Florida Healthy Kids Program Interviews with Plan Administrators

Health Plan Organizational Structure and Processes

Reporting on Calendar Year 2010

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CONTRIBUTORS AND ACKNOWLEDGEMENTS

Jill Boylston Herndon, Ph.D.
Principal Investigator of the Florida Healthy Kids Program Evaluation
Associate Professor, Institute for Child Health Policy
and Department of Health Outcomes and Policy
Affiliate Associate Professor, Department of Pediatrics
University of Florida

Elizabeth A. Shenkman, Ph.D.
Co-Principal Investigator of the Florida Healthy Kids Program Evaluation
Director, Institute for Child Health Policy
Professor and Chair, Department of Health Outcomes and Policy
Professor, Department of Pediatrics
University of Florida

Briony Tatem, M.S.
Research Coordinator
Institute for Child Health Policy
Department of Health Outcomes and Policy
University of Florida

Meleesa Salcedo, B.S.
Research Coordinator
Institute for Child Health Policy
Department of Health Outcomes and Policy
University of Florida

Dan Ralston, B.S.
Research Assistant
Institute for Child Health Policy
Department of Health Outcomes and Policy
University of Florida

Tyag Patel, B.S.
Research Assistant
Institute for Child Health Policy
Department of Health Outcomes and Policy
University of Florida

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1. INTRODUCTION

How managed care plans organize care for their members may impact enrollees' receipt of recommended and necessary services, the quality of care provided, and member satisfaction. The Children's Health Insurance Program Reauthorization Act (CHIPRA) contains a number of provisions designed to strengthen quality of care provided in the Children's Health Insurance Program (CHIP), including external quality review activities similar to those that are required for Medicaid.[1] The Centers for Medicare and Medicaid Services (CMS) recommends that Medicaid managed care external quality reviews include in-depth interviews with managed care organization (MCO) administrators to obtain a thorough understanding of how they provide care to their membership and how they monitor the quality of care their members receive.[2] The Institute for Child Health Policy (ICHP) last conducted interviews with the administrators of health plans participating in the Florida Healthy Kids Program (FHKP) in 2010, and this year's interviews built on those responses.

2. METHODS

A. Administrative Interview Tool

A key initiative during the 2011 administrative interview process was the development and implementation of a web-based interview and data collection tool. The goals of the web-based tool were to facilitate plan responses, ICHP review of submitted information, follow-up processes, and longitudinal tracking. Plan responses are automatically stored in an electronic database. The tool includes a reporting feature that allows for customized queries of the database.

The core aspect of the administrative interview tool is a detailed questionnaire that the ICHP developed for use in interviewing health plan administrators as part of external quality review activities. The questionnaire includes recommended topic areas in CMS external quality review protocols.[3] It also includes questions that relate to health plan contract requirements and additional topics of interest to the FHKP.

The Administrative Interview questionnaire contains the following sections:

1. Organizational Structure;
2. Member Enrollment and Disenrollment,
3. Children's Programs and Preventive Care;
4. Care Coordination and Disease Management Programs for Children with Chronic Conditions or Special Health Care needs;
5. Clinical Guidelines, Performance Measures, and Quality Assessment and Performance Improvement (QAPI);
6. Member Materials, Enrollee Rights, and Member Services;
7. Provider Network;
8. Provider Reimbursement and Incentives;
9. Utilization and Referral Management;
10. Grievance Procedures;
11. Delegation;
12. Health Information Systems; and
13. Data Acquisition.

Collectively, these sections contain more than 300 questions about the plans' structures and processes as they pertain to providing services to FHKP enrollees. The responses to these questions are supported by supplementary documentation such as plan operating policies and procedures and member materials.

B. Administrative Interview Process

Administrative interviews were conducted with the seven MCOs currently serving the FHKP: Amerigroup, Blue Cross Blue Shield of Florida (BCBS) (with two FHKP product offerings – BlueOptions and BlueCare), Coventry Health Care/Vista (Coventry), Florida Health Care Plans, Inc. (FHCP), Simply Healthcare Plans (Simply), United Healthcare Plans of Florida,

Inc. (UHC), and WellCare (with two FHKP product offerings - HealthEase and Staywell).

The ICHP contacted the administrators responsible for administering the FHKP benefits via e-mail with a link to the online tool and instructions. Each plan administrator assigned the appropriate personnel within the organization to complete specific sections of the questionnaire. After reviewing the completed questions, the administrator submitted the questions to the ICHP for review. The ICHP compiled a detailed summary of each plan's responses. Each plan had the opportunity to review the summary of its responses for accuracy and to note any corrections.

3. RESULTS

A. Organizational Structure

There were seven MCOs that participated in the administrative interviews. A brief summary of each is provided below:

Amerigroup was founded in 1994 as Americaid Community Care, which focused on serving Medicaid recipients. As the company's publicly insured populations grew to include CHIP and Medicare, it changed its name to Amerigroup. Amerigroup currently serves approximately 1.9 million people in 11 states, including Florida. Amerigroup Florida has operated in the state and served FHKP enrollees since 2003.

