THE OVERSIGHT OF KENTUCKY'S MEDICAID MANAGED CARE INITIATIVE

FEBRUARY 1999 - PERFORMANCE AUDIT

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AUDITOR OF PUBLIC ACCOUNTS

The Auditor Of Public Accounts Ensures That Public Resources Are Protected, Accurately Valued, Properly Accounted For, And Effectively Employed To Raise The Quality Of Life Of Kentuckians.

February 24, 1999

To the People of Kentucky
    The Honorable Paul E. Patton, Governor
    Senator Gerald Neal, Chair, Medicaid Managed Care Oversight Advisory Committee
    John Morse, Secretary, Cabinet for Health Services
    Dennis Boyd, Commissioner, Department for Medicaid Services

Re: Performance Audit of the Oversight of Kentucky's Medicaid Managed Care Initiative

Ladies and Gentlemen:

We present our report on the Oversight of Kentucky's Medicaid Managed Care Initiative. We are distributing this report in accordance with the mandates of Kentucky Revised Statute 43.090. In addition, we are distributing copies to members of the committees of the General Assembly with oversight authority for the Medicaid program, as well as other interested parties.

After an appropriate period, we will contact the respective Medicaid officials to determine whether the report's recommendations are implemented and will advise the Legislative Research Commission regarding the status of that implementation. Once the Department for Medicaid Services has advised us that the recommendations have been implemented, they will be considered closed.

Our Division of Performance Audit evaluates the effectiveness and efficiency of government programs as well as completes risk assessments and benchmarking of those operations. We will be happy to discuss with you at any time this audit or the services offered by our office. If you have any questions, please call James Rose, Director of our Division of Performance Audit, or me.

We appreciate the courtesies and cooperation offered to our staff during the audit.

Respectfully submitted,

Edward B. Hatchett, Jr.

Enclosure

cc: Dr. Richard Heine, Medicaid Managed Care Program Director

Executive Summary

Kentucky's Medicaid budget has nearly tripled in this decade, from less than $1 billion in 1990 to an estimated $2.9 billion today. In fact, Medicaid expenditures account for almost one-fifth of the state's budget. To limit Medicaid expenditures, states, like private employers, are implementing managed care initiatives. By 1997, only two states were not pursuing some type of managed care program. More than 15 million Medicaid recipients across the U.S., or nearly 48% of the total, are enrolled in a managed care program.

Kentucky's managed care initiative is based on the development of provider partnerships in eight designated regions. The Department for Medicaid Services established several goals for the initiative, including: improving the quality of care and health outcomes for individuals served by Medicaid, emphasizing primary and preventive care, reducing overall Medicaid costs, and improving accessibility and coordination of health care.

Partnerships in Region 3 and Region 5 were formed with few difficulties and began enrolling members in November 1997. Region 3 had some start-up problems, primarily relating to assignment of members to primary care physicians, which have since been resolved. Some ongoing operational problems still exist in both regions, including problems with inaccurate and untimely eligibility data and pharmacy cost overruns.

The other six regions are at various stages of development. Officials in these regions cite high start-up costs and concerns about the accuracy of the historical Medicaid expenditure data as factors contributing to their slow starts. In three regions, competing provider groups had problems agreeing about forming a partnership. While the Department hopes to have all the partnerships enrolling members by July 1, 1999, it seems unlikely that goal will be met.

The Department appears to have established a good system for overseeing the Medicaid managed care program. Its contracts with the partnerships include those provisions necessary for monitoring and overseeing the managed care program and ensuring that program goals are met, although demonstrating improvements in quality of health is a long-term goal. In addition, Department staff appear to be properly overseeing the program. A survey we conducted indicates that recipients were generally more satisfied with the new managed care program, while health care providers were generally more satisfied with the previous fee-for-service program.

We noted that the Department should do a better job of documenting the actions taken in response to the readiness reviews. It also should ensure that partnerships submit encounter data and all required reports in a timely manner. According to the Health Care Financing Administration (HCFA) and our audit work, the Department must do a better job of validating and analyzing the data and reports received from the partnerships. It also must complete several organizational tasks and establish key advisory committees. The Department also should formally document its actual savings from the managed care program.

Consequently, we made recommendations designed to address these areas and to ensure that the partnership program works as intended and that Medicaid recipients' health care is adequately overseen and monitored.

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Abbreviations

Department	Department for Medicaid Services
HCFA	Health Care Financing Administration of the U.S. Department of Health and Human Services

Definitions

HEDIS	Health Plan Employer Data and Information Set is a set of standardized quality performance measures for managed health care plans which are designed to ensure purchasers and consumers have information about performance. HEDIS is sponsored, supported, and maintained by the National Committee on Quality Assurance, which is a not-for-profit organization.
SSI	Refers to those aged, blind, and disabled beneficiaries who are eligible for Medicaid because they receive Supplemental Security Income. These individuals also may receive Medicare benefits.
SOBRA	Refers to beneficiaries eligible for Medicaid under the Sixth Omnibus Budget Reconciliation Act. These generally include children and pregnant women with higher income levels than allowed under AFDC eligibility criteria.
AFDC	Aid to Families With Dependent Children. This is one category of eligible Medicaid recipients. This group includes those beneficiaries who meet the eligibility criteria for Aid to Families with Dependent Children in effect as of July 16, 1996.
Managed Care	A system of providing health care under a fixed budget in which the health care plan exercises some degree of control, or management, over the health care services its members receive.
Fee-for-Service	Fee-for-service is an arrangement whereby providers are reimbursed for the specific health care services they provide. Providers are paid a fee for each service provided.
Capitated Rate	A capitated rate is a pre-established amount that is paid to a health care plan for each member enrolled in the plan. For the Medicaid managed care program, the Department pays the partnership a monthly rate for each member, based on factors such as the member's aid category, age, sex, and service area.
Partnerships	These are legal entities that satisfy certain regulatory requirements and, under contract with the Department, agree to provide, or arrange for the provision of, health services to members, on the basis of prepaid capitation payments.
HMOs	A Health Maintenance Organization is a legal corporation that offers health insurance and medical care, typically at a fixed price.
PSN	A Provider-Sponsored Integrated Health Delivery Network is a health delivery network created by health care providers for the purpose of providing health care services.
KenPAC	The Kentucky Patient Access and Care Program is a mandatory physician case-management program for AFDC and AFDC-related Medicaid beneficiaries operated since 1986 under a 1915(b) Medicaid waiver. The partnership program will replace this program.
Encounter Data	A database of all the health care services provided to each patient. The data is used to analyze, over time, the level of services and diagnosis provided by HMOs or provider partnerships.

Introduction

Kentucky's Medicaid Program and the Shift to Managed Care

Health care costs paid by Kentucky on behalf of low-income citizens have been increasing significantly. Kentucky's Medicaid budget has jumped from less than $1 billion in 1990 to an estimated $2.9 billion in 1999, an increase of more than 190%. Today, Medicaid expenditures account for almost one-fifth of the state's budget.

Figure 1: **Medicaid Expenditures in Billions of Dollars**
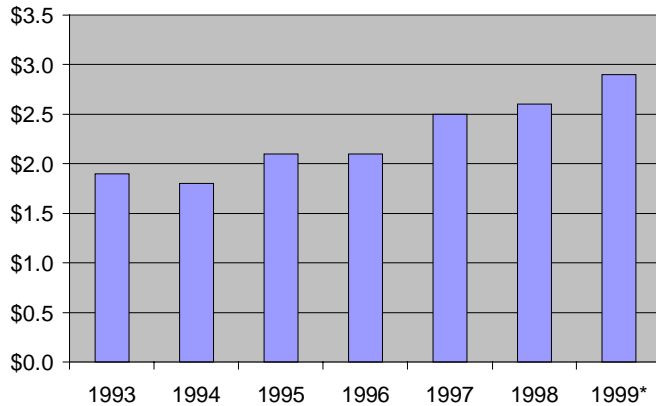
The chart shows that Medicaid expenditures have increased from $1.9 billion in fiscal year 1993 to an estimated $2.9 billion in fiscal year 1999. This is an increase of 53% over the 6-year period, or 8.8% annually on average. *1999 is budgeted expenditures. Source: Department for Medicaid Services

Figure 2: **Governor's Proposed Budget Expenditures for Fiscal Years 1999 and 2000**
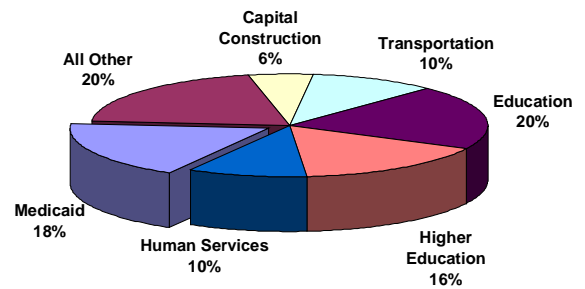
Source: 1998-2000 Executive Budget, Budget in Brief

To try to limit their expenditures for Medicaid, states, like private employers[1], are implementing managed care initiatives. In 1991, 2.7 million Medicaid recipients, about 9.5% of the total nationally, were enrolled in some type of managed care plan. By 1997, every state except Alaska and Wyoming was pursuing some type of Medicaid managed care program. In all, more than 15 million Medicaid recipients, or nearly 48% of the total, were enrolled in a managed care program. A 1997 GAO study reported evidence that managed care programs helped to restrain the increase in Medicaid spending. HCFA also reports that the rate of increase in these costs fell to a 37-year low in 1996.

Managed care programs also are expected to improve the quality of health of people enrolled in them because of their emphasis on preventive care and because one physician is responsible for coordinating all of an individual's health care services. Evidence in this area is mixed: a 1993 General Accounting Office report concluded that, despite an incentive to underserve beneficiaries, Medicaid managed care program services are at least equal to those in traditional fee-for-service plans. A comprehensive 1989 study of the Arizona Health Care Cost Containment System found that the care for children under the Arizona program was better than the care of children under a traditional fee-for-service Medicaid

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[1] According to a 1997 national survey by the consulting group A. Foster Higgins & Co., 85% of employees nationally are in some type of managed care program.

program in New Mexico, although the care in both states was low relative to generally accepted standards. More recently, *U.S. News and World Report* cited a review of 37 academic studies which found that the sick, disabled, and elderly gain a lot from a good HMO, but have more to lose from a bad one. Clearly, moving to managed care may provide benefits, but oversight is critical if quality of care is to be maintained and improved.

Appendix III describes the status of managed care efforts in Arizona, Tennessee, and Oregon. Appendix IV provides information on the trends in Medicaid managed care enrollment. Appendix V provides more detailed information on Medicaid managed care enrollment in the fifty states and the District of Columbia.

Kentucky's Managed Care Efforts

Kentucky provides health care services to eligible low-income residents through the Medicaid program. Medicaid is a jointly funded federal and state government program authorized by Title XIX of the federal Social Security Act. In Kentucky, the Cabinet for Health Services' Department for Medicaid Services administers the program.

Federal law prescribes the basic outline of the Medicaid program, but each state can tailor some aspects of the program to meet its own needs. For instance, within broad guidelines, states have the authority to establish eligibility standards and to determine the type, amount, duration, and scope of services for which they will pay.

If a state wants to deliver health care services to Medicaid recipients in a new and innovative manner, it can request a "waiver" from various federal Medicaid requirements. Two types of waivers are available: program waivers (authorized under Section 1915(b) of the Social Security Act) and research and demonstration waivers (authorized under Section 1115 of the Act).

Kentucky began experimenting with managed care programs in 1986. The KenPAC program waiver (the Kentucky Patient Access and Care Program) used physician gatekeepers to authorize patient referrals to various medical specialists. The program is described more fully in Appendix III.

In the mid-1990s, the Department obtained approval for an expanded and strengthened Medicaid managed care demonstration project: the Kentucky Health Care Partnership Program.[2] In developing this program, the Department divided the state into eight geographic regions. The regions were designed to both

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[2] In 1993, the Department received federal approval for a Section 1115 research and demonstration waiver. This waiver would have allowed the state to build upon its experience with the KenPAC program and create a strengthened managed-care system. It also would have expanded Medicaid eligibility. Before this waiver was implemented, however, the General Assembly took action to prohibit the expansion of Medicaid eligibility to additional groups. The General Assembly did encourage the Department to pursue the managed care components of the waiver and, in 1995, the Department submitted an amended waiver request to the federal government. That amended waiver request, which became Kentucky's current Health Care Partnership Program, was approved in October 1995.

incorporate recognized medical service delivery areas and to include a sufficient number of Medicaid beneficiaries to be actuarially sound. A health care partnership made up of local health care providers would provide health care services to all the Medicaid recipients in its region.

Figure 3: **KENTUCKY MEDICAID HEALTH CARE PARTNERSHIP MANAGED CARE REGIONS**
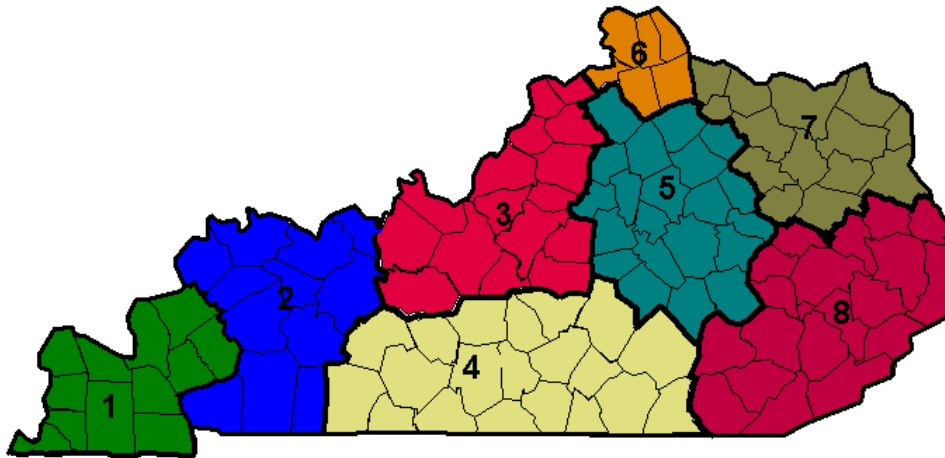
Table 1: **Average Monthly Number of Medicaid Recipients in Managed Care Regions for Fiscal Year 1997**

Region	AFDC, AFDC-Related, Foster Care	SSI with and without Medicare	Total	Estimated Expenditures (Fiscal Year 1995)
1	15,027	8,420	23,447	$69,378,663
2	28,476	13,276	41,752	$92,377,711
3	72,946	32,904	105,850	$258,813,590
4	37,288	28,510	65,798	$158,135,806
5	44,731	26,484	71,215	$166,870,923
6	18,340	7,985	26,325	$62,722,298
7	24,809	14,509	39,318	$76,579,064
8	77,384	48,213	125,597	$319,640,226
Totals	**319,001**	**180,301**	**499,302**	**$1,204,518,281**

Source: Department for Medicaid Services

The Program's long-term goal is to improve the health of medically indigent Kentuckians, while stabilizing costs. Specific program goals include the following:

- To improve the quality of care and health outcomes for individuals served by Medicaid.
- To provide health care through managed care systems consisting of local providers in both the public and private sectors.
- To redirect the emphasis of the Kentucky Medicaid Program to primary care and prevention whenever it is medically appropriate.

