

Risk-Based Managed Care in Kentucky: A Second Year Implementation Report and Assessment of Beneficiary Perceptions

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EXECUTIVE SUMMARY

This is the second year report in a series of reports that will be prepared during a three-year evaluation of the statewide implementation of risk-based managed care in seven of Kentucky's Medicaid regions. The evaluation is designed to assess the short- and medium- term effects of risk-based managed care implementation on the major partners- beneficiaries, providers, plans, and the state, with an eye toward understanding the impacts on the provision of care. This study is funded by the Foundation for a Healthy Kentucky. The evaluation team brings together researchers from the Urban Institute (Dr. Genevieve M. Kenney, Dr. Embry Howell, and Ashley Palmer), the University of Kentucky (Dr. Jeffrey Talbert, Dr. Julia Costich, and James Lutz), and Georgia State University (Dr. James Marton). The Foundation has convened an advisory group for the evaluation that includes representatives from key provider and advocacy groups, the Department for Medicaid Services, the state legislature, and other state agencies. This advisory group has met twice a year throughout the course of the evaluation.

This report provides an update on the implementation issues identified in our year one report based on stakeholder interviews and document review, and incorporates information obtained in ten focus groups across the state to provide insights about beneficiary experiences and their perceptions of changes to care. The insights presented here are not meant to be generalizable to the entire Medicaid population in Kentucky. Instead, our planned quantitative analyses, which will be informed by these focus group findings, will provide information on service utilization changes for the entire Medicaid population following statewide implementation of Medicaid managed care in our year three report.

The main findings of this report include:

- Since our year one report, one health plan has exited the market, but financial trends and enrollment patterns have improved substantially for the remaining two plans. Humana, Passport, and Anthem will soon begin serving the Medicaid expansion population in these seven regions of the state.
- Providers report that they are receiving more timely payments, but still express some concerns with prior authorization procedures and denied claims.
- The state infrastructure for overseeing health plans and monitoring access and quality has improved considerably over the past year. Information flows regularly to the Advisory Council for Medical Assistance and HEDIS scores are now being provided to beneficiaries to help with plan selection.
- Most focus group participants did not experience problems with plan assignment or have trouble changing plans, although some reported having difficulty understanding the differences among plans.
- Focus group participants reported generally positive experiences gaining access to primary care providers, and they were generally satisfied with the primary care that they received.

- A few focus group participants noted difficulty finding a specialist and some said that they had difficulty getting a prior authorization for a needed service. However, extremely high need focus group participants did not have these difficulties, likely due to special systems in place to serve those populations.
- The majority of focus group participants said they had no trouble accessing emergency services.
- Focus group participants also reported very few problems accessing dental and vision services.
- Getting access to needed pharmaceuticals was one area that caused problems for some focus group participants particularly for those using the behavioral health system. Some perceived new medications to be less effective than those they had previously received and some reported not receiving medications that their physician felt they needed. A few complained of a long trial and error period before receiving access to an effective drug.
- Focus group participants using behavioral health services had more concerns about managed care including: uncertainty about case management, changes in outpatient services offered and authorized by health plans, more restricted access to pharmaceuticals, and concern about not being able to access mental and physical health services on the same day in some cases. Some of these issues may be a by-product of a shift in the supply of behavioral health services being offered through the Kentucky Medicaid program.
- Health plan case management programs have been implemented by all the plans, targeting the highest need patients.

Kentucky's Medicaid program has evolved considerably since risk-based managed care was implemented in seven of eight Medicaid regions in November of 2011. The addition of new populations in 2014 to Medicaid under the Affordable Care Act expansion poses new challenges and opportunities for the health care delivery system. Thus, monitoring access to health care will continue to be important, particularly for populations that need behavioral health services who are expected to face significant changes to the structure of available health services.

INTRODUCTION

In November, 2011, the State of Kentucky contracted with three health plans- CoventryCares (Coventry), Kentucky Spirit, and WellCare- to provide Medicaid services to beneficiaries in seven of the state's eight Medicaid regions.¹ This represented a major change for both providers and patients in the delivery and administration of health services. The Foundation for a Healthy Kentucky has contracted with the Urban Institute to conduct a three-year qualitative and quantitative assessment of Kentucky's Medicaid managed care implementation. This year two evaluation report provides an update on implementation issues covered in our year one report (from the perspective of key stakeholders),² and additional information regarding the beneficiary experiences with Medicaid managed care based on focus groups held with 72 Medicaid beneficiaries.

The first evaluation report was based on a review of documents and interviews with key stakeholders. The interviews, completed about eight months after health plans became operational, were designed to gain an understanding of implementation issues impacting each of the major stakeholder groups. Interviewees included representatives from the Kentucky Cabinet for Health and Family Services (which oversees Medicaid), each of the health plans, provider representatives, and patient advocates. We found significant implementation problems, including financial difficulties for plans, which eventually led one health plan (Kentucky Spirit) to exit the market and caused general concern about the sustainability of the managed care system. Providers reported increased administrative and financial burdens, including delays in prior authorization for services, claims denials and appeals to resolve those denials, difficulty communicating effectively with the health plans, and difficulty with the plans' coding and administrative systems. Plans contended that these issues were due to a lack of familiarity on the part of providers with national coding standards and managed care policies. Such issues led to litigation between one key hospital system in the eastern part of the state (Appalachian Regional Healthcare) and Coventry health plan, which tried to terminate ARH's participation status. Judge

¹ The eighth region has been served by Passport health plan since 1997. In 2012, the region also began to be served by WellCare, Coventry, and Humana managed care plans. Because the region has a long history of participation in managed care, it was not a focus of our evaluation.

² Ashley Palmer, Embry Howell, Julia Costich & Genevieve Kenney. "Evaluation of Statewide Risk-Based Managed Care in Kentucky: A First Year Implementation Report." October, 2012.

Karl Forester ordered Coventry to honor the terms of its initial letter of agreement with the hospital system³. Patient advocates also voiced concerns regarding limitations in access to pharmaceuticals and negative impacts on the state's behavioral health system. All stakeholders hoped that case management programs would lead to better provision of health care services for patients in the future, but at the time of our case study interviews these programs were still being developed.

At the time of the first report, the Cabinet was transitioning from operating a fee-for-service system to oversight of managed health plans. Reorganization was underway. The Department for Medicaid Services was adding key staff and expanding their expertise in Medicaid managed care.

In the first section of this report, we update and expand on the implementation information provided in year one. In the second section of the report, we provide information on patient experiences under managed care. This information comes primarily from focus group participants, though contextual information from case study interviews is also included. We focus on understanding how managed care affects continuity of care (primarily through the assignment of plans and providers), and whether patients report changes to access to or quality of primary care, specialty care, emergency care, dental and vision care, prescription drugs, behavioral health services, and case management services.

METHODS

This report is based on a review of public documents, including contracts, financial documents, reports, and newspaper articles, a series of 18 interviews with stakeholders, and 10 focus groups with Medicaid managed care members in 3 regions of the state. These methods derive from the qualitative component of the evaluation, which is designed to describe the implementation process and raise issues pertaining to patient care that will be investigated further using quantitative data. Our approach is to present the comments and topics from the interviews and focus groups, but in most cases we do not editorialize on their likelihood, possible impacts, or

³ Appalachian Regional Healthcare et al. vs. Coventry Health and Life Insurance Company, et al.

investigate their accuracy. Quantitative findings will be the subject of the year 3 report, and will provide an assessment of some of the issues raised in this report. We received Institutional Review Board (IRB) approval for both components of the project, which ensures that the design of the research meets high ethical standards.

The report relies on multiple sources of information in order to assess support for themes that emerged from more than one type of information and themes that were heard from multiple focus group participants across different types of groups. This process is called “saturation” in qualitative research, and is achieved when the same themes are heard multiple times. The focus group findings are not meant to be broadly representative of the Kentucky Medicaid patient population.

Case Study Interviews

Stakeholder interviews took place by telephone during June to September, 2013, and were supplemented by email communication with advisory group members and state officials. Most interviewees had also been interviewed for the first report. Table 1 shows the number and types of interviewees, and Appendix A lists the informants and their affiliations. Interviewees included representatives of: the state; the three health plans which enrolled Medicaid beneficiaries in the seven Medicaid regions pre-expansion (Coventry, Kentucky Spirit, and WellCare); providers; and patient advocates. Provider informants included individual practitioners, association staff, and financial or administrative staff. A semi-structured interview protocol was used to guide each interview; interview questions were carefully crafted for each respondent based on our research questions and year one interview.

Table 1: Types of Stakeholders Interviewed

Interviewee Type	Number of Interviewees
State Official	4
Health Plan Representative	3
Provider Representative	8
Patient Advocate	4
Total Number of Stakeholder Interviews	19

Case study notes were transcribed, and coded using NVIVO qualitative research software. Respondents were assured of anonymity and encouraged to provide honest opinions regarding Medicaid managed care and its impact on their lives.