Blue Cross and Blue Shield of Florida (BCBS) was formed by the merger of two organizations: Blue Cross of Florida, Inc. (formerly Florida Hospital Service Corporation, which began in 1944) and Blue Shield of Florida, Inc. (formerly Florida Medical Services Corporation, which began in 1946). The merger occurred in 1980 to form the consolidated entity Blue Cross and Blue Shield of Florida. BCBS of Florida has served FHKP enrollees since 1996 and has two FHKP product offerings: BlueOptions and BlueCare offered by Health Options, Inc. BlueOptions is an exclusive provider organization (EPO). BlueCare is a health maintenance organization (HMO). Health Options, Inc., which offers the BlueCare product, is a wholly owned and operated for-profit subsidiary of BCBS of Florida that was purchased in 1983 as South Florida Group Health.

Coventry Health Care of Florida, Inc., formerly known as Vista Healthplan, Inc. (Coventry/Vista) is a Florida-based MCO with corporate offices located in Broward County. Vista was originally licensed under HIP Health Plan of Florida, Inc., which was founded in 1985 as HIP Network of Florida, Inc. In 2000, Florida Healthplan Holdings, LLC, purchased HIP Health Plan. In 2001, HIP Health Plan was renamed Vista Healthplan, Inc. Beacon Health Plans, Inc., and Healthplan Southeast, Inc., were merged into Vista Healthplan Inc. at the end of 2001. In 2007, Coventry Health Care, Inc. purchased Vista's parent company. Vista is a wholly-owned subsidiary of Coventry, which is a publicly traded Fortune 500 company. In 2010, Vista changed its name to Coventry Health Care of Florida, Inc. to reflect the affiliation with its parent entity. Coventry/Vista has served FHKP enrollees since 1996.

Florida Health Care Plans, Inc. (FHCP) was incorporated as a not-for-profit entity on June 2, 1971, and began operations on July 1, 1974. FHCP became the first federally qualified HMO in Florida in 1976. In 1994, FHCP became a not-for-profit controlled affiliate of Halifax Community Health Center. Recently, in 2009, FHCP was acquired by BCBS of Florida, transitioning from a not-for-profit to a for-profit entity. FHCP was the original health plan that served the FHKP when it began as a pilot program in 1992 in Volusia County. FHCP currently serves FHKP enrollees in Collier and Volusia counties.

Simply Healthcare Plans, Inc. **(Simply)** is a Florida-based HMO that is focused on government programs. It received its certificate of authority to operate in Florida in January 2010. In 2010, Simply acquired Total Health Choice, Inc.'s assets related to the Florida Medicaid and FHKP lines of business. Simply has been serving FHKP enrollees since June 1, 2010.

United Healthcare of Florida, Inc. (UHC) was incorporated as a for-profit HMO in 1970. In 1973, it received its certificate of authority to operate as an HMO in Florida. UHC of Florida is a wholly owned subsidiary of United Healthcare, Inc., which in turn is a wholly owned subsidiary of United HealthCare Services, Inc., which in turn is a wholly owned subsidiary of UnitedHealth Group, Inc. UHC of Florida has served FHKP enrollees since 1998.

WellCare Health Plans, Inc. is the parent company of WellCare of Florida and HealthEase of Florida. WellCare of Florida was formed in 1985 as Well Care HMO by a group of physicians located in Tampa, Florida. HealthEase of Florida, Inc., was formed in 2000 to acquire Tampa General Health Plan, Inc., which was licensed as a Florida HMO in 1997. In 2002, WellCare Health Plans, Inc. (WHP) was formed to acquire various WellCare subsidiaries that operate health plans focused on government programs. Included in these acquisitions were WellCare of Florida and HealthEase of Florida, which are indirectly wholly-owned subsidiaries of WHP. WHP is a publicly traded company that specializes in providing managed care services for public insurance programs. The WellCare companies offer two product lines for the FHKP, Staywell and HealthEase, which have served FHKP enrollees since 2003.

Table 1 summarizes the plans' FHKP participation and organizational characteristics. Plans have been with the FHKP for an average of 11 years. FHCP has served FHKP enrollees since the program's inception. Simply is the plan that most recently began serving FHKP enrollees in June 2010. Amerigroup has the largest enrollment, serving more than 83,000 FHKP enrollees, followed by Staywell with almost 55,000 enrollees. The two BCBS plans, FHCP, and Simply each serve fewer than 5,000 FHKP enrollees. All plans except the BCBS plans and FHCP also participate in the Florida Medicaid program. Amerigroup, Simply, and WellCare specialize in serving publicly insured populations and have no commercial enrollment. All of the plans except BCBS Blue Options operate as for-profit organizations.