- To implement effective and responsive cost management strategies designed to control growth in Medicaid costs.
- To improve the accessibility, availability, and coordination of services.

According to the Partnership Protocol and 907 KAR 1:705, Section 5, 6(b), the eight regional health care partnerships have "to broadly represent the partnership region's health services providers…," including family practice physicians, specialists, local health departments, federally qualified health clinics, pharmacists, dentists, the University of Louisville and University of Kentucky medical centers for regions in which they are located, and the Commission for Children with Special Health Care Needs.

If the state cannot enter into a satisfactory partnership arrangement with providers in any region, the waiver agreement allows the Department to invite competitive bids from HMOs or provider-sponsored integrated health delivery entities to serve that region. 907 KAR 1:705 states that the Department cannot initiate a competitive bid in any partnership region before January 1, 1999, unless an operational partnership is dissolved or is terminated.

The Regional Partnerships Are the Risk-Bearing Entities in This Program

Each Kentucky partnership has the flexibility to design its program to best meet the needs of the Medicaid recipients and health care providers in its region, although there are some specific requirements. For example, each partnership must have a licensed entity (an HMO or integrated service delivery network) and an oversight board representing all the provider groups in the region. The partnerships must also enroll all the Medicaid recipients in their regions. Each enrolled recipient selects, or is assigned, a primary care physician who is responsible for approving all that individual's health care services.

The Department pays each regional partnership a negotiated monthly capitation rate for each enrolled Medicaid recipient, based on the recipient's category of eligibility. (A capitation rate is a pre-set amount paid each month for each member enrolled in the partnership whether or not that member receives any health care services.)

The partnerships then reimburse health care providers for the services they provide to Medicaid recipients. Partnerships may reimburse providers on a capitated basis, fee-for-service basis, or other basis, as negotiated with each provider.

The partnerships bear the financial risk for the health care services they provide to Medicaid recipients. If it costs the partnerships more to provide health care services to their members than they receive in payments from the state, the partnerships are responsible for the difference. In exchange for this risk, the partnerships keep any savings they realize. That is, if their capitation payments are greater than their expenses, they keep the difference.

They also are eligible for incentive payments if their Medicaid members meet certain pre-established health outcomes, most of which are long-term and may

take several years to achieve. Appendix VIII contains a complete listing of the health outcomes used by the program. Examples of these outcomes include the following:

Table 2: **Examples of Health Outcomes Which Result in Partnership Incentive Payments**

Health Outcome	Screening Benchmarks	Outcome Benchmarks	Incentive Payments
Normal glucose	85% of partnership's population symptomatic for diabetes are screened	80% of partnership's population with diabetes are controlled therapeutically	The partnership can receive an incentive payment of .25% of the capitation payment for each outcome achieved, up to a maximum of 1% of the payment.
Reduced incidence of vaccine-preventable disease	Schedule of immunizations	90% of children in partnerships have received correct immunizations by 35 months	
Live, healthy birth	Birth weight	95% of partnership's births will be greater than 2,500 grams	

Cost Savings Should Result From Improvements in How Services Are Delivered

The Department has estimated that the managed care program will save the state $117 million a year when fully operational. The savings will come in two ways; an initial savings will occur as the Department negotiates capitation payments that are lower than if the managed care program had not been implemented. These savings are possible because the primary care physician will coordinate all health care services. Through this "gatekeeping" function, the primary care physician should be able to ensure that the member does not receive duplicate or nonessential health care. In the long run, the emphasis on preventive care also should improve members' health, reducing the level of services that they require.

Savings will also come from limiting the rate of increase in expenditures to a level that approximates the increase in state spending. The federal HCFA, which oversees the waiver, will allow program expenditures to increase by an average of 6.2% annually over the 5-year life of the waiver. (One of the requirements of the waiver is that its expenditures do not exceed what the state would have spent under the traditional Medicaid program. The 6.2% average annual increase maintains the program's budget neutrality.) Department officials told us they plan to target increases to mirror increases experienced in the general fund.

The capitation rate is set through separate negotiations between the Department and each partnership. The Department provided its actuaries with historical Medicaid fee-for-service expenditures and health care utilization as a starting point. The actuaries then calculated what it should cost to provide similar services in a managed care setting. Assumptions were also made about partnerships' administrative expenses and risk factors. This information was provided to each partnership, which used the information to develop business plans and determine reasonable administrative expenses. Both the Department and each partnership then projected the historical costs and utilization information and negotiated a capitation rate. For the state to save money, the capitation rate must be less than would have been paid under the traditional fee-for-service program.

Audit Objectives

The move to a managed care system represents a fundamental change in the way Kentucky delivers health care services to its low-income citizens. Because of the magnitude of this change, legislative committees and others have raised a number of concerns about the program, including whether the partnership arrangement is feasible, whether anticipated cost savings are reasonable, whether members will receive adequate health care services, and whether Medicaid recipients will be satisfied with their health care. The Auditor of Public Accounts also had concerns about the program because of its substantial implications for the state's budget.

This audit addresses these concerns by reviewing the current status of the health care partnership program, identifying problems the program has had getting started, examining how well the Department is monitoring the program, and recommending ways to improve the implementation and oversight of the program.

Our audit was designed to answer the following questions:

- What is the current status of the Medicaid managed care program?
- How well is the Department overseeing the managed care program, and can its oversight be improved?

As part of the audit, we interviewed federal oversight officials in HCFA, state Department for Medicaid Services officials, and Partnership officials. We reviewed the waiver application and its underlying terms and conditions, the contracts between the state and the two partnerships that are already operating, and the application materials submitted by those two partnerships. In addition, we examined various documents and reports available from each partnership. We also surveyed a sample of members and health care professionals. Finally, we talked with managed care officials in other states. Appendix I contains a complete description of the scope and methodology of this audit. The audit was conducted in accordance with Generally Accepted Government Auditing Standards as issued by the Comptroller General of the United States.

Chapter 1
What Is the Current Status of the Medicaid Managed Care Program?

Summary

Of the eight regions, partnerships in Region 3 and Region 5 were formed with few difficulties and began enrolling members in November 1997. Region 3 had some start-up problems, primarily relating to assignment of members to primary care physicians, which have been resolved. Some ongoing operational problems still exist in both regions, including problems with inaccurate and untimely eligibility data and pharmacy cost overruns.

To-date, the other six regions are at various stages of development. Officials in these six regions cite high start-up costs and concerns about the accuracy of the historical Medicaid expenditure data as factors contributing to their slow starts. In three regions, competing provider groups had problems agreeing about forming a partnership. The Department hopes to have the partnerships enrolling members by July 1, 1999, but it is not clear whether that goal will be met. A description of each region's activities and current status is described in the following sections.

Partnerships Form As Providers in a Region Join to Develop a Plan to Provide Medicaid Services

One of the key aspects of the managed care program is the direct involvement of all health care provider groups in the partnership. In mid-1996, the Department sent information about the managed care waiver to all the various categories of health care providers in each region. The Department's objective was to let the health care providers in each region decide how to design their partnership, since they would be responsible for the Medicaid managed care program in their region.

As groups of providers began to work out how to provide Medicaid services, they sent letters of intent to the Department, indicating their interest in establishing a regional partnership. The Department wanted to phase in the partnerships by implementing them in Region 3 and Region 5 first, and sent a formal request for application to those partnership groups.

One partnership proposal was received from each region. Therefore, in accordance with the state's purchasing requirements set forth in KRS 45A, in February 1997 the Department obtained approval from the Secretary of the Finance and Administration Cabinet to enter into sole source contracts for the partnerships in each region. (If multiple proposals are received from other regions, the Department will follow competitive bidding procedures.) In September 1997, the Department signed a contract with the partnerships in Region 3 and Region 5. These contracts were approved by the Legislative Research Commission Personal Service Contract Review Subcommittee on October 15, 1997. In November 1997, both regions began enrolling members. Region 3's partnership plan is called Passport Health Plan and Region 5's partnership plan is called Kentucky Health Select.

Region 3 and Region 5 Partnerships Developed With Few Difficulties

Region 3 is based in Louisville. The partnership includes University Health Care, Inc., a for-profit HMO created specifically to provide health care services to Medicaid recipients in Region 3, and the Region 3 Partnership Council, the governing board for the partnership made up of consumers and health care provider representatives. The Department has a three-way contract with both these partnership entities. More information about the partnership in Region 3 can be found in Appendix II.

University Health Care, Inc. Has Not Changed to a Non-Profit Entity Yet

Region 3's HMO is for-profit, but is supposed to be changing to a not-for-profit entity. The HMO was incorporated as University Health Care, Inc. It is a for-profit corporation that provides health care services to Medicaid recipients in Region 3. It has no commercial members. Officials told us the reason the HMO was incorporated as a for-profit organization was because the investors thought that structure might make it easier to raise capital. After the initial capital had been raised, the for-profit structure was no longer needed. As a result, these officials also told us the HMO would be converting to a non-profit status, although the change has not been made yet.

Region 5 is headquartered in Lexington, Kentucky. Its structure is a bit different from Region 3: The Department for Medicaid Services contracts with the Region 5 Managed Care Organization, LLC. That organization is a partnership composed of the Central Kentucky Regional Provider Entity (the governing board) and CHA HMO, the for-profit licensed entity for the partnership. CHA HMO was an existing health maintenance organization owned by several regional hospitals including the University of Kentucky, the majority owner. Additional information about Region 5 can be found in Appendix II.

Region 3 officials told us the partnership came together with few difficulties, in large part because of the requirement that the University of Louisville teaching hospital be one of the partnership anchors. In Region 5, University of Kentucky Hospital officials took a leadership role in getting the partnership off the ground. Officials from Region 3 and from several of the other regions we contacted also said the health care professionals in their regions wanted to maintain control over how Medicaid services would be provided. These officials said the health care providers feared they would have faced lower reimbursements from any commercial HMO the Department could have contracted with and would not have been able to influence policy decisions.

Some of the Start-up Problems Have Been Resolved, But Officials in Region 3 and Region 5 Continue To Face Enrollment Difficulties

Region 3 and Region 5 began phasing in enrollment of Medicaid recipients in November 1997. Both regions experienced some initial start-up problems with automatically assigning members to primary care physicians. The problems were more pronounced in Region 3 because the first category of members it enrolled consisted of AFDC recipients in Jefferson County, the category with the largest number of members in the region. According to Passport officials, Region 3 assigned its members to primary care physicians using information on those members' KenPAC physicians or assigned members based on where they lived. This process was not successful. Passport officials said the patient lists from the providers did not match the lists from the state and the geographical assignment was not consistent with how members got their health care. The result of these problems was that members complained about incorrect assignments and a lot of negative press was generated. Passport officials told us this problem has been resolved. If the member is not part of the KenPAC program, the region no longer assigns primary care physicians on a geographic basis, but lets members select a primary care physician when they enroll in the program.

Region 3 officials also said they had a learning curve with respect to the provider community in Kentucky and the Medicaid rules in the state. Additional start-up problems involved miscommunication between Passport and its subcontractors,

difficulties getting up-to-date member eligibility information to subcontractors, particularly the pharmacy subcontractor, and late payments to providers. These problems generally have been resolved.

Region 5 had some relatively minor problems relating to the auto-assignment of members to primary care physicians. According to Region 5 officials, less than 10% of the members had to be assigned a primary care physician because they did not select one. These officials said they used the local health departments to conduct outreach activities with the Medicaid population to get the recipients to select a primary care physician. In the other cases, the region assigned the recipient's KenPAC provider to be the primary care physician. If neither of these efforts worked, the region assigned a primary care physician based on the recipient's zip code. These officials also said that because they began enrollment in six small counties, any problems that may have occurred were much less prominent and could be dealt with more easily.

Other start-up problems partnership officials and providers identified related to data and eligibility problems:

- It was difficult to get newborns enrolled.
- The Department provided them with inaccurate eligibility data.
- The eligibility data was untimely.
- The Partnership had to provide services to enrolled members who were ineligible or lived outside the partnership region.

Most of these problems are ongoing. They are discussed below.

Inaccurate Eligibility Information Received from the State

Partnership officials said one of their biggest problems has been getting accurate eligibility information from the state. Officials in Region 5 said the eligibility information it gets from the state is incomplete. For example, phone numbers and family relationships (such as names of siblings) are not included in the eligibility files. These officials also said the state provided many inaccurate addresses.

The Department assigned a staff member to try to identify the reason addresses were wrong. According to that individual, the eligibility system files have five address lines, while the Medicaid Management Information System has fewer address lines. The Department is working to resolve that issue.

Department officials also noted that data will not always be accurate because some portion of the half million recipients will always be moving and may not provide an updated address to the Department on a timely basis.

Untimely Eligibility Information

Partnership officials said they are not always notified of new members on a timely basis. Region 5 officials said it can take from 45 to 60 days after a person is found eligible for Medicaid before the partnership is notified. In the meantime, the partnership is responsible for that member's health care. Region 3 officials said they had the same problem. They said they might be notified in May of a member who had become eligible for Medicaid the previous November. The partnership would be responsible for that member's health care beginning in November.

Department officials said early on in the program that it sent the partnerships eligibility information by tape and that the partnerships were not necessarily processing the tapes on a daily basis. Now, the Department is transmitting data daily via a dedicated phone line. These officials said they plan to require new partnerships to have a dedicated phone <u>before</u> partnerships enroll members. They also said they have worked with the partnerships to ensure they process the information on a timely basis.

Department officials also acknowledged that there are some timing issues affecting eligibility information. For instance, after a person applies for Medicaid, some time can elapse before an eligibility determination is made. Once the person is found eligible, his/her eligibility begins on the 1st day of the month in which he/she applied. Department officials contend this may not be such a big problem for the partnerships: if the person is found ineligible, he/she is responsible for his/her own care. They said it is likely that the person will not use excessive services until he/she learns whether he/she is eligible.

Department officials also said requiring partnerships to be responsible for the care of members from the date from which Medicaid eligibility began was the most efficient way to handle eligibility. They said making the partnerships responsible for members' health care in this way eliminates the need for dual Medicaid systems (that is, a fee-for-service system until the date eligibility is approved and a managed care system from that date forward).

Providing Care to People Not Eligible for the Partnership Program

Partnership officials said they have had to manage the care of patients who were not eligible for the managed care program, including those who live outside the partnership region and those who are served by other programs. As an example, Region 5 officials in Lexington told us about an individual they were serving who lived in Paducah.

The Department has made the decision that a partnership will provide health care services to all individuals who have been assigned to them. Officials said there likely always will be some sort of problem with ineligible recipients because of the overall complexity of the various system interfaces. For example, they said the Social Security Administration is responsible for making SSI eligibility determinations and the county of residence is not a critical data element for that program. As a result, Jefferson County became the default county for many SSI recipients.