Focus Groups

To obtain a patient perspective, focus groups were conducted in July 2013 with four different groups of Medicaid managed care members:

- Parents of non-disabled children
- Parents of children with special health care needs (CSHCN)
- Adults with disabilities
- Adults utilizing behavioral health services

These groups represent differing levels of health status and interaction with the Kentucky Medicaid system. For example, non-disabled children generally will use the health system less than children with special health care needs⁴. Adults utilizing behavioral health services were expected to be the most affected by Medicaid managed care given the reductions in therapeutic rehabilitation (TR) services and changes to behavioral health medication that were documented in our first report. Adults with disabilities and children with special health care needs also tend to be high-need groups, who use different types of health care services. Participants in focus groups were chosen to provide geographic diversity-- with representation of managed care members in the regions of Lexington, Hazard, and Madisonville—and to represent a range of conditions. These locations were chosen to reflect variations in experience deriving from the varied populations and provider markets in the state. For example, eastern Kentucky has high Medicaid enrollment and longstanding provider shortages, although a large proportion of providers who practice in the area have historically accepted Medicaid patients. In contrast, western Kentucky has lower rates of provider participation in Medicaid. Three focus groups were conducted with parents of non-disabled children (one in each region), three groups of adults with disabilities (one in each region), two groups with adults who had received behavioral health services (from Lexington and Hazard), and two groups of parents of children with special health care needs (from Lexington and Hazard). Table 2 summarizes the demographic characteristics of attendees

⁴ Merle McPherson, Polly Arango, Harriette Fox, Cassie Lauer, Margaret McManus, Paul W. Newacheck, James M. Perrin. Jack P. Shonkoff & Bonnie Strickland. *Pediatrics* 1998; 102; 137.

at each focus group. Focus group attendees are not intended to represent the broader Medicaid population. For example, a majority of attendees were white females.

Table 2: Summary of Focus Group Attendee Characteristics

Group	Type of Focus Group	Location	Number of Attendees	Number of Women	Number of Men	Number of White Attendees	Number of Black Attendees
1	Parents of CSHCN	Lexington	5	5	0	4	1
2	Disabled Adults	Lexington	8	8	0	1	7
3	Adults with Behavioral Health Needs	Lexington	10	9	1	6	4
4	Parents of Non-Disabled Children	Lexington	9	7	2	4	5
5	Parents of Non-Disabled Children	Hazard	6	6	0	6	0
6	Disabled Adults	Hazard	8	7	1	7*	0
7	Adults with Behavioral Health Needs	Hazard	12	12	0	12	0
8	Parents of CSHCN	Hazard	4	3	1	4	0
9	Disabled Adults	Madisonville	4	4	0	4	0
10	Parents of Non-Disabled Children	Madisonville	9	8	1	8*	0
Total			72	67	5	53*	17*

*Two focus group participants were not easily identified as black or white.

**Only one white female participant in group 8 was a new participant. The other 3 participants had also participated as disabled adults.

Recruitment was designed to assure that participants represented a broad spectrum of Medicaid enrollees (not just, for example, those who had particularly good or bad experiences with managed care). For 8 of the 10 focus groups, recruitment took place through local provider organizations (for example, community health centers), which were asked to recruit all eligible patients who visited their site on a chosen date. For the two behavioral health groups, recruitment was managed by the local chapters of the National Alliance on Mental Illness (NAMI). NAMI was asked to use a similar recruitment strategy, identifying individuals

systematically as they arrived on a chosen day to reduce the possibility of bias. One group of disabled individuals was recruited through a home health director; that group had a higher level of medical need than other disabled groups. Further information on recruitment is included in Appendix B.

Focus group notes were transcribed and coded using NVIVO qualitative research software. Respondents were assured of anonymity and encouraged to provide honest opinions regarding Medicaid managed care and its impact on their lives.

FINDINGS

There are two types of findings in this report pertaining to the second year of implementation of Medicaid managed care in Kentucky. The first addresses whether and how the implementation issues identified in year one have been resolved. The second set of findings detail the focus group participants' perspectives on their experiences with Medicaid managed care.

Resolution of Implementation Issues from Year One

Document review and interviews with key informants suggest that there have been several key improvements during the second year of implementation, which have resulted in greater program stability. In addition, the state has substantially increased its capacity to monitor and oversee the health plans, clearly articulating an interest in assuring good patient outcomes.

Health Plan Stability in the Marketplace

During the first year of implementation, plans reported significant churning of membership and a difficult financial position, which led some informants to speculate that one or two plans might decide to exit the Kentucky Medicaid market. During the third quarter of 2012, Kentucky Spirit announced a decision to depart, and it officially left Kentucky Medicaid on July 5, 2013. This created additional enrollment for Coventry and WellCare as Kentucky Spirit enrollees were auto-assigned to them⁵ based on an algorithm that accounted for previous provider relationships, maintaining consistency within the household, and load balancing across plans. It is expected

⁵ Members received notification of the transition by July 6, 2013.

that enrollment will continue to increase for these two plans when the Medicaid expansion is implemented on January 1, 2014. Combined with the enhanced financial position of the two plans (described below), the enrollment increases are likely to lead to improved stability of the remaining two health plans.

The stability of the remaining plans is particularly important in the near-term. New plans (Humana, WellCare and Coventry) are operating in the Louisville region, and beginning next year, Humana, Passport and Anthem will begin serving the Medicaid expansion population in the other seven regions of the state. Having these additional players in the market should increase competition in the Kentucky Medicaid program, which could make it easier for the state to meet the CMS requirement to have at least two plans operating in each region in future years. Providers report that the addition of plans in the marketplace will cause more administrative hassles for them, and one plan noted concern that the presence of additional health plans could give providers additional leverage to raise their prices.

Table 3 shows trends in enrollment growth for the three health plans. WellCare's enrollment has grown substantially, while Kentucky Spirit's enrollment was declining before it exited the market. Coventry had also been experiencing a decline in enrollment until July 2013 when Kentucky Spirit enrollees were re-assigned.

Table 3: Health Plan Enrollment (Calendar Year)

	Coventry	Kentucky Spirit	WellCare
2011, Q4	221,395	180,365	128,901
2012, Q1	234,440	145,700	149,402
2012, Q2	240,410	143,500	153,590
2012, Q3	237,596	145,400	158,490
2012, Q4	199,980	135,800	207,000
2013, Q1	210,704	134,384	228,245
2013, Q2	206,099	130,593	225,016
*2013,Q3	259,076	0	273,842

Source: Citi Investment Research and Analysis

*Source: Kentucky Medicaid Statistics. [<http://www.chfs.ky.gov/dms/stats.htm>]

In our year one evaluation report, some stakeholders we interviewed speculated that the health plans may have underbid their contracts with the state for a variety of reasons. Available data on plan medical loss ratios, which identifies the percentage of income that the plan is spending on health care (see Table 4 below), demonstrated that the plans were experiencing major financial losses in the first year following implementation. Throughout the first two quarters of operations, Coventry experienced the highest level of financial losses. However, the state implemented risk adjustment on April 15, 2012 based on the chronic illness and disability payment system (CDPS) Rx model, which uses diagnosis codes from claims data to determine the risk profiles of each plan's enrollment base.⁶ This methodology was designed to be cost neutral to the state, resulting in a decrease in payment for Kentucky Spirit (the plan deemed to have the healthiest enrollees), and an increase for Coventry and WellCare. Following the risk adjustment, Kentucky Spirit began to see larger financial losses, Coventry began to lose less money, and WellCare's financial position remained consistent (Table 4.)

⁶ The Revision of CDPS and the Development of a Combined Diagnostic and Pharmacy Based Risk Adjustment Model. Accessed online November 9,2013 at [http://cdps.ucsd.edu/CDPS_Update.pdf].

Beginning January 1, 2013, the state increased capitation rates for all three health plans by 7 percent. (Kentucky Spirit declined the offer.) The increase was in response to claims from the health plans about inaccurate data books from which their bids were developed, as well as other legal claims, and also accounted for some additional benefits (such as smoking cessation). The increase has had a positive impact on plan financial performance, and medical loss ratios. The remaining two plans, Coventry and WellCare, no longer spend more money on medical care than they receive from the state (see Table 4).

“Having a rate structure that is appropriate allows us to focus on what we do best... care of members and quality. What’s driving us is the excitement from changing from ‘How are we going to be able to sustain in this market?’ to ‘How are we going to be able to improve health outcomes and what programs do we want to put in place?’”- Health Plan

Table 4: Medical Loss Ratio by Health Plan (Calendar Year)

	Coventry	Kentucky Spirit	WellCare
2011, Q4	116.6%	103.3%	102.5%
2012, Q1	120.7%	104.5%	103.9%
2012, Q2	110.5%	119.7%	107.6%
2012, Q3	108.0%	117.1%	104.6%
2012, Q4	95.9%	123.5%	99.2%
2013, Q1	91.8%	115.9%	87.9%
2013, Q2	87.2%	114.6%	84.6%

Source (for Coventry and WellCare): Citi Investment Research and Analysis

Source (for Kentucky Spirit): Statutory filings, available with the National Association of Insurance Commissioners

State Budgetary Performance under Managed Care

State budgetary performance under managed care is another critical component of program stability. Achieving cost savings was a major goal and rationale for implementing managed care. Although we did not perform a comprehensive assessment of the budgetary implications of Medicaid managed care, the 7% increase in capitation rates that was implemented in 2013 would be expected to exert upward pressure on state Medicaid expenditures, as with the movement of

members from Kentucky Spirit, the lowest cost plan, to Coventry and WellCare. Nevertheless, state officials report that managed care continues to save state dollars, and Governor Beshear recently stated that managed care was still on course towards the goal of saving \$390 million dollars of state funds⁷.