Table 1: Summary of Plan Participation in the Florida Healthy Kids Program and Other Organizational Characteristics

	Amerigroup	BCBS BlueCare	BCBS BlueOptions	Coventry Health Care	FHCP	Simply	UHC	WellCare HealthEase	WellCare Staywell
FHKP Characteristics									
Year Started Serving FHKP Enrollees	2003	1996	1996	1996	1992	2010	1998	2003	2003
FHKP Plan Model Type	HMO (Mixed)	HMO (Network)	EPO	HMO (IPA)	HMO (Mixed)	HMO (Network)	HMO (Group and IPA)	HMO (IPA)	HMO (IPA)
FHKP Enrollment as of 12/31/10	83,467	3,754	2,282	25,662	4,548	1,625	31,810	12,850	54,631
Other Florida Populations Served									
FL Medicaid Children Enrollment (0-21 years)	130,698	N/A	N/A	16,725	N/A	4,555	82,173	269,149 – WellCare overall	
FL Medicaid Adults Enrollment (>21 years)	43,761	N/A	N/A	5,474	N/A	2,351	28,041	79,087 – WellCare overall	
FL Commercial Enrollment	N/A	4,100,509 – BCBS Overall		152,924	30,555	N/A	1,896,378	N/A	N/A
Other Plan Characteristics									
For-Profit	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Publicly Traded	Yes	No	No	No	No	No	Yes	Yes	Yes
National Medicaid Members	1,630,901	N/A	N/A	N/A	N/A	N/A	3,102,924	1,340,366 – WellCare overall	
National CHIP Members	265,595	N/A	N/A	N/A	N/A	N/A	231,299	167,292 – WellCare overall	
National Commercial Members	N/A	N/A	N/A	N/A	N/A	N/A	25,672,373	N/A	N/A

B. Preventive Care & Children's Programs

Preventive Care. All plans use the American Academy of Pediatrics (AAP) preventive care guidelines. Other commonly used preventive care guidelines include those from the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) or United States Preventive Services Task Force (8 plans), Centers for Disease Control and Prevention (7 plans), Advisory Committee on Immunization Practices (6 plans), Bright Futures (5 plans), American College of Obstetricians and Gynecologists (5 plans), and National Institutes of Health (5 plans).

To facilitate provider compliance with preventive care guidelines, all but one of the plans include guidelines in the provider handbook. Other strategies include sending reminder letters to primary care providers (PCPs) (6 plans), including guidelines on the provider web portal (5 plans), providing monthly reports to providers on members due for check-ups (4 plans), and provider incentive programs (4 plans). Seven of the nine plans use internal medical record reviews to monitor preventive care to ensure all required components are included. All plans indicated that they use HEDIS® measures to ensure children are receiving preventive care. Other

common strategies of monitoring receipt of preventive care include reviewing member complaints and conducting claims analyses.

With respect to immunizations specifically, the plans cited the following methods for ensuring that PCPs provide covered immunizations to FHKP enrollees: dissemination of guidelines and immunizations schedule to providers (all plans), contract requirements and monitoring member complaints (7 plans), medical record review (6 plans), and claims data analysis (4 plans). Currently, all nine plans cover HPV vaccinations for FHKP female enrollees 9-18 years old, and eight cover the vaccine for males in the same age group. Six of the nine plans provide information for enrollees or their parents about HPV vaccination. Six of the nine plans monitor provider compliance with Chlamydia screening for female members, and four plans provide information for enrollees or their parents about Chlamydia screening. No plans have special programs to promote coordination with the FHKP dental plans.

Children's Programs. Overall, plans offer a wide range of programs for children (**Table 2**). The only programs offered by all plans were programs to encourage postpartum visits among new mothers and reminders for well-child visits and immunizations. Other programs offered to FHKP enrollees by at least 6 plans include: screening for domestic violence or child abuse, screening for substance abuse, 24-hour nurse program, asthma education, diabetes education, maternity education, and obesity education.

Other than contractual requirements with their PCPs, only three plans indicated they have special programs to encourage providers to serve as medical homes. Two of these plans (same parent organization) are currently running a pilot program that will reward and recognize primary care physicians focused on managing members with diabetes and hypertension. The third plan developed a provider information sharing report to provide individual and peer data to providers, which includes member-level information on participation in disease management programs, prescription drug use, emergency room use, and missed visits for recommended care.

Preventive Care & Children's Programs At A Glance

- All plans use American Academy of Pediatrics preventive care guidelines.
- Seven of the nine plans use medical record reviews to monitor preventive care to ensure all required components are included.
- All plans have programs for reminders for well-child visits and immunizations and programs to encourage postpartum visits among new mothers; none had special programs to promote coordination with the FHKP dental plans.
- Other commonly offered children's programs include screening for domestic violence/child abuse, screening for substance abuse, 24-hour nurse program, asthma education, diabetes education maternity education, and obesity education.
- Three plans reported having special programs to encourage PCPs to serve as medical homes.
- Three plans do not have a formal definition of children with special health care needs.
- All plans have disease management (DM) programs for asthma, and many have DM programs for diabetes, high-risk obstetrics, and congestive heart failure.
- Only four plans measure DM participation rates among their FHKP enrollees.
- All plans use specific clinical guidelines for chronic conditions, most commonly for asthma and diabetes, and all monitor provider use of guidelines.