Department officials also said individuals served by the home-and-community-based waiver program[3] sometimes were incorrectly enrolled in the partnerships. They said when they investigated the problem, they found that staff were not communicating on a timely basis that these individuals had been placed in the home-and-community-based waiver program.

The number of recipients who live outside their regions or who are ineligible for the program represent a relatively small proportion of all Medicaid recipients. Department officials noted that serving all individuals assigned to a partnership

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[3] The home-and-community-based waiver is a Medicaid waiver that provides funding to enable people to stay in their homes rather than go to a nursing home.

was one of the differences between serving a Medicaid population and serving a non-Medicaid population through a commercial HMO program.

Pharmacy Cost Overruns Also Are a Serious Concern and a Potential Threat to the Viability of the Partnerships

Pharmacy costs are running more than one-third higher than either partnership budgeted, as shown in the table below. In Region 3, this overrun has contributed to a capital call, or an additional investment, of $2.5 million for the investors in University Health Care, Inc, the region's HMO. Partnership officials attributed the overruns to inaccurate historical data provided by the Department. Region 3 officials also speculated that under the traditional fee-for-service Medicaid program, pharmacists or physicians were not requesting prior authorizations for certain drugs, but were telling Medicaid recipients that the drugs were not covered and that they would have to pay for them out-of-pocket.

Table 3: **Pharmacy Cost Overruns**

Region	Pharmacy Costs Per Member Per Month			Percent Over Budget	No. of Members in month	Impact of overrun
	Budgeted	Actual Costs August 1998	Difference			
Region 3	$26.02	$35.82	$9.80	37.7%	95,903	$939,849
Region 5	27.46	37.00	9.54	34.7%	60,655[1]	$578,649

Source: Passport Health Plan and Kentucky Health Select. [1]These are estimated numbers based on the initial eligibility counts for the month of August. It understates the actual number of people who are eligible this month because it does not include all those people who applied for Medicaid during August, but who were not found to be eligible until later.

To determine how prior authorization for drugs was handled under the fee-for-service program, we reviewed the Department's prior authorization policy. Our review showed that for those drugs covered under the policy, the physician or pharmacist had to make a written request to the Department for authorization, with the exception of emergency situations. Such a policy served as a barrier to getting particular drugs.

Another Department staff member provided anecdotal evidence that suggested some pharmacies or physicians under the fee-for-service system were telling the recipients that their drugs were not covered. In fact, the drugs may have been covered, but the pharmacists or physicians did not try to get prior authorization for them. However, no statistics were available on how often that might have occurred.

Department officials told us the partnerships had not instituted any policies or procedures to control pharmacy use, but were paying for all drugs on the approved drug list. Region 3 officials corroborated this. They said when their partnership became operational, it removed the prior authorization requirement and essentially approved all drugs on the state formulary.

Both Partnerships Have Made Changes to Address Pharmacy Cost Overruns

In response to the problems the two regions were experiencing with pharmacy cost overruns, Department officials met with the partnerships in June 1998. The Department agreed to review the accuracy of pharmacy data that it had provided to the partnerships. Department officials also discussed with the partnerships what kinds of controls the partnerships could implement to control costs.

As a result of the meeting, Region 3 instituted several measures to bring down pharmacy costs:

- a preauthorization program
- a pharmacy audit program
- a preferred formulary and therapeutic interchange program

The Region does not expect to see any significant reduction in costs from these efforts for three months. Region 3 officials also said the Department agreed to provide them with 1997 historical data to see whether those data were markedly different from the 1995 historical data.

Region 5 instituted the following new drug utilization policies:

- Prior authorization policies for certain class of drugs
- Preferred list of drugs for certain drug categories
- Provider education for those who prescribe a high amount of drugs

The new measures are scheduled to be implemented over the next three to four months. Region 5 officials also plan to review data the Department provided to determine whether there are any discrepancies.

Partnerships Are Being Developed in the Other Six Regions, But None Has Made a Formal Application to the Department

We talked with officials in the other six regions to find out the status of the program. To-date, none of the regions has officially applied to the Department to provide Medicaid services in their areas, although some appear to be farther along in the process than others. The status of the partnerships in each of the other regions is described below, along with reasons given by officials in these regions for the slower development.

Status of Regions Without Established Managed Care Partnerships, as of December 1998

Region 1:	This region has about 23,000 Medicaid recipients in 12 counties in far Western Kentucky (Fulton, Hickman, Carlisle, Ballard, McCracken, Graves, Calloway, Marshall, Livingston, Lyon, Crittenden, Caldwell). Two different groups associated with hospitals expressed interest early on in establishing a regional partnership in this region. However, Department officials said that these two groups have narrowed down to one group. The officials we talked with did not have any specific date by which they expected to be enrolling members. One official told us they hoped to show the Department the region was making good progress by December 1998. That official also said gearing up for implementation after the state selects the partnership may not take long. Another official could not state when enrollment might begin because of the initial difficulties involved in getting the two groups to work together.

Region 2: This region has about 42,000 Medicaid recipients in 12 counties in Western Kentucky (Henderson, Union, Daviess, Hancock, Webster, McLean, Ohio, Muhlenberg, Hopkins, Christian, Todd, Trigg).

A corporation has been formed in this region to be the partnership to provide Medicaid services. The region is working on developing contracts for an administrative services organization that would enroll members and perform claims processing functions. An existing HMO in the region likely will be used as the risk-bearing entity.

Officials said that an optimistic date for enrolling Medicaid recipients was April 1999, although that date could be as late as July 1999. The corporation does not want to complete an application to the Department until it has a reasonable idea of the amount of capitation payments it will receive and the expenditures it will incur. Officials said they have been hampered by the data they have gotten from the Department, saying it was inconsistent and difficult to interpret.

Region 4: This region has about 66,000 Medicaid recipients in 20 counties in Southern Kentucky (Butler, Logan, Simpson, Warren, Edmonson, Allen, Hart, Barren, Monroe, Metcalfe, Green, Taylor, Adair, Cumberland, Clinton, Russell, Casey, Pulaski, Wayne, McCreary).

Two groups of hospitals have come together recently to develop the partnership for this region. The region hopes to contract with an administrative entity that would run the program and serve as the risk-bearing entity. One of the difficulties in this region has been the reluctance of the area hospitals to provide the funds needed to capitalize the program because of their concerns about its financial viability and uncertainty about potential future program changes.

The region is in the process of preparing requests for information to find out which contractors would be interested in the program. The region does not expect to enroll members until the summer of 1999 at the earliest.

Region 6: This region has about 26,000 Medicaid recipients in 6 counties in Northern Kentucky (Boone, Gallatin, Pendleton, Campbell, Kenton, Grant).

An executive director has been hired to develop the partnership in this region and a steering committee has been formed. Several committees, composed of members of the provider community, have been created. The region also has requested additional and more detailed historical utilization data from the Department. No specific decisions have been made about how to structure the partnership in the region. The executive director has discussed sharing some of the program administration infrastructure and costs with region 7 but indicated that each region likely would have its own risk-bearing entity. The executive director said the region wants to be able to enroll members by the Spring of 1999.

Region 7: This region has about 39,000 Medicaid recipients in 14 counties in Northeast Kentucky (Bracken, Mason, Robertson, Fleming, Lewis, Greenup, Boyd, Carter, Rowan, Bath, Menifee, Morgan, Elliott, Lawrence).

A steering committee has been incorporated in this region. A 4-to-5-member work group and a by-laws committee also have been established. According to

the Chair of this committee, the region is negotiating with an organization to provide administrative services for the region. The chair also said the region had requested more detailed and specific data from the Department because its actuaries said the initial data were not adequate. The region has been discussing how it could work with region 6 to provide health care services. No specific date for enrolling members has been targeted, but the Chair said providers wanted to develop a plan locally, rather than let the program be bid out to commercial HMOs. The Chair said the region hoped to have a contract in place with the Department by January 1, 1999.

Region 8: This region has the most Medicaid recipients in the state, with 126,000 people in 19 counties in Southeast Kentucky (Martin, Johnson, Magoffin, Pike, Floyd, Perry, Breathitt, Lee, Owsley, Knott, Letcher, Harlan, Leslie, Clay, Laurel, Whitley, Knox, Wolfe, Bell).

Two groups responded to the public notice as indicating an interest in establishing a partnership in this region. One group has established a steering committee and has issued a letter of intent to AmeriHealth Mercy Health Plan to provide administrative services. (That is the same group that is providing administrative services for Region 3.) Officials from this group said they did not know when they would begin enrolling members. They said the partnership would become operational only after a business plan was developed that would not jeopardize providers or access to care.

The second group does not have a formal steering committee, but it is in the process of negotiating service agreements with various vendors. An official from this group said he could not provide a specific timeframe for enrolling members, but noted that the enrollment process would be relatively simple and based on historical patient/provider relationships.

Competing Groups Have Lengthened the Time To Develop Partnerships In Three Regions

The Department anticipates contracting with a single partnership in each region. One reason Regions 1, 4, and 8 have taken longer to put the managed care partnerships in place is that more than one group of providers was interested in developing the partnership. As a result, efforts to establish one board that represented the broad interests of all the providers in the region required additional planning and negotiation among the parties involved.

Recently, the competing groups have joined together in Region 1 and Region 4 and have submitted a single letter of intent to the Department. This action should speed development of a partnership in those regions.

High Start-up Costs Are Another Reason Cited as Contributing to Slow Starts

Officials from five of the six regions specifically cited high start-up costs as a barrier to partnership development. Each partnership is required to have a licensed entity, such as an HMO, before it can enroll members. To be licensed as an HMO, the Department of Insurance requires minimum upfront cash on hand of $3 million. Other start-up costs include expenditures for staff to establish a provider network, develop policies and procedures for managing health care, outlays for computer infrastructure, consultant and actuary fees, and the like. People we talked with in the various regions estimated start-up costs would range from $6 million to $8 million per partnership.

Region 3 and Region 5 both benefited from having state university teaching hospitals in their areas. 907 KAR 1:705 requires that these teaching hospitals participate in the program. In both regions, these large hospitals contributed a significant amount of the initial capital, either directly or indirectly. These hospitals are part of state universities, but they generally are funded from patient fees, with only a small portion of their financing coming from state revenues. The University of Kentucky Hospital receives just over $1 million from the state for neo-natal services. The hospital at the University of Louisville receives $15.9 million from the state for the Quality Charity Care Trust (a fund used to pay for health care for low-income people who are not eligible for Medicaid). The other regions rely on funding from local hospitals which, several sources said, do not have the funds needed for a program of this type. Officials from at least one region requested that the state provide loans or grants to help defray some of the start-up expenses. According to news accounts of a legislative budget subcommittee meeting, an advisor to the Governor said no money was available for this purpose. One of the reasons given was that any money provided before the partnerships began enrolling members would have to come entirely from state funds—the money would not be eligible for a federal match.

Department officials also said their goal is to get the partnerships to accept the program risk, and they noted that each partnership would be guaranteed an annual stream of revenue ranging from approximately $63 million in Region 6 to more than $300 million in Region 8. In addition, the Department helps reimburse the partnerships for some of their development costs through a one-time, negotiated add-on to the capitation rate. Both Region 3 and Region 5 received a one-time add-on to their capitation rate for fiscal year 1999 that reimbursed them for about 50% of their development costs.

Some Regions Have Complained That They Have Received Inadequate or Incomplete Data from the Department

Because some of the regions have relatively few Medicaid recipients, accurate data is crucial so regions can determine whether a partnership is financially feasible. Five of the six regions specifically said the data they received from the Department were inadequate to develop business plans. As an example, one region said the inpatient utilization data were not broken out by medical days, surgical days, obstetrical days, pediatric days and the like. Instead, these data were aggregated into a single category called inpatient days. That region subsequently requested the more detailed information from the Department so it could develop better estimates of program cost. Officials from these six regions noted two other problems they have had getting their partnerships underway. In particular, they reported the following:

- It takes time to develop a partnership and bring all the various provider groups and individuals together.
- A significant amount of uncertainty exists about the future operation of the program, such as whether covered services will remain the same. The contract with the partnerships does include provisions for changing capitation rates if Medicaid services change.

The Department's Goal Is to Have All the Partnership Regions in Operation by the Beginning of the Next Fiscal Year

In early September, the Department sent a letter to officials in these six regions laying out their hoped-for timeframe for implementing the partnerships. The timeframe includes the following dates, as of November 17, 1998:

November to December 1998: Department will issue applications to the partnerships
December 1998 to January 1999: The regions will submit the application to the Department
March to April 1999: Contracts will be negotiated
June 1999: Enrollment will begin in Regions 1, 2, 6, and 7
July 1, 1999: Enrollment will begin in Regions 4 and 8

According to a Department official, groups in all six remaining partnership regions responded to the Department's letter. However, as of December 4, 1998, no applications had been issued. The Department needs to have the partnerships in place by the beginning of fiscal year 2000 because its biennial budget is based on anticipated savings from having all managed care partnerships in place by that time. It has the option of going out for bid for commercial managed care organizations beginning in January 1999, but is not required to do so. (907 KAR 1:705, Section 2(2).) While the Department hopes to have all the partnerships enrolling members by July 1, 1999, it seems unlikely that goal will be met given the degree of effort and resources needed to put the partnership in place.

Response to Agency Comments

We provided a draft of this report to the Department of Medicaid Services. The Department generally agreed with the audit findings. It provided some additional information in its response, found at Appendix IX.

How Well Is the Department Overseeing the Managed Care Program, and Can Its Oversight Be Improved?

Summary

Department staff appear to be properly overseeing the Medicaid managed care program, and the Department seems to have established good oversight. Its contracts with the partnerships include those provisions necessary for monitoring and overseeing the managed care program and ensuring that program goals are met. A survey we conducted indicates that recipients generally were more satisfied with the managed care program, while health care providers were generally more satisfied with the fee-for-service program.

We noted that the Department should do a better job of documenting the actions taken in response to the readiness reviews. It also should ensure that partnerships submit encounter data and all the required reports in a timely manner. According to HCFA and our audit work, Department must do a better job of validating and analyzing the data and reports received from the partnerships. To ensure that the program operates as intended, Department staff also must complete a number of organizational tasks and establish key advisory committees. We also think the Department should formally document the actual savings it has experienced from the managed care program.

Consequently, we made recommendations designed to address these areas and to ensure that the program works as intended and that partnership activity and Medicaid recipients' health care is adequately monitored.

The Program Protocol Outlines Activities Designed to Assure the Accomplishment of the Five Primary Goals of Managed Care

As noted earlier, the Medicaid managed care program has five primary objectives relating to improved health care and cost containment. The Department ensures these goals are met through a variety of activities that are identified through the Kentucky Health Care Partnership Program Protocol document and incorporated as part of the contracts it signs with partnership entities.

We reviewed the monitoring system the Department has in place for ensuring the program objectives are met. The following table highlights each objective, notes the main applicable criteria, and indicates how the Department ensures that the criteria are being met. The Department's system includes features that other states use to monitor their Medicaid managed care programs.