Provider Reimbursement

Last year, providers reported cash flow issues, largely stemming from health plan delays in providing reimbursement for delivered health care services. Despite managed care rates that were generally on par with or higher than fee-for-service rates, there were reports that providers were extending lines of credit in order to maintain their normal operations.⁸ Providers and plans report that payment issues stemming from billing procedures and coding issues have improved. Only two of eight providers noted ongoing issues with reimbursement. Providers credit the involvement of the Department of Insurance (DOI) in assuring that “clean claims” (those that were not denied by the health plan) are paid in a timely fashion, though one plan informant reported that providers misuse the DOI process by submitting a substantial numbers of claims that are unrelated to prompt payment. Additional experience has also been helpful in allowing providers to adapt specific managed care organization coding policies, an improvement noted by plans and providers. Educational forums held in each of the eight Medicaid regions during the months of May, June and July 2013 were beneficial to resolving some of these issues.

Some providers remain concerned about the level of reimbursement that they are offered through managed care. For example, some providers received a per-member-per-month “KenPAC” payment under fee-for-service, and only a subset of those providers have been able to negotiate a similar payment with the health plans. An informant noted concerns with the level of reimbursement offered to pharmacists under managed care. Dispensing fees have dropped significantly (from about \$4.50 to \$5.00 under fee-for-service to \$1.00 to \$1.50 under managed care), and some specific drugs are now reimbursed below cost.

⁷ Accessed online November 17, 2013 at [<http://www.kentucky.com/2013/10/24/2893374/beshear-says-medicaid-managed.html>]

⁸ “Edelen makes recommendations to improve Kentucky’s new Medicaid managed care system.” Adam Edelen, Auditor of Public Accounts. Press Release. February 29, 2012.

“Significant numbers of Kentucky pharmacies lose money every day on prescriptions they fill.” –Provider

Prior Authorization

Providers now express concern about the number of claims denied for lack of prior authorization. Four of eight providers expressed this concern. One health plan informant noted that the processes for obtaining prior authorization had, in fact, changed. The informant reported that the plan had allowed providers time to transition in the beginning, and are now following more standard prior authorization procedures. Health plans confirmed that a lack of prior authorization is a top reason for claims denial.

State data show that less than 1%⁹ of requests for prior authorization were denied under fee-for-service, and that number is up to 6% under managed care.¹⁰ According to state officials, this is within national norms. Providers point out that this is a large difference, and that formularies and other health plan policies change so quickly that it can be hard to keep up with the policy changes while providing quality care to patients.

Provider confusion may be partly attributable to differences in prior authorization requirements among plans. A state official noted that the prior authorization lists of the three companies were 95% the same. However, the other 5%-- those differences between what is authorized by one plan versus another-- may confuse providers. Table 5 shows that Coventry also had a much higher rate of denied prior authorizations in May, 2013, and this pattern is consistent with data from other months.

Table 5: Percentage of Denied Prior Authorizations

Coventry	Kentucky Spirit	WellCare
12.1%	4.2%	3.4%

Source: May, 2013 Monthly Comparison Dashboard of Health Plans

⁹ Source: Interviews with state and provider informants.

¹⁰ Department for Medicaid Services. Slides Presented by Lawrence Kissner, Commissioner. Regional Meetings June 2013. Commonwealth of Kentucky. Cabinet for Health and Family Services.

This suggests that patients who transition from Kentucky Spirit to Coventry may find that their services are subject to new prior authorization requirements. According to Kentucky Spirit leadership, WellCare and Coventry were provided detailed summaries for medically fragile members and were notified of any prior authorizations that Kentucky Spirit had made on behalf of the transitioned members. However, prior authorization decisions will become the responsibility of the company that covers the member.

When prior authorization is received from a health plan, providers report that it can be imperfectly implemented. For example, two providers described claims that had received prior authorization, but were denied for a lack of authorization. One of these providers reported that there had been a coding discrepancy between the service that was authorized and billed for a small portion of problem claims (about 5%), but the health plan had erred in the remaining 95%.

“Ninety-five percent of the time it was a (health plan) not making a payment on a claim there should have been a payment on.” –Provider

Denied Claims

Although provider payment for “clean claims” has improved over the past year, services that are provided but subsequently denied by plans continue to be problematic for some providers. Four of eight providers noted this issue. A common example of this problem was the issue of multiple well-child check-ups in a particular year. State officials note that physicians sometimes code a sports physical as a well-child check-up, which can lead to a denial for additional check-ups. For providers, this is problematic on two counts: 1. Providers may be unaware of visits that the child has already had in a given year with a different provider and; 2. Providers feel compelled to provide patients with physicals required for participation in foster care, sports, camps, new jobs, etc., but are not able to legitimately bill Medicaid for such services, because they are not considered medically necessary. This Medicaid payment issue predated the adoption of managed care; providers may have become more aware of the policy under managed care.

“Here is the biggest problem with denial of claims: There is an edit with most commercial and Medicaid companies that you can only see a child for one well visit per year. But, we are mandated as pediatricians to do sports physicals, pre-

dental surgery physicals, people going into foster care physicals, and school physicals. All of these are mandated and we do them. But if it's been less than a year since we saw the child we either get nothing or we get a very small amount for that. It's a huge problem at the moment.” -Provider

“We'll call the patient and have them come in here and get the well-child check done and then (the health plan will) deny it and won't pay us for that and say that they have had (the well-child check) done somewhere else.” –Provider

Providers expecting payment for a denied claim may appeal the claim or go through a State Fair Hearing Process in order to obtain reimbursement. A state fair hearing is a complex process that can require financial resources (the presence of an attorney is critical) and time. It is unclear how many of these appeals are won by plans versus providers, but such data would likely be skewed in favor of providers because the cost of appeal provides an incentive to appeal only when a provider has a very strong case. One provider suggests that health plans be required to bear the financial burden of appeals that they lose, to limit their incentive to deny claims unnecessarily.

“The cost of an appeal is X. But, if we win the appeal we get 2/3X. So, you're better off not appealing it.”-Provider

Indeed, data provided by the state shows that few providers appeal claims. In 2012, 27,458 (4.5%) of prior authorizations were denied. Of these, only 502 (1.8%) were appealed. The majority, 454, were worked out between the provider and the plan. Forty-two were upheld, and only 6 were overturned or partially overturned.

Monitoring Access and Quality

On July 1, 2012 Governor Steve Beshear appointed Lawrence Kissner as Kentucky Medicaid Commissioner. Kissner brought with him over 30 years of experience with managed care. He has focused on two major initiatives designed to increase the capacity of the state to oversee Medicaid managed care. First, the Commissioner is undertaking an initiative —“Medicaid University” — funded by the Robert Wood Johnson Foundation to cross-train all current Medicaid employees on managed care principles to enhance the internal resources available to Kentucky Medicaid. The training has been designed to ensure that all employees understand how Medicaid works, how it is funded, how prior authorization works, and other similar managed care principles. Second, he has increased staff capacity for Medicaid managed care oversight by contracting with firms which have experience analyzing Medicaid managed care claims data and overseeing quality and access mechanisms.

From the state’s perspective, one of the greatest advantages of managed care is the fundamental change from a reactive, claims-paying system to a proactive system in which care is managed and monitored. State and health plan representatives argue that quality of care can be expected to improve over time under this arrangement. The hope is to make systemic changes continuously, so that a long term trajectory of improvement can be sustained.

The state has made substantial strides in its capacity to oversee health plan contracts, assuring quality and access to care. The state has contracted with Rector and Associates to audit health plan payment policies, including prior authorization of services and the Island Peer Review Organization (IPRO), to oversee health plan quality and provider networks. The former contract was effective July 1, 2012, the latter September 1, 2012, and the work of both firms has been made available to a longstanding Medicaid oversight committee, the Advisory Council for Medical Assistance, in the past year. The committee is comprised of providers, health professionals, advocates, and Medicaid beneficiaries. Its establishing statute, KRS 205.550 tasks the Council with advising the Cabinet for Health and Family Services about health and medical care services, policy development, and program administration. The Council is also tasked with advising how to increase the participation of recipient members in the policy development and

program administration of the Medical Assistance Program. A health plan noted the prevalence of the new auditing requirements.

“We have three different audits going on at the same time. We have a market conduct limited scope exam going on at the governor’s request from earlier this year. We have an external quality review organization audit going on, and the desk audit from CMS which is about to take off. That is a line by line review of all the operating requirements of the contract.” –Health Plan

State officials noted the importance of increasing staff capacity for monitoring the health outcomes and service utilization of Medicaid beneficiaries, reporting that Kentucky only has about 20% of the staff available to oversee managed care, compared to the neighboring state of Tennessee. Lack of resources has inhibited detailed in-house analysis of state claims data. However, contractors like IPRO and Rector and Associates augment the capacity of staff, analytic skill, and Medicaid managed care expertise, enhancing the department’s ability to analyze claims and oversee the health plans.