Table 2: Summary of Children's Programs Offered by Each Plan

Children's Programs	Amerigroup	BCBS BlueCare	BCBS BlueOptions	Coventry Health Care	FHCP	Simply	UHC	WellCare HealthEase	WellCare Staywell
Reminders for well-child visits/ immunizations	X	X	X	X	X	X	X	X	X
Special programs to encourage providers to serve as medical homes	X	X	X						
Special programs to promote coordination with dental plan									
Special programs to promote coordination between PCP and dentist								X	X
Program to encourage postpartum visits among new mothers	X	X	X	X	X	X	X	X	X
Screening mechanism for domestic violence or child abuse in primary care setting	X			X	X	X	X	X	X
Screening for substance abuse in primary care setting	X	X	X	X		X	X	X	X
24-hour nurse program	X	X	X				X	X	X
Alcohol education				X				X	X
Asthma education	X	X	X	X	X	X		X	X
Children's/family newsletter	X	X	X						
Dental health education								X	X
Diabetes education	X	X	X	X	X	X		X	X
ED follow-up	X				X				
Health education programs	X								
Health fairs	X			X	X				
Maternity education	X	X	X	X		X		X	X
Obesity (childhood) education	X	X	X		X			X	X
Outreach for blood lead testing				X		X		X	X
Sexual health education				X		X			
Smoking/tobacco cessation programs	X			X		X		X	X

C. Care Coordination and Disease Management Programs for Children with Chronic Conditions or Special Health Care Needs

Children with Special Health Care Needs. Three of the plans did not provide formal definitions for children with special health care needs (CSHCN). Of those that do have a definition, three use an internal definition and three use an external definition. The six plans with definitions of CSHCN all use the following strategies to identify CSHCN: concurrent review during inpatient stays, referrals (including self-referrals and those by providers), routine review of claims and pharmacy data, and identification through pre-authorization processes. Five plans also use new enrollee health risk assessments, and the two WellCare plans use a specific CSHCN screening tool. Seven of the nine plans require individual written treatment plans for members with chronic conditions or special health care needs. Among these plans, all include the member's PCP, the member, and the member's family in the development of the written treatment plan. Most also involve the member's specialist providers. Five of the

plans monitor provider adherence to the treatment plan, typically through health plan staff calls to the provider. Member compliance with the treatment plan is monitored through a variety of methods, including follow-up by case managers, medical record reviews, and claims data analysis. Six of the nine plans reported that there were circumstances under which they would allow a specialist to serve as a PCP for an enrollee with a special need or chronic condition. However, no plans waive prior authorization procedures for children with chronic conditions or special health care needs.

Care Coordination. All plans reported offering care coordination for general chronic care, behavioral/mental health, substance abuse and chemical dependency, and high-risk obstetrics. Four plans also offered long-term care coordination. Only two plans have specific care coordination approaches in place to address transition to adult care for CSHCN.

Obesity Programs. Five of the nine plans offer obesity programs for their FHKP members – one through case management, one through disease management, two as value-added services, and one plan provides educational materials to parents and children. Members are identified for participation in the obesity programs through health risk assessments, medical record reviews, and referrals (including self-referrals and provider referrals). Most of the plans with obesity programs include exercise education for parents. Other program components include obesity tools for providers, exercise education for members, referrals to a nutritionist, and nutrition education for members and their parents.

Disease Management Programs. All plans reported having disease management (DM) programs for asthma. Other DM programs offered by the majority of plans included diabetes (8 plans), high-risk obstetrics (7 plans), congestive heart failure (7 plans), chronic obstructive pulmonary disease (5 plans), and HIV/AIDS (5 plans). DM programs for ADHD, oncology, and behavioral/mental health are offered by only two plans. It is more common for the plans to administer their DM programs internally rather than through an externally contracted vendor. Plans reported using a number of methods to identify enrollees for participation in DM programs. All plans reported reviewing medical claims data for high cost/use and for the presence of certain diagnoses. Plans also commonly identify DM-eligible participants through physician referrals and caregiver report on health surveys. Four of the nine plans provide eligible members (not just participants) with written information regarding DM programs.

Eight of the nine plans measure member participation rates in their DM populations for the overall population, and four of those plans do so for their FHKP members specifically. Only one plan measures cost savings resulting from DM activity. None of the plans measure disparities among racial/ethnic groups for participation rates in DM programs. All plans coordinate with community based resources as part of their DM Programs.

Clinical Guidelines for Chronic Conditions. All plans reported using specific clinical guidelines for chronic conditions (**Table 3**). All of the plans reported using guidelines for asthma and diabetes. The majority of plans also reported using clinical guidelines for ADHD, depression, childhood obesity, COPD, and congestive heart failure. All plans reported using their provider manuals and plan websites to disseminate clinical practice guidelines to providers. Other dissemination methods included newsletters/mailings and provider site visits. The majority of plans also use their website to disseminate practice guidelines to enrollees. All plans monitor provider use of clinical guidelines using HEDIS® performance measures and tracking grievances related to quality of care concerns, and seven plans also use medical record reviews. When deficiencies

in provider compliance with clinical practice guidelines are identified, plans engage in provider written and verbal education, peer review processes, and corrective action plans to correct those deficiencies.

Prescription Drug Benefit. All of the plans reported that their prescription drug benefit is identical to that for Medicaid. All plans use a pharmacy benefits manager, step therapy, and require prior authorizations for non-preferred/non-formulary prescriptions. All plans reported that information about the prescription drug benefit is available on the plan website and/or the member handbook.