Table 4: **Medicaid Partnership Program Objectives, and How They Are To Be Met**

Objective	How the Department Ensures That Its Objectives Are Being Met	For Regions 3 and 5, Are the Department's Activities Being Being Carried Out Effectively?
1. Improve health outcomes and quality of care	Monitors member outcomes and compares against standards; requires reports on utilization; requires clinical studies of specific topics	partially
	Monitors, evaluates quality improvement plans and programs	yes
Criteria: National health outcome standards (HEDIS 3.0)	Evaluates reports submitted by partnerships	partially
	Monitors/evaluates health education programs	yes
	Has an external quality review organization look at quality of health care services	yes

		Collects encounter data to review utilization on an on-going basis	partially
		Validates the encounter data and other data submitted by the partnerships	partially
		Ensure an adequate system of complaints that meets requirements of federal government	yes
		Requires member and provider satisfaction surveys	partially
2.	Provide health care through managed care systems consisting of providers *Criteria:* 907 KAR 1:705	Requests an application from partnership and conducts a "readiness" review to ensure partnership is capable of carrying out its responsibilities	yes
3.	Redirect Medicaid to emphasize primary care and prevention	Reviews each partnership's enrollment policies and activities	yes
	Criteria: National health outcome standards (HEDIS 3.0)	Require each member to be assigned a primary care physician who will manage that member's health care services	yes
		Focuses health care outcomes on measures related to prevention; incentives are provided for achieving certain health care screening and prevention targets	yes
		Review each partnership's member education materials and programs	yes
4.	Contain and control Medicaid costs *Criteria*: Costs cannot exceed the upper payment limit (an estimate of program costs under fee-for-service)	Negotiates capitation rates that will control and contain Medicaid expenditures by being lower than what would have been the case under the fee-for-service program	yes
5.	Improve access, availability and coordination of services	Reviews partnership maps and reports outlining members' access to providers	yes
	Criteria: Provider to member ratio =<1:1,500, specific time and distance standard for primary care sites	Reviews list of network providers to ensure all types of providers are included	yes
		Reviews network to ensure most of the fee-for-service providers continue under managed care	yes

Source: Developed by APA using information from the Kentucky Health Care Partnership Program Protocol

The Department's Monitoring System Appeared to Be Operating Adequately in Several Key Areas

We also examined the Department's monitoring system. Three important oversight activities include ensuring that an adequate system for handling and resolving member and provider complaints is in place, ensuring that partnerships have an adequate network of providers to meet the required time and distance standards, and determining how satisfied members and providers are with the system.

- The complaint-handling system gives the Department information about whether the members and providers are satisfied with the partnerships.
- The oversight of the provider network helps ensure that adequate and high-quality health care services can be provided.
- Determining satisfaction through a member and provider survey provides information about problems with the system.

Complaints and Grievances of Members Were Handled in an Appropriate Manner	We reviewed the complaint and grievance systems operated by the Department and by Regions 3 and 5. The waiver terms and conditions specify certain elements that have to be included as part of the complaint/grievance process, including such things as written procedures for maintaining records of complaints, informing members about the complaint process, and evaluating patterns of complaints. In addition, the Department is required to establish an Ombudsman program to assist members in filing grievances; to identify, investigate, and resolve member complaints; to advocate for members; to educate consumer organizations about managed care; and to provide information and referral services to members. The Department and the partnerships had complaint/grievance systems that complied with these requirements. The Department was negotiating a contract with the Office of the Ombudsman in the Cabinet for Families and Children, but the Office declined to provide the services. As a result, the Department is re-evaluating its options for providing Ombudsman services by examining internal and external sources. Department staff said they do not know whether this will cost more or less than what it would have paid the Office of the Ombudsman. We recommend that the Department strive to complete this process as soon as possible.

We also reviewed a sample of complaints handled by the Department and each partnership. Most of the complaints were handled appropriately, although we identified a few that could have been better documented. We also noted that complaints frequently were referred to other areas, without any formal follow up to ensure they were resolved. In Region 3, the complaint-tracking system was set up so that the person making the referral would be notified of the action that was taken after the complaint was referred. That system provided greater assurance that the complaint was resolved satisfactorily. Neither the Department nor Region 5 had that automatic notification function, although the complaint logs showed that informal follow up sometimes was done.

The Department's Complaint Process for Providers Has Not Yet Been Fully Developed, Although Both Partnerships Had Adequate Provider Complaint Systems	Both partnership regions had processes for handling provider complaints that generally met program requirements, including having a process to ensure complaints were resolved, a process to log grievances with key information, an informal resolution process, and a process for submitting quarterly reports to the Department. Few requirements are imposed by the waiver on the Department for handling provider complaints. The program protocol document only requires that provider appeals be handled in accordance with applicable Department regulations.

The Department does not have a single location to receive complaints about managed care that come from providers. Instead, providers typically contact the area they dealt with under the fee-for-service program. No overall system is in place to ensure these calls are coordinated and tracked. Department staff said that as managed care becomes more fully integrated into the Department, staff will become more aware of their responsibilities in this area. However, having a strong system for hearing, tracking, and resolving provider complaints is one element of an effective oversight system. Accordingly, we recommend that the Department establish such a system.

The Department Monitored the Provider Network Adequately	We examined the steps the Department took to ensure the partnerships had an adequate network of providers. Our reviews showed that Department staff actively monitored the provider network before the partnerships enrolled members. As the partnerships were preparing to enroll members, they sent monthly electronic information to the Department, including the providers they had under contract. In addition, Region 5 submitted maps that showed the location of their members and detailed the time and distance these members were from various types of providers. Region 3 also submitted maps showing the locations of their providers and members, but these maps did not provide details about time or distance.

The Department reviewed these submissions to ensure the adequacy of the provider network in each region. Department staff also prepared their own analysis of the provider network to ensure that the partnerships contracted with those providers that previously served Medicaid recipients. As another check, they did a side-by-side comparison of contracted providers with the list of KenPAC providers to ensure those providers under partnership contracts had served at least 85% of the KenPAC members. When staff found problems, they required the partnerships to take corrective action to make sure there were enough providers to serve their members.

The Department continues to monitor the adequacy of the provider network. It plans to prepare maps for both regions to validate the information the partnerships submitted. It also will monitor complaints to see whether any problems with access are identified. It also will include some specific questions on access to providers in the member satisfaction survey being conducted this winter.

Our Survey of Members Showed a High Degree of Satisfaction with the Managed Care Program	The University of Kentucky Martin School completed a baseline satisfaction survey for the Medicaid fee-for-service program in June 1998. The Department has contracted with the Martin School for an extensive satisfaction survey that was mailed to managed care members in the fall of 1998. Because the results of this survey were not going to be finalized during our audit, and to help validate those results, we conducted a mail survey of 610 managed care recipients. We received 139 responses, for an overall response rate of 23%.

Our results showed the following:

- 93 Medicaid managed care recipients (85% of those who responded to the question) said they were very or somewhat satisfied with the managed care program (Officials of Passport Health Plan recently conducted a survey of Passport members. They found that 93% of the respondents were satisfied or very satisfied with the managed care plan.)
- 73 Medicaid managed care recipients (78% of those who responded to the question) said their health care services were the same or better than under the old fee-for-service program

Nearly three-fourths of those who responded to the question said they had tried to get health care from their partnership plan. A total of 43 respondents said they

had made 2 to 4 visits to a doctor, clinic, or hospital; 50 respondents (48.5%) had made 5 or more visits.

We asked these Medicaid recipients how satisfied they were with specific aspects of the health care they had received since being enrolled in the managed care plan. The percent of respondents rating the following aspects as good, very good, or excellent is as follows:

Received enough care to meet my medical needs:	93.1%
Ability to get all the medication I needed:	87.5
Ability to get all the equipment I needed:	80.9
Ability to get referred to a specialist:	83.5
Ability to get an appointment when needed:	87.0
Ability to contact physicians after regular office hours	75.0

When asked how satisfied or dissatisfied they were with their managed care plan, 84.5% of the Medicaid recipients said that they were somewhat satisfied or very satisfied.

When asked how satisfied or dissatisfied they were with their managed care plan, 84.5% of the Medicaid recipients said that they were somewhat satisfied or very satisfied. There were some differences by category: Only about half the Aid to Families with Dependent Children (AFDC) category recipients said they were very satisfied, while about two-thirds of the pregnant women and children (SOBRA) category and Supplemental Security Income (SSI) category recipients said they were very satisfied. These results were consistent with the results of the fee-for-service survey.

At the other end of the spectrum, the SSI recipients were much more likely to report being somewhat or very dissatisfied with the program (13.5%). One SOBRA recipient (3.0%) said he/she was somewhat dissatisfied with managed care, and one AFDC recipient said he/she was very dissatisfied.

Finally, we asked the people in our sample to compare the health care services they received under managed care with those they received under the fee-for-service program. The following table breaks down the responses received by type of recipient and partnership region. Overall, Medicaid recipients rated managed care as:

Somewhat or much better:	40.9%
Stayed the same:	37.6
Somewhat or much worse:	21.5

These results varied somewhat by category of recipient. AFDC recipients generally had a slightly more positive view of managed care, while SOBRA recipients were more likely than the other groups to say they found managed care to be somewhat worse than the fee-for-service program. SSI recipients mirrored the overall results.

We also found that recipients rated the two partnerships slightly differently. A total of 43.4% of Kentucky Health Select members found managed care at least somewhat better than the traditional program. However, nearly one-fourth found it somewhat or much worse. Only 37.5% of Passport Health Plan members found managed care better than the traditional program, but only 17.5% found it to be worse, and nearly half said services remained about the same.

Table 5: **Response of Medicaid Recipients Regarding Their Health Care Services Under Managed Care Versus Fee-For-Service**

	Regions 3 and 5 Combined								Passport (Region 3)		Kentucky Health Select (Region 5)	
	All Medicaid Recipients[1]		SSI Recipients		SOBRA Recipients		AFDC Recipients					
Much Better	23	25%	12	25%	3	12%	6	35%	9	23%	14	26%
Somewhat Better	15	16%	7	15%	6	23%	2	12%	6	15%	9	17%
Stayed the Same	35	38%	19	40%	10	38%	6	35%	18	45%	17	32%
Somewhat Worse	17	18%	8	17%	7	27%	2	12%	5	12%	12	23%
Much Worse	3	3%	2	3%	0	0%	1	6%	2	5%	1	2%

Source: APA Survey of Recipients in Regions 3 and 5.   See Appendix I for survey methodology.   [1]Totals do not add across because for two recipients, no category was indicated. These individuals are included in the "All Medicaid Recipients" column.

Complete survey results from members can be found in Appendix VI.

Health Care Providers Were Not as Satisfied With Managed Care Partnerships

We also surveyed health care professionals to find out how satisfied they were with the managed care program. Their responses indicated they were much less happy with the program than members were. Providers rated their overall level of satisfaction with managed care as depicted in the following table:

Table 6: **Response of Providers Who Were Asked to Rate Their Overall Satisfaction With the Managed Care Program**

	Generally Satisfied	Somewhat Satisfied	Neither Satisfied Nor Dissatisfied	Somewhat Dissatisfied	Generally Dissatisfied
Number of Respondents	14	16	10	18	23
Percentage	17.3%	19.8%	12.3%	22.2%	28.4%

Source: APA Survey of Providers in Regions 3 and 5. See Appendix I for survey methodology.

A total of 80 of those providers who rated their satisfaction with the managed care program (94.1%) said they also had provided services under the old fee-for-service Medicaid system. We asked them to compare various aspects of the managed care program with the traditional program. In general, the level of services provided by the health care professionals remained the same, while most professionals noted a decrease in fees received. This decrease could be a result of fewer Medicaid recipients, as well as a reduction in the fees paid by the partnerships. It should be noted that the actual fees providers receive are similar to what they received under the fee-for-service program, although the partnerships established a withhold on this money to ensure they can operate within their capitation payments. That money may be returned to the provider at the end of each year.

	Greater	Same	Less
Number of Medicaid patients	12 (15.2%)	46 (58.2%)	21 (26.6%)
Number of services provided	4 (5.0%)	62 (77.5%)	14 (17.5%)
Range of services provided	4 (5.0%)	64 (79.0%)	13 (16.0%)
Fees received	4 (5.1%)	20 (25.7%)	54 (69.2%)

We also asked health care professionals how their level of satisfaction with the managed care program compared with their satisfaction with the fee-for-service program. The majority of health care professionals were more satisfied with the fee-for-service program, although 32% were either more satisfied with managed care or were satisfied with both systems.

    43 (57.3%) were more satisfied with the fee-for-service system
    12 (16.0%) were more satisfied with the managed care system
    12 (16.0%) were satisfied with both systems
     8 (10.7%) were not satisfied with either system

Providers indicated that their paperwork requirements had changed. In all, 39 (51.3%) said the amount of paperwork they had to submit to the partnerships was more burdensome. A total of 24 respondents (32.0%) said the amount of paperwork they have to submit to the Department for Medicaid Services or the Department's fiscal agent, UNISYS, was more burdensome. However, a number of respondents indicated that the paperwork burden was the same or less for the partnerships (37) and for the Department (47).

Finally, we asked health care professionals to state their level of agreement with the following two statements regarding the impact of managed care on health delivery and patient outcomes.

Table 7: **Response of Health Care Professionals Regarding the Potential Impact of Managed Care**

	Somewhat Agreed or Mostly Agreed	Neither Agreed or Disagreed	Somewhat Disagreed or Mostly Disagreed
Under managed care, the health care of my patients can be managed better than it was under the fee-for-service Medicaid system.	19 (22.9%)	26 (31.3%)	38 (45.8%)
Under managed care, the potential for improved patient outcomes is higher than under the previous fee-for-service Medicaid system.	19 (23.2%)	22 (26.8%)	41 (50.0%)

Source: APA Survey of Providers in Regions 3 and 5. See Appendix I for survey methodology.

Complete survey results for health care professionals are in Appendix VII.

In a Few Areas, the Department Should Improve Its Oversight Efforts

Even though the managed care program is relatively new, the Department has been monitoring two partnerships for more than one year. Although the Department generally did a good job of meeting its oversight responsibilities, we identified some areas where the Department could do a better job, particularly as it contracts with new partnerships. For instance, the Department could do a better job of documenting that the partnerships took all corrective action required of them. The Department also needs to make getting encounter data from the existing and future partnerships a high priority. In the meantime, it should review and validate the information the partnerships submit because that is one of the primary means the Department has to monitor the program. We also identified some actions the Department must complete, including its reorganization, finalizing its contracts with the Department of Insurance and the Ombudsman, and establishing and convening the key statewide oversight committees.

The Department Should Document the Actions Partnerships Take in Response To the Readiness Reviews	Before allowing a partnership to enroll members, the Department has to certify that the partnership is ready. It sends a team of people to do an on-site review of the partnership and identifies areas that need corrective action. We reviewed the readiness reviews for both regions that were conducted in September 1997 and identified what corrective action each partnership had to take. Although it appears that the actions were taken, we were not always able to locate documentation to show the action was taken or that the action was taken on a timely basis. The reviews involve staff from multiple sections of the Department, making coordination of follow up difficult.