“What IPRO brings to the table is expertise in helping us look at that information. One of the things they are doing is analyzing the encounter claims data to get a picture of who is getting what in what setting and who is providing that. Those pictures will help us drive policies.” –State Official

IPRO is primarily responsible for assessing quality differences among the plans. They are also responsible for quarterly monitoring of the following: “availability/ accessibility of services, continuity and coordination of care, coverage and authorization of services, provider networks, enrollee rights, confidentiality, enrollment/ disenrollment, and grievance systems”. They also do “annual assessments of sub-contractual relationships, under and over utilization of services, and health information systems”.¹¹

A standard way of assessing and comparing the quality of health plans is the Healthcare Effectiveness Data and Information Set (HEDIS), which IPRO will be collecting annually.

¹¹ Commonwealth of Kentucky. Contract with Island Peer Review Organization. Document Number PON2 746 13000000281 1. 2012.

HEDIS is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 75 measures across 8 domains of care.¹² From this information, IPRO has compiled a report card comparing the health plans across certain measures, which was sent to help patients decide between plans during the enrollment process in 2013.

Table 6: Provider Mentions of HEDIS

HEDIS Collection Practice	Number of Provider Mentions (n=7)
No changes to physician practices due to HEDIS	1
Making practice changes due to HEDIS	3
HEDIS is a large administrative burden	2

Note: 3 provider informants were not in a position to know how HEDIS was impacting physicians or practices.

Health plans are in the process of measuring baseline HEDIS scores, and are working with providers to measure and improve their HEDIS rates on particular measures. Providers had a mixed perception of how the collection of HEDIS measures was affecting their practices. Most were aware that HEDIS measures were now being collected, and three out of four providers commenting on the issue noted specific processes had changed due to the collection of HEDIS. Two providers felt that HEDIS added to the administrative burden of managed care.

“There are all sorts of HEDIS measures that (the plans) are developing... for managed care. But none of that is filtering down to the individual physician. I’m not getting calls that, ‘here are five of your patients with chronic asthma that we need to help you manage.’ We’re not getting that.” –Provider

“The one that’s happening so far is the HEDIS measure that concerns follow-up visits after a hospitalization. That’s getting a lot of attention. We are hearing that we are not seeing folks as quickly as we should. If anyone goes to the hospital, and at that stay at the hospital they have a behavioral health diagnosis that is charted, or recorded and written down someplace, that person needs to have a follow-up visit even if it’s not a primary diagnosis.” –Provider

¹² HEDIS and Performance Measurement. NCQA. Accessed online November 9, 2012 at [<http://www.ncqa.org/HEDISQualityMeasurement.aspx>].

“We have one employee who spends 70% of her time getting information together for the HEDIS review.” –Provider

“With (the health plans) pushing HEDIS guidelines, it’s made us pay more attention. After we did the first review it forced us to make improvements in our office.... When done consistently, it actually can make us a bit more money.” – Provider

In addition, IPRO will also be assessing beneficiary experiences using an annual CAHPS survey, which could provide valuable information about beneficiary experiences and perceptions that is more generalizable than the information provided from key informant interviews and focus groups.

PATIENT EXPERIENCES

A primary contribution of the year two research under this evaluation is the addition of focus groups, which allowed us to gain insights about patient experiences with managed care. We sought information on patient experiences with respect to assignment to plans and providers, changing plans and providers, and accessing needed health care and how themes emerging from the focus groups aligned with what we learned from key informant interviews and other sources in year one. Generally, focus group participants reported good experiences; though some wished more information had been available that would enable them to compare health plans before they made a choice. Participants with behavioral health needs experienced anxiety and uncertainty surrounding the move to managed care and the resulting changes to their health care. All types of focus group participants noted the impact of the new formularies under managed care on their prescribed medications.

Assignment to Plans

In year one, we reported that the state auto-assigned Medicaid beneficiaries to health plans using an auto-assignment algorithm which accounted for enrollees' historic physician relationships, consistency of household members' plan assignments, and load balancing across plans¹³.

Beneficiaries could switch their health plan within the first ninety days after initial assignment. After this period, the state reports that there is an ongoing process for ensuring that members receive access to needed services, which includes allowing disenrollment for cause when participants are not able to access needed services or providers through their current plan.

The majority of focus group participants found the enrollment process straightforward, but some participants reported problems. Many stayed with their initially assigned plan, although others switched, sometimes at the advice of their doctors. A few participants reported that their access to care was inhibited by their choice of plan, and that they were patiently awaiting open enrollment. These focus group participants did not report raising their access issues with state staff.

"I called [provider], and she said, 'we're no longer working with Kentucky Spirit, and you know, if you stay with them you'll have to find therapy somewhere else. If you want to stay with us, we're still working with Coventry and WellCare.' She said, 'hint, hint, nudge, nudge, go with WellCare.'"-Focus Group Participant

"The therapist has told me that all of their therapies have been declined through Coventry. And so that's why I've been trying so hard to switch. And I've been told, no, you have to wait for open enrollment. And then it was- no, open enrollment has passed. You can't do it... We've only got a couple more therapy sessions left with that... And she told me the same thing, that they don't deal at all with Kentucky Spirit, and that Coventry has denied every claim so far."-Focus Group Participant

A few participants reported confusion regarding plan assignment, including split assignments for families. For example, one participant noted that after Kentucky Spirit left the market, her two sons were assigned to WellCare, but she was assigned to Coventry. Another participant noted

¹³ A state official noted that that Medicaid expansion population under the Affordable Care Act has been given the opportunity to choose their own plan before being auto-assigned and that over 80% of individuals chose to do so.

that two of his children were assigned to one plan, and the third was assigned to a different plan. Member confusion was heightened by mixed information regarding plan assignments.

“I got (Kentucky Spirit and Coventry) cards all in the mail. And I’m like, ‘which one do I use?’ So we just used Coventry.” –Focus Group Participant

“He has a WellCare card. And I always get calls saying that he doesn’t have WellCare.” –Focus Group Participant

Plan Education and Experiences Changing Plans

After enrollees receive a letter from the state notifying them of their assigned health plan and the 90 day window for changing health plans, they also receive information from their assigned plan. Participants described this information as voluminous, but many noted that the comparative information they would value most had to be sought out. Some participants reported that they asked their health care providers for assistance in selecting a plan, while others were unsure where to turn for assistance. These enrollees were generally looking for more specific information regarding coverage of the prescription drugs and health care services on which they relied. Seven focus group participants out of 72 mentioned this concern. Others simply suggested that the process was stressful and made them feel overwhelmed.

“I immediately started asking, okay, what are the good plans? Which one should I go to? Because they said we could change, but it was a long process. And nobody knew. I asked doctors. I asked therapists. I asked everybody. I said, ‘I have at least one kid in each of the three. Which one is good?’ And they said, ‘well, you’ll be able to tell us.’” – Focus Group Participant

“When you start enrollment, you get a letter saying, here’s the plan we’re putting you on, and you have 90 days to switch to any of these other three organizations, and that’s all it says. It doesn’t say anything about what they do or what they’re covering.”-Focus Group Participant

State officials noted that patients received a report card which offered some comparative information on the quality of the plans starting in 2013 (see quality monitoring section above).

That information was not available in year one, since none of the plans had experience in the state of Kentucky.

Enrollees who changed plans during the open enrollment period generally found the process easy. Most participants reported no lapse in coverage during the time that a change was being applied. This process was particularly easy for those who called their new plan directly.

“You can call WellCare and ask to switch your insurance over. And they’ll do it right there, no problem.”-Focus Group Participant

Assignment to Providers and Changing Providers

At the time of enrollment into a health plan, Medicaid beneficiaries are offered a chance to choose a primary care provider (PCP). If they do not choose, they are assigned a provider. Participants reported assignment to a mix of primary care providers. Some had never met their assigned PCP, while others were assigned to the provider that they saw most often. In spite of this mixed result of PCP assignment, all participants noted that they were able to continue seeing their usual primary care doctor. Some participants seemed to disregard the name on their card, while others noted that the process of changing PCPs was available online and was particularly easy. Participants reported receiving new cards within 3 days.

Physical Health Services

Key physical health care services include: primary care services, specialty care services, emergency care, and dental and vision services. Intended impacts of managed care on these services can include increased use of routine or preventive primary and dental care, reduced use of unnecessary specialty services and unnecessary emergency room visits (this was a particular focus of the health plans’ case management programs), and reduced drug costs through use of lower-cost alternatives (discussed in the next section). However, some of these cost-saving measures may reduce access to necessary services, impede quality of care, or create additional administrative hassles for patients and providers. Examples of such unintended effects were

documented in our year one evaluation report.¹⁴ For example, the volume of providers available to patients enrolled with any health plan was restricted through the health plan contracting process, which necessarily excluded some primary and specialty care providers from select health plan networks.

Because managed care often focuses on eliminating unnecessary services or those with marginal value, one might expect enrollees' commentary on a new managed care system by patients to be primarily negative. Instead, we found the overall tenor of our conversations to be positive, with participants stating that they felt fortunate to be receiving help with their health care needs.