Table 3: Summary of Chronic Conditions or Special Health Care Needs for Which Plans Use Clinical Guidelines

	Amerigroup	BCBS BlueCare	BCBS BlueOptions	Coventry Health Care	FHCP	Simply	UHC	WellCare HealthEase	WellCare Staywell
Asthma	X	X	X	X	X	X	X	X	X
Attention Deficit/Hyperactivity Disorder (ADHD)	X	X	X	X			X	X	X
Behavioral Health (BH)/Mental Health (MH) - other than ADHD and Depression	X	X	X	X		X	X	X	X
Childhood Obesity	X	X	X		X		X	X	X
Chronic Obstructive Pulmonary Disease (COPD)	X	X	X			X	X	X	X
Congestive Heart Failure	X	X	X	X		X	X	X	X
Depression	X	X	X	X			X	X	X
Diabetes	X	X	X	X	X	X	X	X	X
Hemophilia						X	X		
Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)	X				X	X	X		
Oncology					X		X		
Otitis Media/Pharyngitis/URI					X		X	X	X
Sickle Cell						X	X		

D. Quality Assessment and Performance Improvement

HEDIS® measures are commonly used to measure health plan quality of care in state Medicaid and CHIP programs[4] and are prominently featured in the Children's Health Insurance Program Reauthorization Act (CHIPRA) set of initial, voluntary core quality measures. All plans except the BCBS plans and Simply calculated HEDIS® measures for their FHKP enrollees. The BCBS plans include FHKP members in their random sample of all measures, but do not calculate rates separately for FHKP enrollees. Simply started serving FHKP enrollees in June 2010 and, therefore, had insufficient program experience to calculate the rates. All plans conduct a member satisfaction survey, with most participating in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys conducted by the Florida Agency for Health Care Administration. Six plans conduct surveys of their FHKP providers.

All plans assess access to and quality of preventive care as part of their quality assessment and performance improvement (QAPI) programs. All but one also explicitly incorporate clinical practice guideline adoption, national quality of care performance measures (e.g., HEDIS®, CAHPS®), timeliness of access to care standards, and grievances and appeals. Seven of the nine plans explicitly include performance measures related to FHKP contract requirements and detection of over- and under-utilization as part of their QAPI program. Four of the nine plans also incorporate quality and appropriateness of care provided to CSHCN as part of their QAPI. All plans reported that they conduct annual evaluations of their quality assessment and performance improvement programs. When rating their QAPI programs, one plan rated its QAPI program as "very effective" (all or almost all performance goals were met) and all of the other plans rated their programs as "somewhat effective" (most performance goals were met).

E. Enrollment and Member Materials

Enrollment and Retention. There was variation in the plans' definitions of new enrollees and reinstatements. New members were defined as enrollees who had never previously had coverage with the plan in their FHKP product line. However, several plans also included in their new enrollee definitions FHKP members who were enrolled previously but with at least a 60-day or 90-day break in coverage. Reinstatements were defined as enrollees who had a break in coverage, but the length in that break in coverage that distinguished a reinstatement from a new enrollee varied among plans. To monitor for new enrollees, all plans reported using reconciliation between the enrollee list provided by the FHKP enrollment vendor and the plans' internal enrollment databases. Four of the nine plans conduct a health risk assessment during new enrollee intake.

Plans reported a variety of ways that they participate in outreach efforts to promote enrollment in the FHKP, including partnering with local county health departments (6 plans), participating in community outreach events (6 plans), working with community-based organizations (4 plans), partnering with local schools (4 plans), and partnering with health care organizations such as hospitals and clinics (3 plans). All plans except the two BCBS plans also reported a variety of initiatives that they have undertaken to promote retention of existing members, including in-person reminder phone calls to members, reminder postcards, and automated reminder phone calls to members. The two BCBS plans reported that they are looking into postcard mailings and outreach phone calls. Five plans reported that they have formal mechanisms in place to track the effectiveness of their retention efforts, most of which involved monthly tracking. Plans were asked to report on any significant barriers encountered in promoting new enrollment and retention. Two plans indicated they encountered no significant barriers. Four plans indicated lack of data on

the enrollment files, including not having renewal dates, missing telephone numbers, or incorrect/non-working telephone numbers. Lack of clarity about the FHKP's rules regarding community outreach and issues related to member premium non-payment and recertification at the program level were also cited as significant barriers.

PCP Assignment. Because a selected PCP is not included in the initial enrollment file that the plans receive from the FHKP enrollment vendor, all plans automatically assign new enrollees to a PCP. All plans take into account geographic proximity when assigning a PCP to a member. Other commonly-used assignment criteria are age-appropriate PCP, whether the enrollee or enrollee's family member previously used that PCP, and the PCP's capacity for new patients. All plans indicated that enrollees can change their PCP at any time. Only one plan (FHCP) has no specific approaches to facilitate the first encounter of a new enrollee with his/her PCP. Among the plans that do have specific approaches, all include materials in new member enrollment packages and five use new member welcome telephone calls. The WellCare plans reported that if a new enrollee has not seen his/her PCP within 45 days, the family is sent a letter to encourage the caretaker to take the child to see the PCP within 90 days of enrollment.