Six more partnerships will be having readiness reviews next spring, according to the Department's schedule. In addition, the Department also will be preparing to implement behavioral health waivers[4]. To make sure all the required actions are taken, we recommend that the Department establish a centralized system for receiving and reviewing information obtained from the partnerships.

The Department Should Ensure That Encounter Data Are Received and Analyzed

The Department is requiring a significant amount of "encounter" data from the partnerships to help it evaluate the managed care program. Encounter data are records of health care services that have been provided—in essence, records of each encounter a member has with a health care provider. The data are used by Department staff and by the external quality review organization for such things as assessing whether health care services are being underutilized, identifying trends or problems in utilization, evaluating access to care, and updating and evaluating capitation rates. The encounter data are a key element for monitoring the program and ensuring it fulfills its objectives. Department staff said that in November 1998, the partnerships began transmitting encounter data from the early months of the program to the Department. As of early December, the pharmacy encounter data had not been submitted. However, Department staff said they expected those data soon. Department staff also said they thought the encounter data would be "caught up" by late January 1999.

The Department has the authority to assess penalties against the partnerships if encounter data are not submitted timely but, to date, has not done so. We recommend that the Department place a high priority on obtaining and analyzing encounter data.

The Department Should Ensure Required Reports from the Partnerships are Received And Validated, and Areas of Concern are Addressed

The partnerships are required to submit reports on a pre-determined schedule. We reviewed the reports the partnerships submitted for the quarter ending March 31, 1998. Although most of the reports were submitted as required, both partnerships failed to submit a few of the required reports. For instance, Region 3 did not provide information on out-patient drug utilization or Early Periodic Screening, Diagnostic, and Testing (EPSDT) services. Region 5 did not submit information on ambulatory care utilization or primary care physician ratios.

We also reviewed the report the Department submitted to HCFA for the quarter ending June 30, 1998. One of the areas in the report that raised questions

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[4] The Department is in the process of establishing a managed behavioral health care program to provide mental health services to Medicaid recipients. That program also will be provided through a Medicaid waiver.

included the number of complaints reported. Region 3 reported it logged 1,135 complaints, while Region 5 reported 19.

HCFA staff reviewed the reports the partnerships sent in for the quarter ending June 30, 1998. They raised some questions about some of the information presented. For instance, they questioned the reported utilization rates for emergency room visits because the data indicated that all categories of members experienced more than 50% utilization rate for these services. HCFA said those figures seemed extremely high and said the Department should validate these data. In addition, HCFA staff noted that some of the data provided by the partnerships was not consistent from one report to another, and they were reluctant to rely on it.

HCFA staff noted that some of the data provided by the partnerships was not consistent from one report to another and they were reluctant to rely on it.

HCFA officials also told us they want the Department to begin performing more analyses of the data submitted by the partnerships, rather than merely providing HCFA with the raw data. Staff must be sure that any problems or "red flags" the reports raise are fully reviewed. Department staff are starting to do limited validation and analysis of some of the data they have received and are working with the partnerships to ensure the requirements are clear and that they submit the necessary reports.

We recommend that the Department take steps to ensure that all required reports are submitted and fully validate the data submitted by the partnerships. Given the types of problems identified, it is even more critical for the Department to be able to get encounter data from the partnerships so it can adequately monitor the program.

The Department Needs To Continue Its Efforts To Ensure That the Program Operates As Intended

The areas discussed below did not appear to be causing significant problems; however, the Department should continue to keep an eye on them to ensure that the program runs smoothly and to avoid future problems.

Complete the Reorganization of the Department. As noted earlier, the Department anticipates it will have the remaining six partnerships in place by the beginning of the next fiscal year. That means the Department will have to conduct readiness reviews for each of these regions, as well as continue to monitor the activities of Regions 3 and 5. The Department also will be establishing the behavioral health regions and will have to continue to run a traditional fee-for-service program for some of its Medicaid population.

Overseeing a Medicaid managed care program requires different skills from running a Medicaid claims system.

Overseeing a Medicaid managed care program requires skills different from those required to run a Medicaid claims system. For instance, proper oversight will require more staff with medical backgrounds and analytical skills. According to a study of the managed care program in Arizona, overseeing a managed care program may even require additional staff. When HCFA gave the Department its approval to allow the partnerships to enroll Medicaid members, it also said the Department staff working on quality issues "*is operating with a minimum of staff…. Additional staffing should be seriously considered as more regions are implemented since readiness reviews will continue to be resource intensive, and ongoing monitoring efforts will need to be maintained for plans that have already been implemented.*"

According to a study of the managed care program in Arizona, overseeing a managed care program may even require additional staff.

We spoke with a HCFA staff person who said Kentucky historically has had a low level of expenditures for administration. We compared Kentucky's administrative expenditures for fiscal years 1996 and 1997 to other states.

Table 8: **Comparison of Kentucky Medicaid Administrative Expenditures**

Administrative Expenditures as a Proportion Of Total Medicaid Expenditures		
	Fiscal Year 1996	Fiscal Year 1997
Kentucky	2.72%	2.55%
All States	3.66%	3.53%

Source: HCFA

The figure above, coupled with the comments of HCFA staff, suggest that Kentucky does not have an excessive number of administrative staff as compared with the rest of the country. Because monitoring a managed care program generally requires more staff than a traditional Medicaid program, the Department will have to pay particular attention to its staff to ensure it can carry out its monitoring functions effectively.

The Department has begun a reorganization to transform itself from an organization that processes Medicaid claims to an organization that oversees managed care specifically and health outcomes in general. We recommend that the Department finalize the reorganization as soon as possible. As the reorganization takes hold, we recommend that the Department make sure that the reorganization addresses its new role and that it has adequate numbers of appropriately qualified staff.

Administrative Costs May Grow, But The Moneys
Will Be Spent on Different Activities

Concerns have been raised that under the partnership program, administrative costs will grow significantly since both the Department and the eight partnerships will now make expenditures for these types of expenses.

One of the things that should be noted about any change in administrative costs is that program administration is expected to be much different under a managed care program. Administrative costs, therefore, include expenditures for such activities as case management of medically fragile recipients, patient education materials to increase the use of preventive services, pre-authorization of services or medications, and member and provider services systems. Many of these efforts did not exist under the fee-for-service program.

The Department's administration costs also will shift to emphasize their focus on the monitoring of the partnerships. They will be doing more analytical work, coordinating clinical studies, and conducting on-site reviews at the partnerships. These efforts are expected to be directed at improving health care instead of simply paying for health expenditures.

If the Department is successful at meeting its goals of reducing costs while increasing health care quality, it is likely that administrative expenditures will increase.

Sign an Agreement with the Department of Insurance for Fiscal Year 1999. The Department of Insurance has agreed to review the financial reports submitted by the partnerships to ensure they meet the required solvency requirements. An agreement was in place for fiscal year 1998, but the fiscal year 1999 agreement has not been signed yet because Department of Insurance staff said they needed clarifications on how the Department for Medicaid Services wants certain financial information interpreted.

Establish Key Advisory Committees. The Quality and Access Recipient Advisory Committee is supposed to be made up of members and advocates who broadly represent members enrolled in the partnerships. Its purpose is to provide advice on quality and access standards and other policies that affect members. The Committee has not met yet, even though two partnerships have been in operation for more than one year. Department staff said the original makeup of the committee would have included too many members from the two regions that were already in operation. The Department is in the process of contacting additional committee members to ensure broader, statewide representation.

The Quality Council is composed of health care professionals and consumers. It is supposed to advise the Department and the partnerships on various quality improvement activities. This Council also has never met.

Both the failure to get a signed agreement with the Department of Insurance and the slow pace at forming oversight committees may be due, in part, to a limited number of staff and to the lower priorities these staff place on activities that are not directly related to getting partnerships in place. However, these requirements are key elements of the oversight the Department should be providing. We recommend that these committees be placed in operation as soon as possible.

Document Actual Program Savings. As noted earlier in the report, the managed care program has been set up to ensure that it will save money, and the Department's biennial budget has been established assuming that the estimated savings will occur. Nevertheless, we recommend that the Department determine exactly how much it has been able to save by shifting to managed care. With that data, the Department also should try to determine where savings have occurred and in what regions so that good practices can be transferred to other regions to maximize the state's health care dollar.

Another reason for determining actual savings is to certify any savings for transfer to the Indigent Care Trust Fund.

Another reason for determining actual savings is to certify any savings for transfer to the Indigent Care Trust Fund in accordance with KRS 205.6336. This fund, established during the 1994 Session of the General Assembly, requires that savings from managed care be transferred to the fund and held until appropriated by the legislature. While no money is currently in the fund, the General Assembly wanted to ensure that any savings from managed care would be set aside for future health care services for additional categories of citizens and not spent for other purposes.

While the language of the Program Protocol document would indicate that the fund was to include any savings from managed care in comparison to the previous fee-for-service program, the actual legislation establishing the trust fund

Only a thorough analysis of Medicaid costs and identification of unanticipated savings will provide any funding for the Indigent Care Trust Fund.

defines the savings as the difference between the budgeted appropriation to the Department and actual managed care costs. Since the Department's budget factored in the reduction in Medicaid expenditures due to managed care implementation, only unanticipated savings from managed care will be eligible for the transfer to the fund. Only a thorough analysis of Medicaid costs and identification of unanticipated savings will provide any funding for the Indigent Care Trust Fund.

Concerns Which Should Be Addressed

During the course of our audit, we also identified some other areas of concern. These areas were beyond the scope of this audit, but they merit further consideration.

Budget Impact If Partnerships Do Not Become Operational: One concern is what will happen if partnerships do not get established in the other six regions. The Department has the authority to contract with commercial HMOs or provider-sponsored delivery networks if a partnership does not get established. If commercial plans end up providing health care services in one or more of the regions, there could be a negative impact on the Department's budget, which has been established based on operating partnerships. Perhaps an even greater concern is whether commercial HMOs or other entities would even be interested in providing services in a region. In recent months there have been news reports indicating that numerous commercial HMOs are pulling out of Medicaid managed care programs. If the Department has to revert to providing health care using the traditional fee-for-service approach, there will certainly be an impact on its budget. The Department may wish to develop some degree of contingency planning and alternative budget scenarios well ahead of any such outcome.

Impact of Managed Care on Local Health Departments: According to legislative testimony, local health departments have seen their revenues drop since the partnerships began operation. The health departments' clinical work also has declined, and some departments have had to cut staff. The concern is that the health departments will not be able to serve the role as safety net for indigent people not eligible for Medicaid. The Cabinet and the Legislature may wish to evaluate the role of the health departments and also evaluate different funding mechanisms. The Department, working with the partnerships, can ensure that the services of health departments are used when justified on a cost and health care management basis.

Recommendations

To ensure that the Medicaid managed care partnership program works as intended, that partnership activities are adequately overseen and monitored, and that Medicaid recipient health care remains of acceptable quality, we recommend that the Department of Medicaid Services:

1. Develop an Ombudsman program, as required by the waiver, as soon as possible.

2. Establish a centralized repository for documenting the corrective actions required of the partnerships by the Department. One person should be designated to ensure that all the required actions have been taken before the partnerships begin enrolling members.

3. Develop a centralized repository for receiving, recording, and following up on provider complaints and grievances. Use the information about such complaints to determine what changes should be made to the program.

4. Make receipt and analysis of encounter data a high priority, including 1) penalizing regions who fail to submit encounter data within 6 months of operations and 2) designating a certain number of staff with full-time responsibility for encounter data analysis. As new partnerships begin to develop, the Department should use the lessons it learned about encounter data in Regions 3 and 5 to make the process of submitting these data smoother. As necessary, the Department should make changes to its information systems, including the Medicaid Management Information System, to ensure it can use the encounter data to effectively monitor the program.

5. Ensure that partnerships submit all their required reports. Department staff should review those reports to make sure the information contained in them is logical and reasonable. The Department also should analyze the information contained in those reports to help it monitor the program, particularly until the encounter data are submitted on a regular basis.

6. Finalize the Department reorganization. Department staff should periodically evaluate the reorganization to ensure it meets the Department's needs as managed care becomes more integrated within Medicaid Services. This analysis should include an evaluation of proper staffing levels and appropriate background, skills, and knowledge of staff.

7. Evaluate the cost of the managed care program and determine the actual savings it has generated compared to what expenditures would have been under the traditional program. It should provide this information to the appropriate legislative committees so they can keep informed about the success of the program.

8. Make all necessary appointments of members of the Quality and Access Recipient Advisory Committee and the Quality Council, as well as ensure that these committees are convened and have regular meetings, and have adequate orientation to their important role.

Response to Agency Comments

The Department generally agreed with our findings and said it would implement each of the recommendations. For instance, one person in the new Division of Physical Health will be designated as the central repository for documenting corrective action required of partnerships. That Division also will be responsible for designing a uniform method for handling provider complaints. The Department's complete response can be found at Appendix IX.

Scope and Methodology

Scope

We performed our audit in accordance with generally accepted government auditing standards. The audit's purpose was to provide an overview of the Medicaid managed care partnership program and to recommend ways the program could be improved as the Department expands it across the state. The fieldwork was conducted in the Department for Medicaid Services and in each partnership region from June 1998 through October 1998.

Methodology

To obtain an overall understanding of the program and the Department's oversight of the program, we interviewed officials of the managed care development team at the Department for Medicaid Services. We also interviewed officials from the Region 3 partnership in Louisville and the Region 5 partnership in Lexington. We also interviewed officials who were trying to establish partnerships in the other six regions of Kentucky.

In addition, we reviewed the following information:
- The Commonwealth of Kentucky, Section 1115 Waiver, Abstract of the Kentucky Health Care Partnership Amendment
- The Kentucky Health Care Partnership Program Protocol
- The Department's "Request for Application" document and attachments
- The Rate-Setting Methodology prepared for the Department by William M. Mercer, Inc.
- Applications submitted by the partnerships in Regions 3 and 5
- The Department's contracts with the partnerships in Regions 3 and 5
- Quarterly reports submitted by the partnerships in Regions 3 and 5
- Quarterly reports the Department submitted to HCFA
- "Readiness Reviews" for Regions 3 and 5 and materials submitted by the partnerships in response to those reviews
- Minutes of various committees created to oversee the partnership program at the Department and at each partnership

Review of Complaint System

To determine whether the state has a system to handle beneficiary and provider complaints, we reviewed the requirements set forth in the Program Protocol for handling complaints and grievances. We reviewed Department and partnership policies and procedures and interviewed Department and partnership staff to find out how the process actually worked. We also selected a sample of member complaints to review:

- We reviewed 27 complaints received by the Department from the period October 1997 through August 1998. The Department received 189 managed care complaints through June 1998. The number of managed care complaints received in July and August 1998 was not readily available. However, if the Department received complaints during that period at about the same rate it received in the previous quarter, we estimate managed care complaints during July and August 1998 to be about 85. Thus, we sampled about 10% of the estimated 274 managed care complaints during the time period reviewed

- We reviewed 23 complaints in Region 3. We selected two dates and reviewed the complaints handled by different member services representatives on those days. Because this resulted in such a small sample,

we selected another day at random and reviewed all the complaints received that day.

