additional staff were a much needed resource, the impact and backlogs created by the unfunded C/I implementation took several months to resolve which directly impacted the call center and the voice mail process. As you can see by the sampling distribution, almost 50% of the voice mails sampled were taken during the months when the backlogs and call volumes were still extremely high.

The sampling distribution for this audit is reported below.



The applications, reviews, case maintenance requests, phone calls and voice messages received since 2003 are reported below.

See Attachment 3: Requests Received from Consumers FY 2007 - Current.

C. FINDINGS

C.1 FINDING 1:

We found 28 messages that weren't handled according to these criteria:

- Messages should be returned by the end of the next working day.
- Three attempts should be made to contact the caller before considering follow-up on the call to be completed.

C.1.1 Maximus Response:

MAXIMUS thanks the State of Kansas for reviewing our Customer Service Policies and Procedures.

Following the implementation of the citizenship and identity verification standards, the Clearinghouse Customer Service Center was overwhelmed with calls. When it became obvious that we would not be able to answer calls timely, MAXIMUS working with KHPA, opened the voice message system to receive calls 24 hours a day seven days a week. Customers who left voice messages could declare that their issue was a priority which shifted their message to the "front of the line." In doing this, the Clearinghouse was able to help children and families who were experiencing a medical need or who had doctor appointments and needed their benefits determined prior to keeping their appointment. This effort increased the number of voice messages at the same time the number of incoming calls were increasing and Customer Service Staff was not able to return all voice messages within one working day.

MAXIMUS strives to provide outstanding customer service and creates internal standards to help accomplish this goal. Making three attempts to return a call left after hours on the voice mail system is one of the MAXIMUS internal standards. We are committed to meeting this goal as often as the call volume allows.

C.2 FINDING 2:

MAXIMUS officials haven't clearly documented all of the requirements their customer service representatives should meet.

- No written policy exists governing deadlines for returning phone messages left during "normal working hours."
- No written policy exists spelling out the level of effort that needs to be made to return a call.
- MAXIMUS lacks clear guidance on how its staff should handle voicemail messages forwarded to staff who determine whether clients are eligible for services.

C.2.1 Maximus Response:

We appreciate the State's review of our materials. MAXIMUS believes our current document meets the requirements of the existing contract. We will coordinate with KHPA to further clarify the voice mail policies.

The Customer Service Policy and Procedures Document, Version 2 (State approved 11/29/2006) indicates the specific work tasks to be performed by the Customer Service Representatives based on the work requests provided in the Contract. These include answering voice mails and transferring calls to eligibility. (Sections A, B, B.1., B.8., B.9., B.1.)

See Attachment 1: Policies and Procedures – Customer Service.

The Quality Assurance Desk Guide for Customer Service also addresses the specific contractual requirement for the Call Center. Section A bullet number 3 states "Respond within one (1) working day from the date of receipt for a voicemail or e-mail received after hours. If further research is needed follow up within five (5) working days…"

See Attachment 2: Customer Service QA Desk Guide

D. RECOMMENDATION MADE IN THE PERFORMANCE AUDIT REPORT FOR MAXIMUS OFFICIALS:

D.1 RECOMMENDATION:

Develop a system that allows them to document that all voice messages left on the voice mail machines on any given day are transcribed to daily call logs or other acceptable media.

D.1.1 Maximus Response:

MAXIMUS has developed and is currently testing an electronic voice message data tracking system available on a shared network for use by the Call Center Staff. This data system is available for review by KHPA and the MAXIMUS Management and Quality team. The Call Center leadership team is responsible for reviewing this on a daily basis as well as performing quality checks. The Quality team will perform 25 random checks of this system each month. The Call Center management will also perform 25 supervisor reviews each month. Results of these quality findings will be included in the Kansas HealthWave Monthly Status Report.

See Attachment 5: Electronic Voice Mail Data Tracking Log.

D.2 RECOMMENDATION:

Develop additional written policies and procedures that clearly spell out such things as how many attempts Call Center or eligibility staff should make to contact callers, how often those attempts should be made, and what further steps should be taken if staff are unable to contact the caller by phone.

D.2.1 Maximus Response:

MAXIMUS will work with the Kansas Health Policy Authority to review our written policies and procedures and update materials based on their direction.

D.3 RECOMMENDATION:

Train staff on those revised policies and procedures.

D.3.1 Maximus Response:

MAXIMUS will work with the Kansas Health Policy Authority to review our written policies and procedures and update materials based on their direction. We will train staff based on any revisions to those policies and procedures.

D.4 RECOMMENDATION:

Capture additional information for each call that would allow management to readily ascertain what actions were taken in response to a voice mail message, when those actions were taken, and what the outcome was.

D.4.1 Maximus Response:

MAXIMUS has developed an electronic voice message data tracking system available on a shared network to use by the Call Center Staff. This data system is available for review by KHPA, the MAXIMUS Management and the Quality team.

Tracking of the after hours voice messages utilizing our new system along with our enhanced quality review of the process will provide a more comprehensive assessment of the voice mail standard. MAXIMUS has created new voice mail boxes to be used during working hours that are different than the voice mail boxes used after hours to improve tracking of the message. The system will stop the evening and weekend voice mails at 6:59 a.m. and not accept voice mails into the evening and weekend voice mail boxes until 6:00 p.m. At 7:00 a.m. when the Customer Service Center goes live, the day time voice mail boxes will be available.

D.5 RECOMMENDATION:

Revise the reports it provides to the Health Policy Authority to show more details on the number of messages that remain to be returned on each date.

D.5.1 Maximus Response:

MAXIMUS has developed an electronic voice message data tracking system available on a shared network for use by the Call Center Staff. This data system is available for review by KHPA and the MAXIMUS Management and Quality team. This system breaks out each day of the month and each type of voice mail box for ease of oversight.

Following the implementation of citizenship and identity verification, a daily snapshot report was developed and reviewed at daily meetings between MAXIMUS and KHPA to track progress or discuss risks. Since the KHPA monitors sit a few feet away from MAXIMUS staff, monitoring and oversight is a daily occurrence. These meetings currently take place a minimum of once a week or more frequently if required. As a routine of the Kansas HealthWave project oversight, the Clearinghouse management made up of KHPA and MAXIMUS officials meet each Wednesday to address any issues or concerns. This provides an opportunity to review the voice mails left over the weekend and make sure they have been returned timely. Mondays and

Tuesdays are generally high call volume days and a Wednesday meeting provides a good measurement of the status each week.

See Attachment 4: Daily/Weekly Summary to KHPA.

D.6 RECOMMENDATION:

Periodically review a sample of messages and how staff handle them in order to determine whether established policies and contract requirements are being followed.

D.6.1 Maximus Response:

The Call Center Quality Assurance Desk Guide was revised in April 2008 including adding quality checks of handling the voice mails.

The Quality team will perform 25 random checks of electronic voice mail data tracking system each month. The Call Center management will also perform 25 supervisor reviews each month. Results of these quality findings will be included in the Kansas HealthWave Monthly Status Report.

See Attachment 6: Voice Mail QA Form.