Member Materials. In their new enrollee packets, all plans included a member handbook and provider directory. All plans indicated that the member handbook is available on the plan's website. All plans have both English and Spanish versions of their member handbooks, and four also make member materials available in Creole. In addition, five of the nine plans indicated that the member website is available in Spanish as well as English, and UHC's website is also available in Creole.

All plans have methods to assess whether adjustments need to be made to meet the language needs of their FHKP enrollees and whether those needs have changed. These methods include analyzing U.S. Census data (6 plans); monitoring member language assistance requests, complaints and grievances (5 plans); analyzing state-supplied data for CHIP/Medicaid populations (5 plans); conducting annual or biannual assessments of language needs (4 plans); and monitoring services accessed through interpreters (4 plans). All plans except FHCP include in their provider directory whether the provider speaks any non-English languages; FHCP's online provider search provides this information for FHCP members.

All plans have measures in place to ensure that member materials are written at a level not greater than a 4th grade reading level. All plans except FHCP use a standard readability assessment (Flesch-Kincaid). FHCP tests materials on children/families. Five of the plans make materials available in large print or Braille to assist members who are visually impaired, and three of those plans additionally provide audio recordings.

F. Enrollee Rights and Member Services

Enrollee Rights. The plans reported several means by which they ensure that providers and plan employees are informed of enrollee rights. All plans require employees to complete HIPPA privacy training and to renew this training on an annual basis. Most plans also conduct new employee orientations, have ongoing training curricula for existing employees, and require employees to complete HITECH training. All plans inform their network providers about enrollee rights through their provider manuals, and most conduct new provider orientations. Plans use several strategies to ensure network providers observe the plan's and FHKP's policies regarding privacy and confidentiality of enrollee information, including medical record review, site visits to provider offices, and review of materials in provider's offices for enrollees (e.g., notification of privacy rights and

practices). To monitor provider compliance with federal/state laws and FHKP policies that pertain to enrollee rights, plans monitor member complaints about providers and conduct both routine and complaint-driven site visits to provider offices. To monitor health plan staff compliance with federal/state laws and FHKP policies that pertain to enrollee rights, plans review and monitor member complaints and conduct random monitoring of plan staff phone calls with members.

Plans reported different mechanisms for ensuring that their members receive information about available treatment options appropriate to their condition and ability to understand. Among the methods reported were the use of case management, information contained in the member handbook, and educational materials.

Member Services. All plans except two have customer service operations located in Florida. Most of the customer service operations are available Monday through Friday from 8:00 a.m. until 6:00 p.m. or later. UHC and FHCP reported having a live call center available 24 hours a day, every day. All other plans have an automated voice system or voicemail mailboxes to handle after-hours calls. Five plans have a nurse help line available 24 hours a day, 7 days a week. Four of the nine plans have a dedicated customer service line for just their FHKP members. All plans reported that they have customer service representatives who speak English and Spanish, and the two BCBS plans reported also having representatives who speak Creole. All plans reported the use of Language Line or another vendor to provide interpreter services for languages not spoken by customer service representatives.

Enrollment, Member Materials, and Member Services At A Glance

- Plans varied in their definitions of new enrollees and reinstatements.
- To facilitate the first encounter of a new enrollee with the PCP, eight plans include information in the new member materials that they mail to enrollees and five plans use new member welcome telephone calls.
- Most plans use a standardized readability assessment to ensure that member materials are written at not greater than a 4th grade reading level.
- All plans have printed member materials available in English and Spanish, and four also provide these materials in Creole.
- Four plans have a dedicated customer service line for their FHKP members.
- All plans have English- and Spanish-speaking customer service representatives, and the two BCBS plans have representatives who speak Creole.
- All plans offer language interpretation services and services for hearing impaired members.
- Two plans offer 24-hour live customer service assistance; the remaining plans have voice mail message systems or automated voice systems for after-hours calls.
- Plans reported a variety of ways in which they participate in outreach efforts to promote enrollment in the FHKP and to promote retention of existing members.
- Four plans indicated that missing renewal date and contact information on the enrollment files presented a significant barrier to promoting enrollment and retention.

G. Provider Network

All plans require that physicians undergo a credentialing process. All plans except two indicated that all of their FHKP PCPs are board certified. Among the remaining two plans, one does not assign a PCP to each enrollee and allows families to choose among entire provider network, which includes non-board certified physicians, and the other plan has been granted waivers for non-certified PCPs through the FHKP. Four of the nine plans require board certification for a specialist to join their plan.

The two problems most frequently cited in identifying and recruiting PCPs and specialists were that the provider has misconceptions about HMOs and the provider has issues with the amount of reimbursement. Reimbursement levels were also cited the most frequently as the "most significant" problem (4 plans). Difficulty recruiting in rural areas and limited availability of specialists were also commonly cited as problems encountered in recruiting physicians to the plans' provider networks. Plans reported the most difficulty recruiting pediatric specialists in the following areas: endocrinology/diabetes (4 plans), developmental/behavioral (3 plans), and rheumatology (3 plans). Factors that plans considered contributed to PCP and specialist turnover rates included provider relocation, retirement or death, providers not meeting the requirements of the re-credentialing process, and providers leaving the contracted group. Providers leaving the contracted group was cited as the "most significant" factor by seven of the nine plans.