- We also reviewed all 13 complaints in the Kentucky Health Select complaint log for April 1998.

We did not verify that the various complaint systems adequately summarized complaint totals because that was outside the scope of this audit. Instead, our purpose was to determine whether the complaints we reviewed were handled appropriately.

Review of Department's Efforts to Ensure an Adequate Network

To determine whether the Department has a system to ensure beneficiaries have adequate access to health care, we interviewed Department staff about how they ensure access. We also reviewed information submitted by each partnership documenting their network, and reviewed the activities Department staff undertook to determine whether each network was adequate.

Survey of Members and Providers

To determine how satisfied members and providers were with the managed care program, we conducted a mail survey of members and providers in Region 3 and Region 5.

Each partnership provided us with a list of their members as of July 1, 1998. We asked for information about each member so we could break the population down by type of member and number of encounters. We did not verify the accuracy of the information provided; however, we checked the number of members in each partnership against Department records on the number of members paid for each month. The numbers were reasonably close so we were fairly confident that we had received a full listing of all the members at each partnership.

We divided each partnership into nine groups and randomly selected members from each group as shown below:

Region 3 [a]:

Group	Total Members	Sample Size	Returned Surveys
AFDC with "0" encounters	14,917	20	3
AFDC with 1 to 16 encounters	20,062	60	6
AFDC with >16 encounters	619	20	3
SOBRA with "0" encounters	8,614	20	3
SOBRA with 1 to 16 encounters	12,727	60	13
SOBRA with >16 encounters	498	20	3
SSI with "0" encounters	12,305	20	11
SSI with 1 to 16 encounters	16,367	60	19
SSI with >16 encounters	1,081	20	7
Totals	**87,190**	**300**	**68**

(a) In addition, there were 6 cases with no membership category and 28 foster care cases. Because these were such small groups, we eliminated them from our sample.

Region 5 [a] **:**

Group	Total Members	Sample Size	Returned Surveys
AFDC with "0" encounters	5,407	20	1
AFDC with 1 to 16 encounters	14,448	60	8
AFDC with >16 encounters	656	20	6
SOBRA with "0" encounters	3,938	20	2
SOBRA with 1 to 16 encounters	12,077	60	15
SOBRA with >16 encounters	717	20	4
SSI with "0" encounters	9,787	20	8
SSI with 1 to 16 encounters	11,610	60	22
SSI with >16 encounters	529	20	3
No category listed	4,161	10	2
Totals	**63,330**	**310**	**71**

(a)   There were 16 foster care cases in this population. There also were 24 members with a negative number of encounters. We eliminated both these groups from the population. In addition, there were 4,161 members with no category listed. We sampled 10 of these to reduce any bias from not including these members in our population. As a result, we ended up surveyed a total of 310 members enrolled in Kentucky Health Select.

Region 3 Providers: We obtained the three provider directories from Region 3: the Provider Directory, the Specialist Directory, and the Direct Access Provider Directory. (These directories were current as of January and February 1998. The partnership was in the process of updating these directories at the time of the audit, but the updated information was not yet available. Region 3 officials said the directories would include most of the existing providers, and we decided the directories were the best source of information.) We went through the directories and eliminated duplicate listings and counted the number of providers in several different categories. Because each member has to have a primary care physician, we decided to make that category the largest. Members also have a lot of contact with pharmacists, so we surveyed a relatively large number of pharmacists. Because of concerns that managed care results in underutilization of health care services, we wanted to be sure we had adequate coverage of specialists. Finally, we wanted to make sure we surveyed some members from the other groups of health care professionals. We selected an interval sample from each category. Our final survey distribution was as follows:

Provider Category	Total Providers	Sample Size	Returned Surveys
Primary Care Physicians	676	40	⎱ 20
Specialists	1,024	31	⎰
Pharmacies	248	30	12
Hospitals	20	5	0
Multi-Specialty Groups [a]	39	7	⎱
Ancillary Services [b]	79	5	⎰ 10
Direct Access [c]	271	8	⎰
Totals	**2,357**	**126**	**42**

(a)   These include family planning providers, an ambulatory clinic, and local health departments.
(b)   These include radiologists and home health providers.
(c)   This group includes dentists and vision professionals.

Region 5 Providers: We obtained a computer diskette that contained the names and provider specialty codes of the providers under contract with Kentucky Health Select. We also obtained two provider directories. One directory had specialists listed. The other was the Provider Directory for Members. It generally contained the primary care physician listing and the direct access and ancillary providers. We eliminated the duplicate ancillary providers and multi-specialty groups from the Provider Directory. We also eliminated the Jefferson County pharmacies from the population because they would have been included in the Region 3 population. (We did sample the other counties that also were in Region 3 because they generally bordered on counties served by Kentucky Health Select and seemed more likely to serve Region 5 members.)

We used the information on the diskette to select primary care physicians and specialists. We sorted the listing by provider code. We eliminated 6 specialists because there was no last name on the computer listing. Because we were not able to obtain a key to the specialty code listing before we mailed our surveys out, we also eliminated 28 providers from our listing because we thought the provider code was included in other groups. (This was a small proportion of our population so we do not think it biases the survey to any extent.) After we had the population we wanted to survey from, we selected an interval sample to obtain the number of providers in each category. Once we identified the providers in our sample, we located their addresses in the directories we had obtained from Kentucky Health Select. Our final survey distribution was as follows:

Provider Category	Total Providers	Sample Size	Returned Surveys
Primary Care Physicians	464	44	23
Specialists	1,712	28	
Pharmacies	430	31	13
Hospitals	29	5	1
Multi-Specialty Groups [a]	36	7	
Ancillary Services [b]	132	11	11
Direct Access [c]	337	8	
Totals	**3,140**	**134**	**48**

(a) These include family planning providers, rural health centers, the Commission on Children with Special Needs, and local health departments.
(b) These include imaging centers, ambulatory surgical centers, dialysis centers, and home health providers.
(c) This group includes dentists and vision professionals.

Organizational Information About The Partnerships in Regions 3 and 5

Region 3 - Passport Health Plan, Louisville, Kentucky

Region 3 serves about 95,000 Medicaid recipients in 16 counties in North Central Kentucky: Carroll, Trimble, Henry, Oldham, Shelby, Jefferson, Spencer, Bullitt, Meade, Breckinridge, Hardin, Larue, Nelson, Washington, Marion, Grayson. (Originally, the region was expected to serve about 106,000 recipients.)

The Department for Medicaid Services contracted with the Region 3 Medicaid Partnership Council and with University Health Care, Inc. to provide services to Medicaid recipients in the region. The Region 3 Partnership Council serves as the region's Board of Directors. University Health Care, Inc. is the licensed HMO. It was specifically created to provide health care services to Medicaid recipients in Region 3. The following chart provides more detail about these two groups:

Region 3 Partnership Council
*(25-seat Board of Directors for
the Region, representing all
groups of providers and consumers)*

University Health Care, Inc.
*(licensed, risk-bearing entity that
was created to provide health care
for the Region)*

Seats Held By…	Owners	% Ownership
4 Hospitals	University of Louisville	
1 Federally Qualified Health Center	Medical School Practice Association	51%
7 Physicians	Jewish Hospital HealthCare Services	13%
1 Pharmacist	Alliant Health Systems	13%
1 Home Health Agency	University Medical Center, Inc.	13%
1 Nurse	Louisville-Jefferson County	
4 Consumers	Primary Care Association	10%
1 Other Practitioner		
2 Health Departments		
1 Dentist		
1 School of Medicine		
1 Commission for Children		

Administrative services, including claims processing, member and provider services, medical management, information systems, case management, and health education are provided to the partnership under a contract with AmeriHealth Mercy Health Plan, an administrative services organization based in Pennsylvania with experience managing Medicaid programs. The name given to the Medicaid plan in Region 3 is Passport Health Plan.

Medicaid recipients were phased in for enrollment as follows:

November 1997: enrolled Jefferson County AFDC recipients
January 1998: enrolled Jefferson County SSI population
March 1998: enrolled all recipients in remaining 15 counties in region

Region 5 - Kentucky Health Select, Lexington, Kentucky

Region 5 provides services to about 63,000 Medicaid recipients in 21 counties in East Central Kentucky: Nicholas, Harrison, Scott, Owen, Franklin, Bourbon, Montgomery, Clark, Fayette, Woodford, Franklin, Mercer, Jessamine, Madison, Estill, Powell, Garrard, Boyle, Lincoln, Rockcastle, Jackson. (Originally, the region was expected to serve about 71,000 recipients.)

Health care professionals in Region 5 started working on the partnership when the initial waiver was approved and eventually established the Central Kentucky Regional Provider Entity. The Fayette County Medical Society appointed a subcommittee to look at the waiver and brought in officials from the University of Kentucky. These groups formed a steering committee and broadened the representation to include members from 16 other counties in the region. These individuals formed the basis of the Central Kentucky Regional Provider Entity, a non-profit corporation that serves as the board of directors of the partnership. That group selected CHA HMO to be the licensed entity for the region. The plan name for the Medicaid recipients in Region 5 is Kentucky Health Select.

The Department for Medicaid Services has contracted with the Region 5 Managed Care Organization LLC to provide health care for the Medicaid recipients in this region. The members of this limited liability corporation are CHA HMO (the licensed, risk-bearing entity which has 99.9% of the shares in the limited liability corporation) and the Central Kentucky Regional Provider Entity (the oversight board for the region, which has the remaining shares.)

The following chart provides more detail about the two main groups in the partnership:

Central Kentucky Regional Provider Provider Entity, Inc.

(24-seat Board of Directors for the Region, representing all groups of providers and consumers)

CHA HMO

(licensed, risk-bearing entity that provides health care for the Region. Medicaid is a new part of CHA HMO's business.)

Seats Held By…	Owners	% Ownership
6 Hospitals	University of Kentucky Hospital	51.93%
6 Physicians	UK Appalachian Regional	
2 Health Departments	Health Care	23.35%
1 Dentist	St. Luke's Hospital, Northern Kentucky	14.93%
1 Home Health Agency	Our Lady Bellefonte Hospital, Ashland	4.17%
1 Pharmacist	Patti A. Clay Hospital, Richmond	3.05%
2 Other Providers	Mary Chiles Hospital, Mt. Sterling	1.73%
1 Commission for Children with	Rockcastle County Hospital	.84%
Special Health Care Needs		
4 Consumers		

Medicaid recipients were phased in for enrollment as follows:

November 1997: enrolled 10,000 AFDC members from 6 small counties in region
January 1998: enrolled the remaining 30,000 AFDC members in the region
April 1998: enrolled all elderly and disabled SSI members (23,000)

**The KenPAC Waiver Was Kentucky's Initial Attempt
To Manage Medicaid Recipients' Health Care**

In 1986, Kentucky requested a 1915(b) program waiver to establish the Kentucky Patient Access and Care program, known as KenPAC. Through this waiver, the state was allowed to enroll Medicaid Aid to Families with Children (AFDC) recipients in a mandatory physician case-management program. Essentially, the state obtained a "waiver" from the federal Medicaid requirement that recipients could select their own Medicaid providers.

Under KenPAC, the Department for Medicaid Services assigned Medicaid recipients to a primary care physician who served as their "gatekeeper." Whenever a Medicaid recipient wanted to see another physician, his/her primary care physician/gatekeeper had to approve his/her request. The state paid these primary care physicians $3 per month for each recipient whose care they oversaw. Certain services were excluded from KenPAC, such as optometry and dental. In addition, the Supplemental Security Income (SSI) category of recipients was excluded from the program.

The Department estimated that the KenPAC program saved the state $100 million annually. However, KenPAC was not truly a complete managed care program. Under KenPAC, the state paid providers fees that were based on services rendered, rather than on the basis of managed or coordinated services. As a result, primary care physicians had no incentives to encourage them to deny their patients' requests for additional or unnecessary services. Also, patients were not prohibited from "shopping around" for doctors.

**Most States Have a 1915(b) Program Waiver, but the
Use of 1115 Research and Demonstration Waivers is Growing**

According to information available from HCFA, as of June 30, 1997, 36 states had a Section 1915(b) program waiver. More than 11 million Medicaid recipients were enrolled in one of these waivers.

A total of 12 states plus the District of Columbia had Section 1115 research and demonstration waivers as of June 30, 1997. Nearly 3.6 million Medicaid recipients were enrolled in these programs. (This group does not include Kentucky, which did not enroll members in its managed care waiver program until November 1997.)

We talked with officials in Arizona, Tennessee, and Oregon about their managed care programs and reviewed available program evaluations. All three states have mandatory enrollment of virtually all their Medicaid recipients in their programs, each of which is part of a Section 1115 research and demonstration waiver just like Kentucky's managed care partnership waiver. A brief synopsis of each program follows:

Arizona: Arizona's program, called the Arizona Health Care Cost Containment System, began in 1982 when it first began to operate a Medicaid program. Virtually all Medicaid recipients receive health care services through this program, including those receiving long-term care services. The program's dual purposes are to contain costs and maintain quality. In contrast to Kentucky's regional partnership approach, services are provided through commercial and county-based HMOs. The state monitors the program using encounter data (a database of all the health care services provided to each member) submitted by the HMOs. Several studies have been conducted to evaluate the success

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of the Arizona program. In general, these studies found that, compared with estimated expenditures under a fee-for-service program, the acute-care program produced an average savings of 7 percent per year, while the long-term care program produced an average savings of 16 percent per year. The studies also found that administrative costs were higher because of expanded administrative responsibilities and functions. When compared with health care quality in a neighboring state, the studies found that Arizona's program provided a higher quality of care for children, but lower quality indicators for nursing home and prenatal care.

Tennessee: TennCare was started in 1994. It serves all Medicaid recipients. It also provides services to a large group of uninsured individuals who are not eligible for Medicaid. TennCare's program goals are somewhat broader than the goals in Kentucky, and include saving costs and providing access to those who did not previously have health insurance. Services are provided by 9 HMOs under contract with the state. The state monitors the program through analysis of encounter data and through clinical studies conducted by an external quality review organization. Savings realized from implementing the TennCare program have allowed Tennessee to enroll nearly 400,000 additional uninsured or uninsurable people with no new taxes. A 1995 report by the General Accounting Office on TennCare raised a number of concerns about the program, including its rapid approval and implementation, absence of provider buy-in, delays in implementing systems for monitoring access and quality of care, and the soundness of the rate-setting methodology. More recently, a March 1998 survey found that beneficiaries are increasingly satisfied with TennCare and that the provider community has improved the care available under the program.