“We’ve got between 15 and 20 prescription medications that we don’t have to pay for... and that is such a blessing to us. We’ve got 5 people with 1 income right now... and it’s frustrating at times, with the different prescriptions and the therapies and everything. But at the same time, if that was all coming out of pocket... there is no way we could do that. So it is a blessing.”-Focus Group Participant

Table 7, below, demonstrates that very few focus group participants encountered difficulties locating a primary care provider or establishing an appointment time.¹⁵ Overall, patients faced more difficulties when they needed a specialty service, such as physical or occupational therapy, and often their difficulties were related to prior authorization for the service from their health plan. These troubles were sometimes due to Kentucky Medicaid rules, not specific to managed care. A few participants also described difficulties receiving timely emergency services, but the majority of these problems (5 out of 7 complaints) were voiced by those living in the Hazard region.

¹⁴ Ashley Palmer, Embry Howell, Julia Costich & Genevieve Kenney. “Evaluation of Statewide Risk-Based Managed Care in Kentucky: A First Year Implementation Report.” October, 2012.

¹⁵ It is important to note that patients were often recruited through the primary care system, which may have biased results in favor of those who were established patients at a primary care facility.

Table 7: Mentions of Problems Receiving Necessary Health Care Services by Type

		Number of Focus Group Participants Who Mentioned this Problem					
		Parents of Non-Disabled Children (n=24)	Parents of CSHCN (n=6)	Disabled Adults (n=20)	Adults with Behavioral Health Needs (n=22)	Total (n=72)	
Primary Care	Difficulty Finding A Primary Care Doctor	1	1	0	1	3	
	Difficulty Getting Primary Care Appointments When Needed	2	1	0	0	3	
Specialty Care	Difficulty Finding A Specialist	2	2	2	0	6	
	Difficulty Getting Prior Authorization for Specialized Care (i.e. physical or occupational therapy)	5	4	4	0	13	
Emergency Care	Difficulty Receiving Needed ER Care	1	2	1	3	7	
Dental Care	Difficulty Receiving Needed Dental Care	0	1	1	0	2	

In spite of these generally positive opinions about their care under the new system, in focus groups we heard of some unresolved conflict between patients, providers, and health plans. For example, the denial of pain medication as not medically necessary was a common complaint among focus group participants. Some of the patient-perceived problems that we heard about are described in the paragraphs that follow.

Primary Care Services

Participants reported generally positive experiences with their primary care doctors. As table 7 shows, besides dentistry, receipt of primary care was one of the most positively discussed aspects of patient care, with only 4% of focus group participants noting difficulty finding a doctor. Most healthy and disabled focus group participants identified a primary care clinic (often the place where they were recruited) as their main site for primary care, while parents of children with

special health care needs most frequently identified Kentucky's Commission for Children with Special Health Care Needs (the Commission) as their provider of primary care services. Mental health patients primarily went to a local clinic for primary care. Generally, patients noted that wait times for appointments were manageable, and that the quality of primary care they received was high.

"I go to (Clinic), and they're wonderful people. They don't treat you any different than anybody else. They're wonderful."-Focus Group Participant

"My primary care doctor, she knows everything about my kids."-Focus Group Participant

"When I make an appointment, they usually get me in 15 minutes after I get there."-Focus Group Participant

"We never have to wait."- Focus Group Participant

Most participants reported few problems getting the care that they needed once they identified a primary care provider. Those who sought care with a provider in private practice rather than from a clinic sometimes had trouble identifying one who would accept their insurance. For example, a behavioral health patient noted that it took her seven months to find a private primary care doctor. She did not want to go to a clinic. Another participant in a healthy group noted that she spent a lot of time on the phone trying to locate a private doctor before giving up and visiting a clinic.

"You call and call and call, and they're all like, no, we don't take that. No, we don't take that. No, no, no, no.... Basically, you're relegated to a clinic. It's pretty much the option you have."-Focus Group Participant

Specialty Services

The majority of focus group participants reported good experiences receiving specialty care. Six of 72 participants reported difficulty finding a specialist and 13 of 72 patients had difficulty getting a prior authorization for a needed service (see Table 7). Extremely high need participants, such as those receiving services from Kentucky’s Commission for Children with Special Health Care Needs or home health care services, reported particularly good access to specialists. This is likely attributable to the special systems that are in place for these populations, as well as to the fact that we recruited some focus group participants from settings where they had specialty care access. Kentucky’s Commission for Children with Special Health Care Needs is a state agency funded by the federal Title V maternal child services block grant that supports children with special health care needs by providing medical services other than primary care, including therapy services to children in particular diagnostic groups. Similar services have been developed in many states to provide proper service coordination, case management, transitions from tertiary to community care, and links among services within a community for this specialty population.¹⁶ Those receiving home care services were also likely to have a health plan case manager who was regularly involved in ensuring their health care needs were met, a type of support that seems likely to improve access to specialty services.

“My wife, she’s on physical therapy now. And they come to the house. And we’ve had no problems. She had a bad, bad stroke. It messed up her speech. And (health insurance) was a real gift. Everything’s been taken care of.”-Focus Group Participant

“It’s been great. You know, (a counselor was) like ‘I’m really booked up’, but if you call and just tell them I need to see you next week... and they got me an appointment this Friday. I haven’t had any problems with (specialists).”-Focus Group Participant

Other focus group participants noted difficulty locating specialists who accept Medicaid, or who accept their particular health plan. As noted in our year one evaluation report, less than 20% of

¹⁶ Ian Hill, Renee Schwalberg, Beth Zimmerman, Wilma Tilson, Henry Ireys. “Achieving Service Integration for Children with Special Health Care Needs: An Assessment of Alternative Medicaid Managed Care Models.” *Journal of Health Care Policy and Law*. Volume 5, No. 1. 2002.

specialists in three counties that were analyzed (Hopkins, Perry and Warren) contracted with all three plans.¹⁷ One participant noted that provider directories did not seem to be well-maintained, leading to lost time spent looking for a pulmonologist who was accepting Medicaid patients.

“I call (the health plan) and ask them what doctors (I can see). I need to see a pulmonologist. Can you tell me where I can go? (They say) well, tell me the name. Well, I’m wanting (them) to tell me where I can go. I went through two or three doctors (on the website)... Then I’d call, ‘oh she’s no longer here’ ‘she doesn’t take that insurance anymore’ ... I was like, my goodness, update your website so I’m not sitting here picking people...”-Focus Group Participant

“The doctor thinks (my son) has psoriasis. And he has told us that we need to see a pediatric dermatologist. And we’ve been told that there is not one in the state of Kentucky, that the medical card is not going to pay for it, so I need to be thinking about finding a dermatologist that will see my son.”-Focus Group Participant

Participants whose primary care physicians had referred them for specialized services sometimes had trouble receiving prior authorization for the service from their health plan. Table 7 shows that 13 of the 72 focus group participants experienced this difficulty. These participants often felt that their doctor’s advice regarding their health care services should not be overruled by a health plan. The prior authorization process in general was confusing for some patients, who were accustomed to simply showing up at a specialist’s office instead of going to a primary care provider for a referral. Participants most often noted that pain management and occupational therapy were among the denied services. One participant noted that her oxygen had been denied. Participants thought that the prior authorization process was inefficient and required a lot of unnecessary steps.

“I go to a respiratory doctor, and she is the one to put me on it (oxygen). So how can (the health plans)... send her a letter telling her it’s not necessary?”- Focus Group Participant

¹⁷ Ashley Palmer, Embry Howell, Julia Costich & Genevieve Kenney. “Evaluation of Statewide Risk-Based Managed Care in Kentucky: A First Year Implementation Report.” October, 2012.

State officials stated that physical therapy and occupational therapy services will become more accessible to Medicaid patients in coming years. Currently, Kentucky Medicaid does not recognize these providers as licensed professionals, which gives patients limited options for receiving services. The service must be received as a hospital outpatient service or through home health care. Physical and occupational therapy services are also available through early and periodic screening, diagnostic, and treatment (EPSDT), but failure to recognize the practitioners as independent billing entities can limit children's access.

Emergency Services

Generally, participants did not report problems accessing the emergency room. Table 7 shows that 7 of the 72 focus group participants we spoke with described difficulty accessing the emergency room services that they needed. Five of these 7 participants were from the Hazard region (5 of 27 total patients participating in Hazard). These participants were generally covered by Kentucky Spirit and Coventry, and reported more frequent travel to Lexington for needed emergency services. This may reflect the contracting situation of ARH, the largest provider of care in southeastern Kentucky which operates ten hospitals across eastern Kentucky and southern West Virginia. The ARH system is only under contract with WellCare and has pursued litigation against both Kentucky Spirit and Coventry.¹⁸ In compliance with federal law, they provide emergency services to any patient who presents at their emergency room and is in need of services, in spite of their continued difficulties with Coventry and Kentucky Spirit. However, participants sometimes found that they could receive more timely services if they traveled to a participating facility.