All plans indicated that they include federally qualified health centers (FQHCs) in their network, and most plans also include rural health centers (RHCs) and county health departments (CHDs). The majority of plans indicated that FQHCs, RHCs, and CHDs are "very important" in providing primary care services to FHKP members.

Provider Network and Reimbursement At A Glance

- All plans require that physicians undergo a credentialing process.
- The two problems most frequently cited in recruiting PCPs were that the provider has misconceptions regarding HMOs and the provider has issues with the reimbursement amount.
- Plans reported the most difficulty recruiting pediatric specialists in endocrinology, developmental/behavioral health, and rheumatology.
- All plans include federally qualified health centers in their provider network and most include county health departments and rural health centers. Plans cited these health centers as being "very important" in providing primary care services to FHKP members.
- All plans use GeoAccess to evaluate whether they are meeting FHKP standards for geographic access to PCPs and specialists.
- Plans reported a variety of strategies for monitoring whether their provider networks meet the FHKP timeliness of appointment standards, including monitoring member complaints, secret shopper phone calls to network providers, and member survey responses.
- Only one plan relies primarily on capitation to reimburse PCPs. Most plans primarily use negotiated fee-for-service or the Medicaid fee schedule to reimburse PCPs and specialists.
- Five of the nine plans provide incentives to their FHKP providers to encourage timeliness and completeness of well-child/well-adolescent visits.

In order to ensure that their network is adequate to serve enrollees in the FHKP, all plans review the geographic location of providers and enrollees, and most plans reported that they review the numbers and types of providers needed to furnish contracted services. All plans use GeoAccess to evaluate whether they are meeting FHKP standards for geographic access to PCPs and specialists The plans cited a variety of strategies for monitoring whether their provider networks meet the FHKP timeliness of appointment standards, including monitoring member complaints, grievances, and appeals (all plans), secret shopper phone calls to network providers (4 plans), and CAHPS® member survey responses (3 plans). Two plans conduct on-site audits at provider offices.

H. Provider Reimbursement and Incentives

Plans were asked which mechanisms they use to reimburse the PCPs and specialists who participate in the FHKP. The percentage of PCPs who receive capitation payments ranges from 0% for the two BCBS plans to 90% for FHCP. The remaining plans reimburse the majority of their PCPs using the Medicaid fee schedule, but also use negotiated fee-for-service (FFS) and capitation. Only a small percentage of specialists are reimbursed using capitation payments; most are reimbursed based on the Medicaid fee schedule or through negotiated FFS. The factors cited most frequently as being of "high importance" in developing capitation rates were projected costs, historic trends, and the Medicaid fee schedule. For PCPs who are paid capitation, most plans allow the PCP to bill immunizations and well-child visits on a FFS basis. Five of the nine plans provide incentives to their FHKP providers to encourage timeliness and completeness of well- child/adolescent visits.

To form their networks, all plans reported contracting with individual physicians, single specialty groups, and multiple specialty groups. The majority of plans also contract with academic health centers, CHDs, FQHCs, and RHCs. Plans that contract with single specialty groups, multiple specialty groups, academic health centers, CHDs, FQHCs, or RHCs are more likely to make payments to the groups rather than individual physicians. With the exception of WellCare, the plans did not know how that group payment was distributed to the individual providers in the group.

I. Utilization and Referral Management

Table 4 summarizes the approaches used by the plans to manage utilization. Requiring adherence to clinical practice guidelines was used by all plans and rated as being "very effective" or "moderately effective" by all except one of the plans. Requiring preauthorization for tests and for hospitalizations were the methods that most plans cited as being "very effective" for managing utilization.

Five of the nine plans require PCP referral to participating specialists. Insufficient clinical information was cited most frequently as a problem encountered from PCPs during the referral process, whereas untimely submission of service authorization requests and lack of coordination with the member's PCP were cited most frequently as the problems encountered from specialists during the referral process.

When asked how problematic inappropriate use of emergency department (ED) services is, only one plan indicated that it was "a big problem" and only one plan indicated that it was "not a problem." The remaining plans indicated inappropriate ED use is "somewhat a problem." Only one plan does not asses inappropriate ED use by individual members. The most common methods used by plans to assess inappropriate ED use are monitoring trends in ED rates, severity of illness, and members' PCP use. The most common approaches used by plans to address inappropriate ED use are member outreach and assigning members to case management/care coordination. All plans except one require ED facilities to notify the plan when the member is admitted for inpatient care.