Oregon: Oregon's managed care program was started in 1994. It was part of an overall statewide effort to extend health insurance coverage to additional low-income residents. All Medicaid recipients receive services. People with incomes up to 100% of the federal poverty level also are eligible for the program. The primary goal of the program is to improve Medicaid recipients' quality of health care. As an inducement to improve access, Oregon raised the reimbursements it made to health care providers to a level that would be sufficient to cover costs. Anecdotal evidence suggests this effort has been successful, but a formal evaluation has not yet been completed. In a unique effort to pay for the program, the state developed a prioritized list of health services and tied the list of services that would be funded to the budget process. Health care services are provided through 13 commercial HMOs or IPOs (independent practice organizations). As in Kentucky, the state monitors the program through the analysis of encounter data and through satisfaction surveys.

Summary of Trends in Medicaid Managed Care Enrollment
As of June 30, 1997

Year	Managed Care Enrollment	Fee-For-Service Enrollment	Total Medicaid Enrollment	Percent Managed Care
1991	2,696,397	25,582,603	28,280,000	9.53%
1992	3,634,516	27,291,874	30,926,390	11.75
1993	4,808,951	28,621,100	33,430,051	14.39
1994	7,794,250	25,839,750	33,634,000	23.17
1995	9,800,000	23,573,000	33,373,000	29.37
1996	13,330,119	19,911,028	33,241,147	40.10
1997	15,345,502	16,746,878	32,092,380	47.82

1997 Managed Care Enrollment by Type of Plan

Type of Plan	Number of Plans	Number of Enrollees
Health Insuring Organization	6	351,053
Health Maintenance Organization		
Federally Qualified	118	2,752,264
State Plan Defined	252	5,654,681
Primary Care Case Management	60	4,337,486
Prepaid Health Plan	113	3,850,589
Other	19	2,510,808
Totals	568	19,456,881 [a]

(a) Includes 4,111,379 individuals enrolled in more than one plan

Source: Health Care Financing Administration

Managed Care Enrollments (Section 1115 and Section 1915b Waivers)
As of June 30, 1997

State	1115 Managed Care Enrollment	1915(b) Managed Care Enrollment	Total Medicaid Enrollment	Percent Enrolled In Managed Care
Tennessee	1,188,570	0	1,188,570	100.00
Oregon	312,345	0	376,345	82.99
Alabama	407,643	0	497,434	81.95
Hawaii	135,200	0	166,725	81.09
Arizona	349,142	0	431,813	80.85
Delaware	65,061	0	80,561	80.76
Colorado	184,000	0	228,558	80.50
District of Columbia	80,721	0	125,000	64.58
Rhode Island	70,944	0	114,162	62.14
Oklahoma	222,818	0	437,161	50.97
Minnesota	169,329	0	402,787	42.04
Ohio	352,833	0	1,095,268	32.21
Vermont	22,946	0	96,985	23.66
Alaska	0	0	87,475	0.00
Arkansas	0	159,458	267,525	59.60
California	0	1,854,294	4,791,253	38.70
Connecticut	0	231,966	360,246	64.39
Florida	0	896,559	1,410,881	63.55
Georgia	0	560,771	881,632	63.61
Idaho	0	32,428	80,553	40.26
Illinois	0	187,048	1,370,354	13.65
Indiana	0	220,000	405,000	54.32
Iowa	0	88,282	217,668	40.56
Kansas	0	94,430	185,301	50.96
Kentucky	0	268,205	527,211	50.87
Louisiana	0	40,469	635,672	6.37
Maine	0	12,511	155,524	8.04
Maryland	0	347,640	465,136	74.74
Massachusetts	0	461,989	716,465	64.48
Michigan	0	865,434	1,115,903	77.55
Mississippi	0	81,255	543,560	14.95
Missouri	0	264,496	614,783	43.02
Montana	0	62,004	70,821	87.55
Nebraska	0	93,085	144,238	64.54
Nevada	0	26,376	88,500	29.80
New Hampshire	0	9,102	70,922	12.83
New Jersey	0	384,644	684,880	56.16
New Mexico	0	139,337	242,445	57.47

State	1115 Managed Care Enrollment	1915 Managed Care Enrollment	Total Medicaid Enrollment	Percent Enrolled In Managed Care
New York	0	660,725	2,296,479	28.77
North Carolina	0	351,043	825,464	42.53
North Dakota	0	24,295	45,303	53.63
Pennsylvania	0	870,365	1,585,807	54.88
Puerto Rico	0	702,250	1,261,769	55.66
South Carolina	0	14,311	393,475	3.64
South Dakota	0	41,542	60,412	68.76
Texas	0	275,951	2,079,297	13.27
Utah	0	93,785	118,343	79.25
Virgin Islands	0	0	16,654	0.00
Virginia	0	306,804	522,080	58.77
Washington	0	730,052	730,052	100.00
West Virginia	0	125,521	310,710	40.40
Wisconsin	0	205,523	422,870	48.60
Wyoming	0	0	48,348	0.00
Totals	**3,561,552**	**11,783,950**	**32,092,380**	**47.82%**

Source: Health Care Financing Administration

To: Member, Passport/Kentucky Health Select Health Plan

(The surveys noted the appropriate Health Plan, for illustration purposes, Passport is used throughout this Appendix.)

The Kentucky Auditor of Public Accounts is conducting a performance audit to determine how well the Kentucky Department of Medicaid Services is overseeing the Medicaid managed care program. The managed care plan in Louisville and surrounding counties is called Passport Health Plan.   The managed care plan in Lexington and surrounding counties is called Kentucky Health Select. To help us in our review, we are asking a sample of members of these managed care plans how satisfied they are with their health services.

We would appreciate it if you would take a few minutes to answer the following questions. We sent the survey to people who are enrolled in a managed care plan. Sometimes, the person whose name is on the survey will not be able to answer the survey themselves. In those cases, we would appreciate someone who knows about that person's health care needs to respond to the survey.   We have a place on the survey document to indicate who is responding to the survey.

The survey responses are confidential. We will not report the results of the survey in any way that will personally identify you. We would appreciate your returning the completed survey by October 2, 1998, and have enclosed a stamped, return envelope for your use.

Thank you for your assistance. If you have any questions, please feel free to call Ellyn Sipp of the Auditor's Office at (502) 564-7494 or (800) 247-9126.

Survey of Medicaid Managed Care Recipients

Name (optional)   _____
Address (optional) _____
Phone Number (optional)   _____

Who is completing this survey form? *Please place a check in the correct box:*
____   Person whose name is on the envelope
____   Spouse or partner of person whose name is on the envelope
____   Other family member of person whose name is on the envelope
____   Friend of person whose name is on the envelope
____   Someone else? What is their relationship to person
          whose name is on the envelope?   _____

Background information *(Please respond for the person whose name is on the envelope)*

1.   What county do you live in?   _____

2.   In general, would you say your health is:

18	Excellent
26	Very Good
22	Good
29	Fair
27	Poor
17	No response

3.   What month did you enroll in the managed care plan: _____

4. Are you still enrolled in the managed care plan?

    114 Yes
      5 No   **IF NO, PLEASE STOP AND RETURN THE SURVEY IN THE ENVELOPE PROVIDED**
     20 No response

5. How many people in your household are enrolled in the managed care plan?   _____

6. *What are their ages? (please put the number of people in each age group)*
    _____ Under 2
    _____ Ages 3 to 5
    _____ Ages 6 to 12
    _____ Ages 13 to 17
    _____ Age 18 or older

7. Did you receive a member handbook when you enrolled in the managed care plan?

    Yes   105
    No   11
    No response 23

Questions about your primary care physician

8. How did you get a primary care physician? (Check only one answer)

    22 I was assigned to a primary care physician who was my regular doctor
    10 I was assigned to a primary care physician who was <u>not</u> my regular doctor
    59 I selected a primary care physician who was my regular doctor on my own
    21 I selected a primary care physician who was <u>not</u> my regular doctor on my own
    27   No response

9. How would you rate the health care services provided by your primary care physician in the following areas?

	Excellent	Very Good	Good	Fair	Poor	Not Sure
Provides me with enough care to meet my medical needs	50	31	17	7	3	3
Listens to me and talks with me about my care	49	35	11	8	3	2
Is available when I need an appointment	45	30	16	4	8	2
Lets me influence the treatment I receive	29	30	18	9	2	10
Refers me to a specialist when necessary	48	28	12	4	3	10

10. Have you changed your primary care physician?

    Yes 15   No 97   No response 27
    ↓
    If yes, when did you make this change? _____

Check the reason that best describes why you changed your primary care physician.

  6   I was assigned to a primary care physician who wasn't my regular physician
  7   I didn't get along with the primary care physician I used to have
  6   I wanted a primary care physician who was closer to my home
  2   I wasn't getting the services I thought I should be getting
  4   Other

Questions about the complaint process

11. Do you know how you can make a complaint or grievance about your health care services?
    Yes 25   No 84   No response 30

    ↓

If yes, please indicate how:

12. Have you made a complaint?

    Yes 9   No 103   No response 27
    ↓

If yes, who did you complain to:

The Department of Medicaid Services	7	
My managed care plan	4	
The Office of the Ombudsman	0	
Other	0	Please tell us who _____

13. If you have made a complaint, was your problem taken care of?

    Yes _8_ No 11___
           ↓
          If no, why not?

Questions about your health care services

14. Have you tried to get health care services since being enrolled in the managed care plan?
    Yes 78   No 27   No response 34
↓
If yes, answer the following questions:

    Since being enrolled in the managed care plan, about how many visits did you make for
    yourself to a doctor's office, clinic, or hospital emergency room?

     4   None
     6   1 visit
    43   2 to 4 visits
    23   5 to 9 visits
    27   10 or more visits
    36   No response

    For the following areas, please rate your satisfaction with the health care you have received since being enrolled
    in the managed care plan:

	Excel-lent	Very Good	Good	Fair	Poor	Not Sure
Received enough care to meet my medical needs	44	32	19	3	4	0
Ability to get all the medication I needed	46	29	16	6	5	2
Ability to get all the equipment I needed	35	19	18	6	3	8
Ability to get referred to a specialist	43	25	13	3	5	8
Ability to get an appointment when needed	47	25	15	5	7	1
Ability to contact physicians after regular hours	35	20	17	4	7	13

15. Overall, how satisfied or dissatisfied are you with your managed care plan?

   70 Very Satisfied
   23 Somewhat Satisfied
    8 Neither Satisfied nor Dissatisfied
    5 Somewhat Dissatisfied
    4 Very Dissatisfied
   29 No response

16. Did you receive Medicaid benefits under the old system (before you were enrolled in the managed care plan)?
Yes 95   No 13
↓
If yes, answer the following question:
Since you have been enrolled in Passport Health Plan, have your health care services gotten better, stayed the same, or gotten worse than they were under the old Medicaid system?

   23 Much Better
   16 Somewhat Better
   38 Stayed the Same
   17 Somewhat Worse
    3 Much Worse

Do you have any other comments about the health care services you are receiving under Passport Health Plan? (We included those responses which were listed by four or more members of one of the managed care plans.)

     I'm very happy with the system, think the system is better than the old system   16
     The referral process is confusing, problematical   9
     General and specific concerns relating to availability of prescription drugs   7

Thank you for taking the time to complete this survey. If you have any questions, or would like to talk to someone about the managed care program, please feel free to call Ellyn Sipp of the Auditor's Office at (502) 564-7494 or 1-800-247-9126, or write your name at the top of the survey and place a check below:
____   I would like to talk to someone at the Auditor's Office about the managed care program.
A phone number where I can be reached: _____

To: Health Care Services Professionals

The Kentucky Auditor of Public Accounts is conducting a performance audit to determine how well the Kentucky Department for Medicaid Services is overseeing the Medicaid managed care program. To help us in our review, we are surveying a sample of physicians, pharmacists, hospital staff, home health service agency staff, and other health care professionals in Regions 3 and 5 to get their opinions about the managed care program.

We would appreciate it if you would take a few minutes to answer the following questions. The survey responses are confidential. We will not report the results of the survey in any way that will personally identify you. We would appreciate your returning the completed survey by September 30, 1998, and have enclosed a stamped, return envelope for your use.

Thank you for your assistance. If you have any questions, please feel free to call Ellyn Sipp of the Auditor's Office at (502) 564-7494 or 1-800-247-9126.

Survey of Health Care Professionals About the Medicaid Managed Care Program

Background information

1. What county(ies) do you practice or provide health care services in? _____

2. What is your specific health care profession?
   40 Physician
    3 Nurse practitioner
   25 Pharmacist
    2 Home-health services agency staff
    1 Hospital staff
    4 Durable medical equipment provider
   15 Other *(please identify)* _____

3. Are you participating in either Passport Health Plan or Kentucky Health Select? (Circle which)

   85 Yes   3 No   2 No response

           If no, please answer the following two questions only and return your survey in the enclosed envelope:
                   When did you stop participating in the plan?_____
                   Why did you stop participating in the plan?

Please complete the rest of the survey.

Comparisons of the managed care system with the previous fee-for-service system

4. Did you provide services under the Medicaid fee-for-service program (the Medicaid program that existed before the managed care program)?

   80   Yes   5 No   5 No response

   If yes, please answer the following questions:

5. Compared with the previous fee-for-service system, under the managed care plan

	Greater	Same	Less
The number of Medicaid patients I provide services to is	12	46	22
The number of services I provide to each of my Medicaid patients	4	62	14
The range of services I provide to each of my Medicaid Patients	4	64	13
The fees I receive for the services I provide are	4	20	54

6. Compared with the previous fee-for-service system, the amount of paperwork I have to submit to the Partnership for the managed care program is

      39   More Burdensome
      12   Less Burdensome
      25   About the Same
      14   No response

7. Compared with the previous fee-for-service system, the amount of paperwork I have to submit to the Department for Medicaid Services or UNISYS is

      24   More Burdensome
      13   Less Burdensome
      34   About the Same
       2   I don't submit paperwork to the Department
       2   I don't submit paperwork to UNISYS
      15   No response

Questions About Program Operations:

8. Are you aware of any problems the managed care program in your region had getting up and running? If so, please explain.

    See open-ended responses after question 13.

9. Are you aware of any on-going problems the managed care program in your region has?
If so, please explain.

    See open-ended responses after question 13.

Satisfaction with managed care:

10. Overall, how does your level of satisfaction with the managed care program compare with your satisfaction with the previous fee-for-service program?

    44 I was more satisfied with the previous fee-for-service Medicaid system
    12 I am more satisfied with the managed care system
    12 I have been satisfied with both the previous fee-for-service system and the Medicaid managed care system
     8 I haven't been satisfied with either the previous fee-for-service system or the Medicaid managed care system
    14 No response

11. Please rate your overall level of satisfaction with the managed care program:

    14 Generally Satisfied
    16 Somewhat Satisfied
    10 Neither Satisfied Nor Dissatisfied
    18 Somewhat Dissatisfied
    23 Generally Dissatisfied
     9 No response

12. Please indicate your level of agreement with the following statements:

	Mostly Agree	Somewhat Agree	Neither Agree Nor Disagree	Somewhat Disagree	Mostly Disagree
a. Under managed care, the health care of my patients can be managed better than it was under the fee-for-service Medicaid system	10	9	26	17	21
b.Under managed care, the potential for improved patient outcomes is higher than under the previous fee-for-service Medicaid system	7	12	22	21	20

13. Please describe whether your access to the following services for your patients is better, worse, or about the same under the managed care plan, as compared with the previous fee-for-service Medicaid program.