“They knew that (my daughter) was coming in. We called them and told them that we were coming in with a child that was not breathing. And they said they’d meet me at the ER doors. I get there, and there’s nobody there to meet me at the ER doors.... So they told me that I would have to register her, and it would be three hours. So I told them, no, we can leave there, and I can be in Lexington in two. And so we called UK hospital, and we told them, and a cop followed us all the way to UK hospital.”- Focus Group Participant

¹⁸ “Appalachian Regional Healthcare Sues Medicaid Managed Care Companies.” April 20, 2012. Available online at [<http://www.kentucky.com/2012/04/20/2158935/appalachian-regional-healthcare.html>].

“I took (my child) to ARH, and they sent her to Lexington (in an ambulance). And she was okay.”-Focus Group Participant

“I’ve heard all the stories that you’ll have to take (your sick child) to Lexington or Jackson or somewhere (if they need emergency care).... But, we didn’t have any problem. I was told by somebody that it’s probably because she’s a minor.”-Focus Group Participant

Governor Steve Beshear gave a directive in April 2013 to improve emergency room management. A joint task commission was developed which focuses on decreasing utilization by so-called “super-utilizers”, who have 10 visits to the emergency room over a 12 month period. Sixteen hospital sites have been identified and asked to identify super-utilizers and develop a plan for improving their utilization of emergency services. A discussion of plan efforts to reduce emergency room utilization is included in the case management section of this report.

Dental and Vision

Case study informants noted concern about the supply of dental providers accepting Medicaid beneficiaries in the state. This concern was expressed by health plan informants, a health department representative, and advocates in the state. However, when focus group participants were asked about their access to dental care, only two participants reported difficulty receiving needed care (see Table 7). The majority of focus group participants said they were able to easily locate a dental provider for medically necessary services, such as regular cleanings, orthodontics, and extractions.

“Dentistry takes care of my kids, and it’s all covered.”-Focus Group Participant

Patients in the Lexington and Hazard regions noted that their children receive basic dental services from the University of Kentucky (UK) dental clinics. In Hazard, informants noted that students receive dental care at a local clinic as part of UK’s dental training program, and the services are not billed to Medicaid. The two complaints about the availability of dental care were focused on the services that were not authorized by the health plans. For example, one patient noted a lack of available pain medication for dental services.

“My oldest, who is four and a half, they said he didn’t have a cavity, but he had a soft spot, and they wanted to drill. And Coventry said that he didn’t need any kind of gas or anything like that to drill. Just drill in a four-year-old’s mouth, and he’ll be fine. So... I don’t agree with that at all; I’m not going to let them just drill in my child’s mouth without anything... So, we paid for that. But that was something that should have been covered by Coventry.” –Focus Group Participant

Occasionally patients had trouble with prior authorization procedures, when unexpected dental care became necessary. Some patients seemed confused regarding what procedures were and were not covered.

“I got a letter saying WellCare was not going to pay the dentist, because while she was in the child’s mouth, and she was cleaning, and she was, you know, assessing the gums and everything, she had to take four teeth out because they were really loose. And (the child) has Down’s syndrome, and (the baby teeth) were not coming out the way they should have come out... and they did not pay. To my knowledge, they never paid (the dentist) for removing those four teeth, because she didn’t have prior authorization... but it didn’t affect me, because we still see the same dentist, and you know, we didn’t know she was going to have to do that going in there.” –Focus Group Participant

Patients in the focus groups also reported no problems receiving vision services. Eye exams and basic glasses were covered by health plans, and patients reported no problems accessing these services.

“My oldest son has glasses, and his eye care is covered. He can get one pair every year, and his check-ups are covered. He gets two check-ups a year.” –Focus Group Participant

Prescription Drugs

As shown in Table 8, 13 of 72 patients reported a problem with pharmaceuticals designed to control physical or behavioral health problems¹⁹. The problems were most apparent for the focus group participants utilizing the behavioral health system, with about 1 in 4 of these patients

¹⁹ The passage of House Bill 1 in 2012 caused a reduction in prescriptions of unnecessary pain pills and other narcotics. It required prescribers to register with the Kentucky prescription drug monitoring system, and to run a report before writing the script.

reporting problems. Prescription drug utilization and associated costs were targeted by health plans for cost control,²⁰ which led to restricted access to certain drugs, confusion regarding which drugs were covered, and occasional delays receiving medications.

Table 8: Mentions of Problems Receiving Necessary Prescription Drugs

		Number of Focus Group Participants Who Mentioned this Problem				
		Parents of Non-Disabled Children (n=24)	Parents of CSHCN (n=6)	Disabled Adults (n=20)	Adults with Behavioral Health Needs (n=22)	Total (n=72)
Prescription Drugs	Desired Drugs Not Covered by Health Plans	3	2	2	6	13

Participants who had a problem in this area complained that formularies resulted in substitution of generics or lower dosages of medication than they had previously received under Medicaid fee-for-service. Some perceived the new medications to be less effective than those they previously received. Although formularies are typically used by health plans, some focus group participants reported not receiving the medication that their physician felt they needed. Patients reported trouble getting access to pain medication and diabetic test strips. Participants with behavioral health needs had the most difficulties, accounting for 6 of the 13 complaints.

“I was on Abilify, and they (the health plan) took me off. Medicaid won’t cover my Abilify. And I’ve been taking it for years, and I was doing great. And now they put me on Risperdal... it’s the generic kind. And it’s just making me crazier. I’m afraid to tell them, though. I’m afraid to tell them, because I’m trying to get my son out of state custody.” –Focus Group Participant

“I used to get Lipitor for my cholesterol and it was good medicine. Well, they changed it. Wouldn’t pay for it no more. They put me on something called Lovastatin. My cholesterol went through the roof with Lovastatin. I’ve been on that for close to two months. My pain patches for my hips, they don’t want to pay for them. It’s a lot of my meds. My asthma inhalers, they took my good inhalers

²⁰ Ashley Palmer, Embry Howell, Julia Costich & Genevieve Kenney. “Evaluation of Statewide Risk-Based Managed Care in Kentucky: A First Year Implementation Report.” October, 2012.

and they gave me cheap ones. And then my nebulizer, they changed it too and gave me a substitute. So none of my medicine is working good no more.”-Focus Group Participant

“(My son) is on two different antipsychotics. Yes, essentially they are the same drug, but one is used more as a stabilizer than an actual antipsychotic. Coventry will not cover both antipsychotics. They say ‘you can choose one or the other’.”-Focus Group Participant

Other focus group participants reported being able to get their preferred medications, but with some delay caused by the prior authorization process. A few participants reported that the prior authorization process entailed a long period of trying medications that were ineffective.

“We had to try about four or five different reflux medications and give it a two-week span to fail, and to have him be in pain, before we could finally get to what we needed. But we had to go through I think it was either three or four different medications, and each one for two weeks. And that had to not do well, and we had to go back to the doctor, and she had to try something else. And she apologized. She said, you know, I’m sorry. This is how we have to do it. This is how, you know, Medicaid is making us do it now.” –Focus Group Participant

For other participants, their doctor’s lack of familiarity with health plan formularies caused delays in getting needed medications. This sometimes resulted in the patient acting as the intermediary between the health plan, the pharmacy, and the doctor.

“I said, just give me a few names of medications that I could take back to my doctor. And that was what I was having to do. I was having to go from Kentucky Spirit, then back to the doctor, then back to Kentucky Spirit, and back to the doctor.... I was the go-between. That’s why I was saying I feel like the insurance plan should be talking to the doctor instead of me and having me try to relay information and information getting mixed up that way.” –Focus Group Participant

In general, issues pertaining to formularies appear to be less problematic now than they were a year ago, as doctors become more accustomed to working with them and more familiar with their contents for each of the three plans.

Behavioral Health Services

Focus group participants who received services from Kentucky's behavioral health system expressed the highest levels of concern about managed care. Concerns consistently expressed by both participants and behavioral health providers included: uncertainty about the future of case management for mental health (described below), changes in authorizations for outpatient services (especially therapeutic rehabilitation), restricted access to pharmaceuticals (described in the previous section), and concern about inadequate integration of behavioral and physical health services. A few behavioral health patients expressed concerns about their ability to continue functioning as productive members of society due to these changes.

"I suffer from mental illness. What is the guarantee that I will receive medicine in the future? Is there any guarantee that I will, or is it going to disappear some day?... That is on my mind all day. Our reality depends on our meds." –Focus Group Participant

Outpatient Services

For behavioral health patients in the Kentucky Medicaid program, a typical array of services has included case management, therapeutic rehabilitation (TR) twice weekly, medications, and the services of a clinician. Of these, behavioral health patients participating in the focus groups expressed most concern about disruption in the availability of TR programs and the availability of medications.

Therapeutic rehabilitation programs are offered by Kentucky's Community Mental Health Centers (CMHCs) for adults with serious and persistent mental illnesses who live in a non-institutional setting for the specific purpose of assuring that individuals possess the physical, emotional, and intellectual skills to live, learn and work in their particular environment.²¹ In TR, patients discuss their diagnosis, the value of medication and the importance it plays to a person's recovery, personal skills (e.g. meal preparation) and pre-vocational skills. TR as delivered in Kentucky is unfamiliar to Kentucky's new Medicaid health plans, and in some cases these plans

²¹ Kentucky Medicaid Therapeutic Rehabilitation Services for Adults. Accessed online November 9, 2013 at [http://www.mhnet.com/web/groups/public/@cvty_regional_mhnet/documents/document/c074198.pdf]

have refused to cover TR services. Lack of reimbursement has caused some therapeutic rehabilitation programs to close. Examples of such closures include the Bluegrass mental health center in Lexington, the Intensive Outpatient Program in northern Kentucky (for children coming out of psychiatric hospitals), and some TR programs offered by Lifeskills, a CMHC in Bowling Green. Other TR centers are reducing or discontinuing illness management recovery (a group model of care) due to reimbursement issues. Yet other centers have stopped offering intensive substance abuse services for adolescents, because they were designed to be 4 to 6 months in duration, but health plans will only cover the service for 30 days.