Table 4: Summary of Plans' Approaches for Managing Utilization

	Amerigroup	BCBS BlueCare	BCBS Blue-Options	Coventry Health Care	FHCP	Simply	UHC	WellCare HealthEase	WellCare Staywell
Require reauthorization for specialty referrals					X				
Require reauthorization for tests	X	X	X	X	X			X	X
Require reauthorization for hospitalizations	X	X		X	X	X	X	X	X
Profile physician utilization patterns for hospitalizations	X	X	X			X	X	X	X
Profile physician utilization patterns for ambulatory care services	X	X	X			X	X	X	X
Require adherence to clinical practice guidelines	X	X	X	X	X	X	X	X	X
Provide educational programs to providers about cost effective utilization of services	X	X	X		X	X	X		

J. Grievance Procedures

Plans reported different reasons for grievances among their FHKP enrollees for calendar year 2010. Six of the nine plans listed balance billing by providers as a reason for grievances, and two of those plans indicated that it was the "most significant" reason. Other reasons that plans indicated as the "most significant" reason for grievances were requests for denied payments and out-of-network denials. All plans reported that each grievance and appeal is tracked through to resolution. All plans reported that their member handbooks and websites contain information about the grievance and complaint process in general. They all also provide assistance to members in completing forms and other procedural steps in the grievance and appeal process. In order to ensure that FHKP enrollees who are denied services are notified of their right to appeal, all plans send letters. The two BCBS plans, Coventry, and FHCP also include this information in their explanation of benefits documents, and BCBS enrollees have access to member advocates. Several plans also commented that the member handbook contains information about enrollees' rights to appeal. All plans indicated that physicians may request expedited appeals on behalf of an enrollee and that expedited appeals must be resolved within 72 hours.

K. Delegation

Administrative functions that are frequently delegated include credentialing and establishing and maintaining provider networks. The health service functions that are frequently delegated by plans are pharmacy, radiology, therapy, hearing, and vision. All plans conduct a pre-delegation audit and/or conduct site visits to determine that an entity is capable of performing delegated functions. All plans monitor enrollee grievances and appeals as one strategy to ensure that subcontractor networks are adequate to serve FHKP enrollees. Additional strategies used by most plans include routine meetings with delegated entities, annual performance reports, and GeoAccess analyses.

L. Health Information Systems and Data Acquisition

Six of the plans indicated that they had undergone a formal Information Systems (IS) capability assessment in the past two years. Four of those plans stated that this assessment specifically addressed the IS capability with respect to the FHKP product line. All plans except one use relational database management systems for their claims and encounter data. The average programmer experience ranged from 5 years to 26 years.

Three plans track the percentage of providers who have implemented an electronic health record (EHR). Both WellCare plans reported that 1% of providers have implemented EHRs, and Simply reported that 30% of its providers had implemented EHRs. Under the federal Health Insurance Portability and Accountability Act, all MCOs must use National Provider Identifiers (NPIs) to refer to their providers in administrative and financial transactions. All plans require providers to submit their NPI number in order to be reimbursed, and all except Simply have processes in place to validate provider NPI and taxonomy.

All plans indicated that they have controls in place to assure that all FHKP fee-for-service claims data are fully accounted for. Among the plans that have capitated encounter data, none have performed studies on the completeness of the information collected on capitated services. BCBS noted that it monitors encounter data and has implemented a process to validate that the data are complete and submitted in a timely manner.
All plans reported that overall their FHKP claims and encounter data are equal to or greater than 85% complete at 3 months and greater than 97% complete at 6 months. All plans except FHCP audit FFS claims data regularly and the majority of plans also audit capitation data on a regular basis. Audits typically involve the selection of a random sample, and three plans validate against medical records. All plans work directly with providers to improve the quality of the data submitted. In order to do this, most plans telephone providers with data quality submission issues. Other methods used to improve data quality include provider office visits and communicating general information about data submission processes through mailings and fax blasts.

All plans reported contracting with third-party vendors to provide certain health care services to FHKP enrollees. Only BCBS reported concerns with the completeness or quality of the encounter data received from its delegated entities, noting data submission issues with its mental health provider. All plans have in place formal policies and procedures for protecting against FHKP claims and encounter data loss and corruption and for ensuring the privacy and confidentiality of FHKP claims and encounter data.

4. SUMMARY AND RECOMMENDATIONS

Conducting interviews with health plan administrators and keeping these interviews updated on a regular basis promotes meeting external quality review requirements under CHIPRA. The administrative interviews collect data on a comprehensive set of plan structures and processes. The administrative interview tool is most effectively used when it complements other evaluation activities, such as evaluating whether plans are meeting program performance standards and conducting special focus studies. As part of ongoing quality improvement initiatives, the ICHP recommend that the FHKP prospectively identify a core set of program performance standards and special topic areas to be evaluated in greater depth through the administrative interview process for each evaluation period. In summary, the health plan administrative interview data provides rich information about health plan organizational characteristics and the structures and processes that health plans use to deliver care.

End Notes

[1]Children's Health Insurance Program Reauthorization Act of 2009. Public Law 111-3. Available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ003.111.

[2] Centers for Medicare and Medicaid Services. 2003. *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al., Final Protocol, Version 1.0, February 11, 2003*

[3]Centers for Medicare and Medicaid Services. *Medicaid and CHIP Quality Practices: Tools, Tips and Protocols.* Available at: http://www.cms.gov/MedicaidCHIPQualPrac/07_Tools_Tips_and_Protocols.asp.

[4] Duchon L. and Smith V. 2006. *Quality Performance Measurement in Medicaid and SCHIP: Results of a 2006 National Survey of State Officials.* (Prepared for the National Association of Children's Hospitals). Lansing, MI: Health Management Associates. Available at: http://www.childrenshospitals.net/AM/Template.cfm?Section=Publications2&CONTENTID=46835&TEMPLATE=/CM/ContentDisplay.cfm.

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