My access under managed care is…

	Much Better	Somewhat better	About the Same	Somewhat Worse	Much Worse
Specialists	2	4	30	9	11
Prescriptions	5	16	26	13	5
Hospitalizations	1	2	35	8	3
Home health services	1	2	24	10	4
Durable medical equipment	2	5	23	10	3
Other (list) _____	0	0	1	0	4

Additional comments: (We listed responses from five or more health professionals from either one of the partnerships.)

Problems identified with billing: timeliness, explanation of benefits	18
Problems with the eligibility data, including eligibility for pharmacy	16
Fees under managed care are too low	11
Problems identified with the referral process	9
Need better patient education	9
Partnership staff need more training	5

Thank you for taking the time to complete this survey. If you have any questions, or would like to talk to someone about the managed care program, please feel free to call Ellyn Sipp of the Auditor's Office at (502) 564-7494 or 1-800-247-9126.

Health Promotion Program

A goal of the Health Care Partnership Program is to improve the health status of Medicaid recipients. Listed below are specific health care outcomes, health indicators and benchmarks which have been targeted and designated by the Department for Medicaid Services in collaboration with the Commissioners of Public Health and Mental Health & Mental Retardation. The benchmarks are general for the State and will be adjusted in collaboration with each Regional Partnership based on the health status of Recipients in the Partnership's region. The Department, as well as the regional Health Care Partnerships will be monitoring these health care outcomes, indicators and benchmarks. During the first, second and third years of operation, Partnerships will be required to collect health indicator information on their population as described in column 2. During the second year of operation Partnerships must meet agreed upon adjusted screening benchmarks. Year 3, Partnerships must meet agreed upon adjusted outcome benchmarks.

HEALTH OUTCOME	SENTINEL INDICATOR (Years 1,2,3 of Partnership operation)	SCREENING BENCHMARKS (Year 2 of Partnership operation)	OUTCOME BENCHMARKS (Year 23 of Partnership operations)
Normal body weight for height for adults and children	Over/under weight/height Normal body weight for height: ≤27.8 kg/m² for men and ≤ 27.3 kg/m² for women.	85% of the Partnership's population is screened and received counseling for over or underweight	10% of the Partnership's population who were screened are within normal body weight for height.
Reduced incidence of anemia in children: Normal hemoglobin.	Abnormal Hemoglobin, Hematocrit Hgb. ≤11.0% Hct.≤ 33.0%	90% of Partnership's child population is screened for hemoglobin, 9 months of age.	65% of partnership's child population is within normal hemoglobin limits, 9 months of age.
Reduced incidence of hypertension in adults	Blood pressure more than 140/85	30% of Partnership's population is screened for hypertension, age 18-44 years. 50% of Partnership's population is screened for hypertension, age 44-64 years. 80% of Partnership's population is screened for hypertension, age 65+.	__ % of partnership's population screened for hypertension is normontensive or determined to be therapeutically controlled age 18-44 years. __ % of Partnership's population screened for hypertension is normontensive or determined to be therapeutically controlled, age 44-64 years. __ % of Partnership's population screened for hypertension is normotensive or determined to be therapeutically controlled, age 65+ years.
Reduced incidence of dental caries in children	Dental caries	40% of Partnership's child population are screened for dental caries, age 3 yrs. 20% of Partnership's child population are screened for dental caries, age 9-15.	80% of Partnership's population screened are free of dental caries, age 3 years. 80% of Partnership's child population screened are free of dental caries, age 9- 15 years.
Normal Glucose	HgA1c	85% of Partnership's non-pregnant population symptomatic for diabetes mellitus are screened.	80% of Partnership's non-pregnant population with diabetes mellitus are therapeutically controlled as measure by HgA1c <8% or no more than 15.8 deaths per 100,0000 persons.
Normal growth and development for children	EPSDT for children up to age 21	80% of infants, children and adolescents under the age of 21, will have age-appropriate EPSDT services.	80% of infants, children and adolescents under the age of 21, will have age-appropriate EPSDT services
Reduced incidence of depression in adults	Depression as detected through clinical judgment or a standardized instrument, such as (Beck Depression Inventory or Zung Self-reported Depression Scale)	30% of Partnership population is screened for depression using a standardized instrument or clinical judgment.	80% of partnership's population who receive a new prescription for an anti-depressant are personally seen to evaluate medication response no sooner than two weeks and no greater than eight weeks after the date of the prescription. Severe cases, weekly for 6-8 weeks then every 4-12 weeks after symptoms resolved.

Fiscally Incented Healthcare Outcomes

A Health Care Partnership may receive financial incentive payments based on the achievement of health outcomes. Health outcomes may be achieved before the end of year 3. The Partnership may select up to 4 health outcomes from the fiscally incented list. The incentive payment shall be an amount up to one percent of the capitation payment or .25 percent for each outcome. The payment will be made annually upon submission of documentation that the benchmark related to the health care outcome has been achieved. An external organization under contract with the Department for Medicaid Services will validate the achievement of the benchmarks.

HEALTH OUTCOME	SENTINEL INDICATOR	OUTCOME BENCHMARK
Live, healthy birth*	Birth weight: - less than 1500 grams; - less than 2500 grams	95% of partnership's live births will be more than 2500 grams.
Pregnant female with normal delivery*	Prenatal visit during first trimester	90% of the Partnership's pregnant population will have a prenatal visit in the first trimester or within four weeks of enrollment; and
		90% of the Partnership's pregnant women will have been screened for hepatitis B and other sexually transmitted diseases; and
	11-13 prenatal visits during pregnancy	90% of the Partnership's pregnant women will have documentation of history, assessment and counseling about the effects of nicotine, alcohol or other substance use in fetal development; and
		80% of the partnership's pregnant women will receive expected number of prenatal care visits; and
	Postpartum visit within 42 days of delivery	65% of the Partnership's pregnant women who had a live birth had a postpartum visit by the 42nd day.
Reduced incidence of vaccine - preventable disease*	Immunizations: 4 DTP or DtaP; 4 HIB; 3 Polio; 1 MMR3; 3 hepatitis B	90% child members of Partnership's by 35 mos. have received appropriate immunizations.
Well children and adolescents	Counseling	75% of children and adolescents ages 9-21 of Partnership will have received counseling related to the risks associated with the use of alcohol, drugs, sexual activity, not using seat belts.
Well infants and children	Fluoride is <0.6 ppm in water supply	80% of children of the Partnership to age six whose water supply is <0.6 ppm. fluoridated will have received fluoride supplementation.
Reduced mortality from breast cancer*	Mammogram and follow-up to abnormal finding	60% of women, ages 52-69 of the Partnership's population have a mammogram every year.
Reduced mortality from cervical cancer*	Pap test and follow-up to abnormal finding	95% of women ages 21-64 of the Partnership's population (or younger if sexually active) have at least one Pap test every three years.
Reduced incidence of unintended pregnancy	Counseling	75% of women of the Partnership's population at risk of pregnancy have received risk appropriate counseling.
Reduced mortality from heart disease*	Serum cholesterol screening	75% of adults, ages 21 and older, of the Partnership's population have serum cholesterol screening every five years.
	Beta blocker after heart attack	75% of Partnership's population who were hospitalized and discharged alive received a prescription for beta blockers upon discharge.
Optimal nutrients/antibodies for infants up to age six months.	Counseling for mothers about infant feeding, and breastfeeding first six months of life	25% of infants of the Partnership have human milk as their primary nutrition for the first six months.

* Health Plan Employer Data & Information Set measures

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

December 17, 1998

Mr. James Rose
Director of Performance Audit
144 Capitol Annex
Frankfort, Kentucky 40601-3448

Dear Mr. Rose:

We appreciate your review of our managed care program and the opportunity to comment on your report "Oversight of Kentucky's Medicaid Managed Care Initiative".

On page 1 in the chart narrative:

$1.9 million should be replaced with $1.9 billion.

On page 3, KenPAC Waiver box:

After-hours telephone coverage was required in KenPAC. This was accomplished by various telephone transfer methods in order to reach the primary care provider or his/her designee.

On page 7, last line:

Department officials told us they plan to keep target increases to about 3% mirror increases experienced in the general fund.

On pages 10-11, Start-Up Problems:

Eligibility Data
The report makes note in several locations of inaccurate eligibility data. While it is true that the Department has included (on the member listing of the plans) certain recipients that were not initially intended to appear on those listings; 1) the Department pays the appropriate capitation payment as required, and 2) the plan agreed to serve all members who appear on their member listing. Some of the members who appear on that listing may be in other programs, which were not expected to be assigned to managed care such as people in home and community-based waivers, nursing homes, etc.

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While individual plans may have additional administrative coordination activities for some of their members, the plan is responsible for all of their services, which are covered by their contract. The Department makes every effort to modify the member listing as quickly as possible. This approach to the member listings is taken to guarantee that eligible Medicaid recipients receive all covered services. The word is unanticipated not necessarily mean "inaccurate".

On page 13, Pharmacy Costs Overruns:

Actuarial Data-Pharmacy
The most consistent complaint by both operating plans regarding inaccurate data is related to the pharmacy per member per month figures in the Mercer data book. Page 5 of the data book contains the following statement: "The data contained in this rate setting process has been adjusted to reflect these (pharmacy) rebates. Mercer reduced claims and TPL for Pharmacy by 18.43% for FY95 and FY96."

In reviewing the budgeted figures on page 13 of the audit report, it appears that both plans adopted pharmacy expenditure targets close to the Mercer numbers. Neither Region 3 nor Region 5 expected drug rebates of 18%. While we believe that savings equivalent to the amount of the rebate may be achieved in the third or fourth year of a plan because of changes in prescription practices, improved prior authorization and other managed care practices, it is not expected that such a savings could be achieved in the first year. Therefore, a plan would have had to plan and achieve savings in other service areas to make-up for the delay in savings in pharmacy costs.

On page 24, Health Care Providers:

We believe that one of the important components of the dissatisfaction of providers is the risk sharing arrangements within the plan, which implements a provider withhold. To date, plans have not returned these withholds but are expected to do so at least on a partial basis within the first quarter of calendar year 1999. This action by the plans should temper some of the provider dissatisfaction.

On page 30, Concerns Which Should be Addressed:

Budget Impact if Partnerships do not become operational:

The Department is very aware of the potential negative of the Partnership start-ups but is committed to implementing them as quickly as possible and will develop alternative actions if necessary.

Impact of Managed Care on Local Health Departments:

The Department for Medicaid Services is continuing its dialogue with the Department for Public Health, local health departments and the Partnership Plans to guarantee the role of local health departments as significant participants in managed care and in their role as safety net providers. The Department is considering several options in response to potential adverse actions.

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Recommendations

The following numbered responses are provided to the numbered recommendations, which begin
on page 30 of the draft report:

1. The Department is currently in discussion with the Cabinet's Office of Program Support to
   evaluate whether to implement the Ombudsman program at the Cabinet level or release a
   request for proposal. We intend to have contracting completed by the end of the first quarter of
   the 1999 calendar year.
2. Within the reorganization of Medicaid Services, one person in the Division of Physical Health
   will be designated as the central repository for documenting corrective action required of the
   Partnerships to ensure that all the required actions have been taken before the Partnerships
   begin enrolling members.
3. The Division of Physical Health will be the responsible agent for designing a uniform method of
   receiving, recording and following up on provider complaints. The Division may also adopt
   changes in policy and/or procedure resulting from valid complaints. Provider complaints are
   expected to be received throughout the Department, but particularly by the Division of Member
   and Provider Services.
4. To date Region 3 has submitted encounter data through May 1998, excluding pharmacy.
   Region 5 has submitted encounter data through February 1998, excluding pharmacy.

   In order to emphasize the need for timely receipt of encounter data, the Department will require
   that new partnerships have a dedicated telephone line for transmission of encounter data.
   Thorough testing of the system will be required prior to start-up. After start-up, if encounter
   data received from the partnership does not include encounter data from all the partnership's
   subcontractors within six months, then, the Department will impose a penalty on the next
   month's capitation.

   The Department for Medicaid Services has developed and is currently using its managed care
   information system (MCIS). Pandora MCIS now contains 3 years of historical fee-for-service
   data that will be used for trend analysis of hospital, emergency room, physician office, and
   other health provider utilization as well patterns in high volume, high cost procedures and
   diagnoses. The health care partnerships have submitted managed care encounter data that is
   being incorporated into the Pandora MCIS. The Department has performed some baseline
   analyses of Medicaid claims over the last year for the purpose of establishing existing health
   care patterns and utilization trends. The Department has also started comparing this with
   health care utilization data submitted by the partnerships in their quarterly reports to Medicaid.
   The overall responsibility for monitoring will reside in the Division of Physical Health.
5. The Department has already initiated procedures to ensure that reports submitted from
   partnerships undergo additional evaluation and analysis and will continue to perform
   additional analyses.
6. The Department for Medicaid Services' reorganization is scheduled to be implemented January
   16, 1999. Part of the reorganization includes a transition team, which will identify necessary
   work assignments, staffing, orientation and skill building to accomplish all components of the
   Department's work plan including the managed care components.
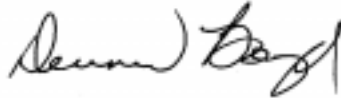
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7. The Department will annually identify savings, which are attributed to managed care and report to the appropriate legislative committees.
8. The Department expects to have all appointments to the Quality and Recipient Access Advisory Committee and the Quality Council completed in order to have the initial meeting in the first quarter of the 1997 calendar year.

If you have any questions, please contact Richard T. Heine at (502) 564-7940.

Sincerely,

Dennis Boyd, Commissioner
Department for Medicaid Services

JM:DB:RH/vls

cc: John Morse
        Larry McCarthy
        Richard T. Heine

EDUCATION
PAYS

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Services Offered By Our Office

The staff of the APA office performs a host of services for governmental entities across the state. Our primary concern is the protection of taxpayer funds and furtherance of good government by elected officials and their staffs. Our services include:

Performance Audits: The Division of Performance Audit conducts performance audits, performance measurement reviews, benchmarking studies, and risk assessments of government entities and programs at the state and local level in order to identify opportunities for increased efficiency and effectiveness.

Financial Audits: The Division of Financial Audit conducts financial statement and other financial-related engagements for both state and local government entities. Annually the division releases its opinion on the Commonwealth of Kentucky's financial statements and use of federal funds.

Investigations: Our fraud hotline, 1-800-KY-ALERT (592-5378), and referrals from various agencies and citizens produce numerous cases of suspected fraud and misuse of public funds. Staff conduct investigations in order to determine whether referral of a case to prosecutorial offices is warranted.

Training and Consultation: We annually conduct training sessions and offer consultation for government officials across the state. These events are designed to assist officials in the accounting and compliance aspects of their positions.

General Questions

General questions should be directed to Donna Dixon, Intergovernmental Liaison, or Ed Lynch, Director of Communications, at (502) 564-5841 or the address above.