*“I don’t know what I’d do without our TR program because... it means so much to us. The way they have groups with us and we get to see our psychiatrist through them, and they help us make doctor’s appointments and everything.”-
Focus Group Participant*

Focus group participants reported differences in the coverage of TR services among the health plans.

*“Coventry won’t cover TR, and TR... checks you daily to make sure that you’re not having delusions or hallucinations or the things that we fear most if you’re bipolar or schizophrenic. And they’re very careful about having people to check up on you and continually keep your medicine in you. I know I’ve not been in the hospital since I’ve attended TR with WellCare helping me. That’s a miracle.”-
Focus Group Participant*

As an alternative to TR provided in CMHCs, Coventry has partnered with three hospitals in the state (The Ridge, Baptist Corbin, and Our Lady of Peace) to provide intensive outpatient programs for mental health and substance abuse treatment.

Health plan coverage decisions may reflect differences in treatment philosophy between providers and health plans. Plans argue that the current system creates dependency for seriously mentally ill patients and that plans of care can seem ineffective when a patient has been treated for years without any sign of progress. In turn, providers argue that such serious mental illness

requires constant attention and care, that a goal of delivering less care to them is unrealistic, and that a lack of deterioration in a patient's condition can be a success.

“They (the health plans) would say you are creating dependency, not independency. They want to move people off of that. They don't want to create a patient for life.”-Focus Group Participant

Same Day Visit Coverage

The lack of integration of behavioral and physical health services is a concern among behavioral health advocates, and a common contention is that by contracting behavioral health services to a subsidiary company, Coventry and Kentucky Spirit undermine service integration. Both of these companies respond with insistence that their subsidiary companies work closely with them to achieve a comprehensive picture of each individual's care needs. Patients had a far different perspective on the issue, speaking of policies designed to assure that physical and behavioral health care are received separately. There is speculation that the separation may stem from a longstanding state-level Medicaid policy, the consequences of this lack of integration were identified as a real disruption to the daily lives of patients and an inefficiency that they perceive in the system. They were also identified by focus group participants as a recent change to care and misidentified by some as a health plan policy, which may indicate that plans are enforcing this rule more stringently than Medicaid fee-for-service had in the past. In particular, patients were bothered by health plan policies that require delivery of behavioral health and physical health services on different days in order to be authorized for payment.

“My children will see the psychiatrist... I get them out of school, we go see the psychiatrist (who prescribes medication). But we have to make sure not to schedule therapy on the same day, or Medicaid won't pay for it. So we might have to come back the next day, even though I have to take the kids out of school again. Even though we're there already, and there was an opening there. And they even accidentally scheduled us for the same day.”-Focus Group Participant

“I know with Coventry... if you go to your medical doctor, you can't go to your psychiatrist. They have to be different days. So for people that are having to make appointments, you know, several appointments throughout the week, it messes them up with their jobs. Your boss doesn't want to hear every day, ‘well, I

got to go to the dentist this day, I got to go to the doctor this day’.”-Focus Group Participant

“(Providers) are like, ‘You’re either here for this one (behavioral health services), or you’re here for that one (physical health services) and we’re not going to do both.’” –Focus Group Participant

Case Management Services

Health plans and providers offer case management services as a means of ensuring that a patient’s basic health care needs are met. These programs include patient education, coordinating doctor’s appointments and transportation, providing social services, ensuring that prescriptions get refilled and that people have the equipment at home that they need, and connecting patients to community resources. Non-disabled focus group participants and those with mild disabilities were generally not working with a case manager. Participants with behavioral health needs and children with special health care needs reported receiving case management through their local service provider (the local community mental health center or the Commission for Children with Special Needs), and state officials noted that the plans are required to reimburse all enrolled providers to provide essential functions of case management (assessment, planning, implementation, coordination, monitoring and evaluation).

Each health plan developed their own program, so there is variation among their approaches-including how people are identified for case management and how the programs are staffed. Health plan case management services are largely focused on those who frequently visit the emergency room. In general, case managers are registered nurses or social workers who help members understand their health problem, set up care with participating providers and manage the provision of care provided to the member.

A state official reported that the health plan case management programs generally focus on the 3-5% of the Medicaid population that consume the most resources and those that visit the ER frequently. Health plans usually identify high use enrollees for case management services through claims data. For example, they look at different levels of use of the emergency room, and follow-up with patients by telephone after their visit to link them to primary and specialty care after the visit.

“We actually saw a 16% decrease in ER levels 2-4 visits (those that are preventable). I think that speaks very loudly when you are talking about the volume of visits that the members actually had.” –Health Plan

Health plan case management is being monitored by the state through the plans’ reports. IPRO will also be monitoring these services and notifying the state of any issues.

Case management was generally well received by focus group participants. The sickest and most vulnerable participants whom we spoke with could identify their health plan case manager. For example, parents of CSHCN frequently commented on the Commission’s ability to coordinate their care needs.

“(The case manager at the Commission) she’ll let me know when there is a problem. We had to get my daughter into a program for her hearing aids, and (the case manager) was on top of it. She knows (about a problem) before I do.”- Focus Group Participant

All four individuals in the most disabled group (who were receiving home health care) also reported a relationship with a health plan case manager.

“(A Coventry case manager) called me on the phone and talked to me and offered me more help if I needed it... She calls me. She keeps in touch now”-Focus Group Participant

“I had an actual person call me last week and said they were sending me material for Coventry. I will have a personal case manager. I like that because, you know, if you have any trouble at all, you call her. They can help straighten out anything from a prescription mix-up to, you know, billing problems.” –Focus Group Participant

“(A WellCare case manager) checked out the house, ordered everything I needed. She ordered me a shower chair, but (the patient ended up with a bedside commode) because they (the health plan) wouldn’t give her the shower chair.” – Focus Group Participant

Case management for mental health services is offered to patients through two pathways. The Community Mental Health Centers (CMHCs) have offered case management services to patients, although the function is largely limited to mental health needs. The health plans and their subsidiaries also work directly with the CMHCs to provide care coordination services. The care coordinators hired by managed care organizations are often former CMHC employees, baccalaureate- and masters- level social workers who work with the CMHCs to ensure that a patient is receiving proper behavioral health services. The programs often focus on patients who have recently been hospitalized, ensuring that they receive proper follow-up care. Focus group participants were unable to comment on the helpfulness of care coordinators, since they generally did not interact with them directly. However, participants reported finding the CMHC case managers to be helpful in assuring that they received timely and appropriate services. A few behavioral health participants noted a decline in case management availability.

“(The case manager will) take you to the doctor... Sometimes they help you if you have a doctor bill, they’ll take you and explain who they are and see if you can get that bill marked down, you know. They take you to the eye doctor, groceries, whatever you’re really in need of and can’t afford to get to.”-Focus Group Participant

“My case manager said that he can’t spend as much time with me now (presumably because of managed care).” – Focus Group Participant

“(Case managers at) Commcare are kind of overloaded... They don’t have enough case managers to work with everyone, so they get overloaded.” –Focus Group Participant

Debate about the proper role for the CMHC case manager is ongoing. CMHCs would like to expand these case management programs to include management of physical health services. The additional service offering could help the CMHCs maintain their financial viability, and would fill a gap in services perceived by behavioral health advocates given that many patients with behavioral health issues also have other physical health care problems, and coordination of physical and behavioral health services is perceived to be a challenge. However, without the ability to bill for such services related to physical health, this type of care coordination cannot be offered. Another obstacle to the integrated care model is the absence of a Medicaid

reimbursement mechanism for primary care doctors working at CMHCs, which inhibits CMHCs from providing physical health services at their centers.

“Whether a nurse, a physician’s assistant, or a doctor, we get paid around a clinic rate which is what master’s level clinicians get paid. You can’t get a doctor for that amount. However, that would be a profound change in the service- we would be held accountable for the outcomes in that subpopulation.” –Provider

CONCLUSIONS

Since our first report on the implementation of Medicaid managed care in Kentucky, our key informants report that the state and health plans have made substantial improvements in all the problem areas that we heard about in year one. At that time, both plans and providers were very dissatisfied with many facets of Medicaid managed care and the stability of managed care was in question. Now the most serious issues have largely been resolved. The plans that remain in the market continue to undergo some transition, but their leadership is committed to remaining in the state, particularly now that trends in enrollment and financial stability make their long-term participation in the Kentucky Medicaid managed care market more feasible.

Financial Sustainability

Providers continue to report some financial difficulties stemming from prior authorization and denied claims, but they report that payment issues stemming from billing procedures and coding issues have improved over the course of the past year. In addition, the state has adjusted rates paid to plans, and the two plans remaining have improved their medical loss ratios. Their enrollments have also grown with the exit of Kentucky Spirit from the market, and will likely continue to grow under the Medicaid expansion.

State Oversight and Quality of Care Monitoring

Many of the recommendations made in our year one report have been put in place by the state, under the leadership of Commissioner Lawrence Kissner. The Commissioner has demonstrated strong leadership, bringing his own Medicaid managed care expertise to his staff, offering additional training to staff through the “Medicaid University”, and enhancing oversight of the

managed care plans through contracts with organizations that are tasked with assuring that health plans are held to the standards written in their contracts. The state has also fostered stronger collaboration with stakeholders, through regular meetings with other state agencies, support for educational forums between plans and providers, and monthly information sharing with the Advisory Council for Medical Assistance, which includes a standardized dashboard of findings at each meeting. The collection of HEDIS data has begun, and IPRO has begun to analyze the data.

Patient Experiences

In general, focus group participants reported good access to the health care services that they needed. While this may be partly due to our recruitment strategy, which focused on those who were already accessing care at particular sites, when we take the limitations of the recruitment strategy into account, it seems that providers have done what they can to insulate patients from managed care's reported adverse impacts on their practices during the implementation period, including the administrative hassles. Patients also appear to have been protected from the financial difficulties experienced by plans. The patient complaints that surfaced in the focus groups were focused on those services subject to the strictest prior authorization required by plans, particularly for certain types of specialty services, prescription drugs, TR services, and same day physical and mental health services. Case management services delivered by the health plans were generally well-received by patients, and the plans appeared to be making progress toward improving their case management approaches. Over the next year, the evaluation team will be working to assess changes in healthcare utilization quantitatively, which will give a much better understanding of the overall impact of managed care on utilization across the state.

Medicaid Expansion

Since year one of this evaluation, there have been important developments in the Medicaid managed care market in Kentucky, including the addition of plans in the Passport (greater Louisville) region of the state, and Kentucky Spirit's withdrawal from the Medicaid market. Passport, Humana, and Anthem have signed contracts to serve the Medicaid expansion population in the seven Medicaid regions that are the subject of this report.

The Medicaid expansion will provide Medicaid eligibility to an estimated additional 390,000²² Kentuckians currently earning less than 138 percent of the federal poverty level. Also, the eligibility simplification required under the Affordable Care Act (ACA) will likely result in additional Medicaid enrollment.²³ This increase in demand for Kentucky Medicaid services may strain the provider capacity in the state, particularly in areas that are already vulnerable (such as the behavioral health system). Further, the administrative burden that providers report will likely be exacerbated by the addition of new plans. The risk of having insufficient provider capacity to meet increased demand has been mitigated somewhat by increased levels of support for community health centers and primary care clinicians in the state, which have received \$75 million under the Affordable Care Act to support ongoing operations, establish new sites, expand services, and support capital improvement projects.

Behavioral Health Services

The state plans to enhance the supply of behavioral health services available in Kentucky, following a report commissioned by the Kentucky Health Benefit Exchange which found that over 80% of Kentucky counties have a workforce supply gap for mental health service providers.²⁴ The strategy is twofold. First, the state has announced a decision to expand the behavioral health network by allowing privately practicing psychologists, psychiatrists, and other behavioral health professionals to be recognized under Kentucky Medicaid rules. Second, the state will be working with IPRO to quantify and understand problems with behavioral health care. The state is interested in learning more about follow-up care being received by mental health patients leaving the hospital, and also wants to know how long patients have to wait to see a behavioral health provider.

²² Eligibility for Assistance and Projected Changes in Coverage Under the ACA: Variation Across States: Timely Analysis of Immediate Health Policy Issues. Matthew Buettgens, Genevieve Kenney, Hannah Recht, and Victoria Lynch. October 2013. Available online at: [<http://www.urban.org/UploadedPDF/412918-Eligibility-for-Assistance-and-Projected-Changes-in-Coverage-Under-the-ACA.pdf>]

²³ Analysis of the Affordable Care Act (ACA): Medicaid Expansion in Kentucky. By the Kentucky Cabinet for Health and Family Services. Accessed online November 9, 2012 at [<http://governor.ky.gov/healthierky/Documents/MedicaidExpansionWhitePaper.pdf>].

²⁴ The Commonwealth of Kentucky Health Care Workforce Capacity Report. Authored by Deloitte and sponsored by the Kentucky Health Benefit Exchange. May 2013.

Kentucky Medicaid will also be adding additional behavioral health and substance abuse benefits next January, as required by section 2001c of the Affordable Care Act (ACA). The ACA mandates mental health parity; the behavioral health benefit package must mirror the essential health benefits package. It also requires expanded coverage of substance abuse (an essential health benefit), which will be available to those enrolled in Medicaid, Medicaid expansion enrollees, and others enrolled through the Exchange.

Summary

In summary, the state has made substantial progress toward maintaining the viability of the managed care program and developing capacity to oversee health plans during year two of Medicaid managed care implementation in Kentucky. Providers and plans have also made progress in their coding and billing procedures, which has improved provider reimbursement for services, and plans have begun targeted care management programs for high-cost users. Overall, focus group participants had a positive experience with Medicaid managed care, with small percentages of participants reporting problems. Access to effective pharmaceuticals was an area of particular concern for those with physical and behavioral health needs, and individuals utilizing the behavioral health system face the greatest level of uncertainty regarding the future of their health care services.

The focus groups convened in year two have drawn attention to important areas that the quantitative component of the evaluation will address in year three using claims and encounter data on service utilization patterns. It will also be important for state leadership and the Foundation to continue to track implementation issues and implications for plans, providers, and beneficiaries as the state proceeds to absorb a large number of new enrollees into Medicaid managed care and as managed care contracts are renegotiated in the summer of 2014.

Attachment A: Key Informants

Informant Type	Name	Organization	Title
State Official	Julie Denton		State Senator
	Adam Edelen		State Auditor
	Commissioner Lawrence Kissner	Cabinet for Health and Family Services	Medicaid Commissioner
	Lisa Lee	Cabinet for Health and Family Services	State Director of Provider Operations
Health Plan Executive	Russell Harper	Coventry	Director of Government Relations
	Michael Murphy		Chief Executive Officer
	Helen Homberger	Kentucky Spirit	VP of Medical Management
	Jean Rush		Chief Executive Officer
	Kelly Munson	WellCare	Chief Operational Officer
	Pat Russell		Director of Operations
	Dr. Florence Shafiq		Medical Director
	Rhonda Warner		Director of Quality
Provider Representative	Rick King	Appalachian Regional Healthcare	Chief Legal Officer
	Bob McFalls	Kentucky Pharmacists Association	Executive Director/ Chief Executive Officer
	Annie Williams	Hazard Clinic	Hazard Clinic Practice Administrator
	Steve Shannon	KARP	KARP Executive Director
	Lindy Lady	Kentucky Medical Association	Medical Practice Advocacy Manager
	Peggy Halcomb	KY Medical Services Foundation	Director of Business Operations
	Linda Sims	Lincoln Trail District Health Plan	District Director
	Dr. Donald Neel	Pediatrician (Private Practice)	Pediatrician
Advocates	Sheila Schuster	Advocacy Action Network	Executive Director
	Tara Grieshop- Goodwin	KY Youth Advocates	Deputy Director
	Rich Seckel	KY Equal Justice Center	Director
	Regan Hunt	KY Voices for Health	Executive Director

Attachment B: Focus Group Recruitment Detail

Participant Category	Location	Date	Recruitment Strategy
1. Parents of children with special health care needs	Lexington	July 8 and July 10	Clinic staff at the Commission for Children with Special Health Care Needs recruited parents on particular days until 12 agreed
2. Medicaid beneficiaries with disabilities	Lexington	July 8	Front desk staff discussed the focus groups with all potentially eligible patients until 12 were recruited.
3. Medicaid beneficiaries with behavioral health care needs	Lexington	July 9	Recruited the first 10 patients who walked through the door on a given day and agreed to participate
4. Parents of non-disabled children	Lexington	July 9	Front desk staff distributed information and sign-up sheets to all potentially eligible patients until 12 agreed to participate.
5. Parents of non-disabled children	Hazard	July 10	A particular day was targeted and patients were recruited until 12 agreed.
6. Medicaid beneficiaries with disabilities	Hazard	July 10	Front desk staff distributed information and sign-up sheets to all potentially eligible patients until 12 were recruited.
7. Parents of children with special health care needs	Hazard	July 11	Front desk staff distributed information and sign-up sheets to all potentially eligible patients until 12 agreed.
8. Medicaid beneficiaries with behavioral health care needs	Hazard	July 11	Recruited 6 patients from Perry TR and 6 patients from Perry Solutions. Recruited the first patients encountered until 6 of each type agreed.
9. Medicaid beneficiaries with disabilities	Madisonville	July 13	Contacted home health patients to ask for their participation in focus groups. Began with a random number in the patient roster of a home health agency and called until 12 participants were recruited.
10. Parents of non-disabled Medicaid children	Madisonville	July 13	Front desk staff distributed information and sign-up sheets to all potentially eligible patients until 12 agreed to participate.