

# Evaluation of Statewide Risk-Based Managed Care in Kentucky

**A First Year Implementation Report**

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## Abstract

This report is the first of a series of reports that will be prepared during a three-year evaluation of the statewide implementation of risk-based managed care in Kentucky's Medicaid program. The evaluation will assess the short- and medium-term effects of risk-based managed care implementation on the major partners- beneficiaries, providers, plans, and the Cabinet, with an eye toward understanding the impacts on costs and 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, Dr. Amy Burke, 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 Cabinet, the state legislature, and other state agencies. This advisory group will meet twice a year throughout the course of the evaluation, and has already met in March and October of 2012.

In this report, we provide an overview of managed care implementation in Kentucky as of mid-2012 based on our case study analysis, conducted about eight months after the state began enrolling Medicaid beneficiaries in risk-based managed care state-wide. The case study included review of important documents, such as health plan contracts, provider directories, and the initial request for proposals. We also interviewed key stakeholders, including representatives from the state and the four Medicaid managed care plans operating in Kentucky at the time of our site visit, providers, advocates, and a state legislator. Subsequent reports will cover later phases of managed care implementation, relying on input provided by focus groups with beneficiaries in different regions of the state and follow-up interviews with stakeholders to assess the extent to which their perceptions are changing. We will also develop quantitative assessments of Medicaid claims data and hospital discharge data to describe changes in service use patterns and patient outcomes following the adoption of risk-based managed care in Medicaid.

Nationally, states are relying on the managed care delivery model to serve more Medicaid populations. Implementation of Medicaid managed care in Kentucky is in keeping with this national trend. Kentucky phased in all populations (except those in waiver programs), services and counties (with the exception of Region 3, which has had a single plan, Passport, providing risk-based managed care in Medicaid since the mid-1990s) on November 1, 2011. The implementation timeline was extremely short. Stakeholders indicated that the compressed timeframe challenged the ability of the state to oversee the expanded managed care system, and also contributed to communication issues among the major partners.

Implementation issues and other observations from our initial case-study include the following:

- There were high rates of beneficiary auto-assignment into health plans, and high rates of beneficiaries switching plans during the start-up phase.
- Seventy-three percent of hospitals statewide contracted with all three plans as of June 2012.
- In Hopkins, Perry, and Warren counties, we found that primary care provider participation with all three plans was between 18 and 41% in June 2012. Fewer than

20% of specialists in these counties contracted with all three plans. Twenty-nine to 50% of dentists contracted with all three plans, and more pharmacies tended to contract with all plans (63-88%).

- Provider networks continue to fluctuate.
- Plan informants in the state indicated dissatisfaction with their monthly capitation rates and other informants also were skeptical that plans could provide quality services at the rate paid. As of this writing, one of the three plans has indicated its intention to withdraw from the market in 2013.
- Providers who receive wrap payments have not been able to reconcile claims, and have been paid based on estimated instead of actual claims.
- Providers noted increased administrative difficulties in working with the newly contracted managed care organizations in these areas: administrative burden, delays in prior authorization for services, claims denials resulting in higher levels of appeals, difficulty getting needed information from plans, and difficulty understanding the coding systems that plans use.
- Long-standing behavioral health service gaps were reportedly exacerbated following the implementation of risk-based managed care. Behavioral health advocates were also concerned about the behavioral health carve-in, indicating that it did not seem to be leading to the desired improvement in care coordination and continuity of care.
- Providers reported that patients had difficulty maintaining continuity of needed prescription medications for chronic conditions.
- Providers and advocates indicated that they had not yet seen substantial evidence of new case management programs or other service delivery innovations under managed care.
- Finally, the state's oversight of Medicaid managed care plans is still developing. State managed care expertise is expanding and efforts to monitor health plan quality and beneficiary access are underway, though the state is still determining how best to use and disseminate the information they are collecting from plans.

These issues represent the status of the statewide implementation of risk-based Medicaid managed care in Kentucky at a very early juncture. Kentucky's long-term success with Medicaid managed care will depend on strong relationships among the partners—which, in part, depend on a viable financial environment for the state, the plans and providers. Additionally, the cost-savings associated with Medicaid managed care are premised on improvements and greater efficiencies in the delivery of care. This evaluation will explore the evolution of these and other issues in future reports.

## Background

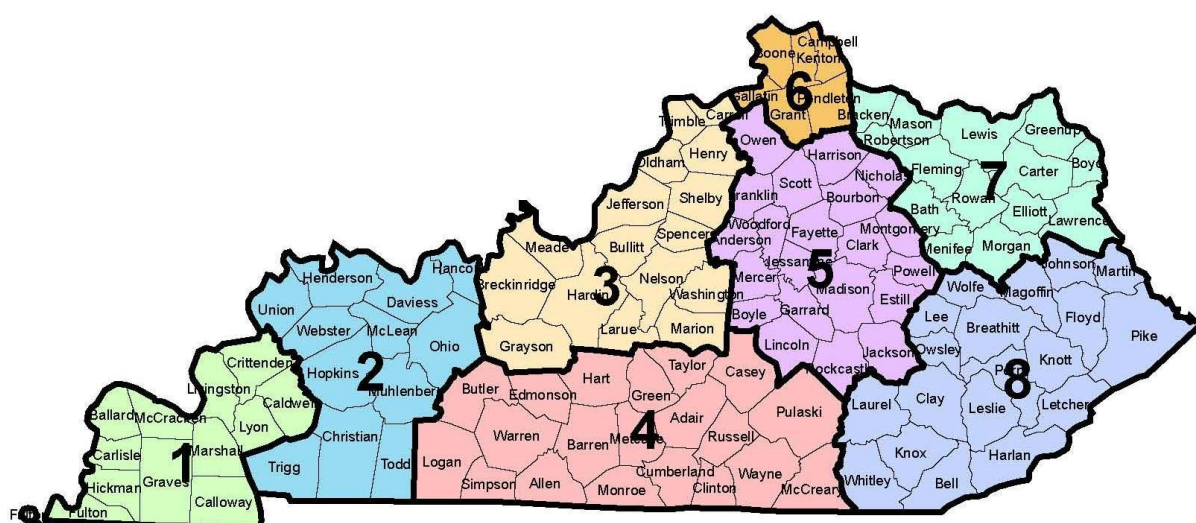
In November, 2011 the state of Kentucky transitioned about 550,000<sup>1</sup> Kentucky Medicaid patients from a fee-for-service delivery system with a primary care case management component (called Kentucky Patient Access and Care, or KenPAC) into risk-based managed care. The state received federal approval allowing them to do so from the Centers for Medicare and Medicaid Services (CMS) on September 8, 2011. Kentucky is one of many states that have recently chosen to increase the number of Medicaid beneficiaries enrolled in risk-based managed care plans.<sup>2</sup> States often view risk-based managed care as a means of promoting better quality and greater control of access to care while containing Medicaid costs through enhanced management of medical and behavioral health services.

The transition to Medicaid managed care took place in 7 of the state's 8 Medicaid regions (see figure 1). Medicaid beneficiaries in the state comprised two groups: families and children (64 percent), and aged, blind, and disabled (36 percent),<sup>3</sup> and about 69 percent of these individuals were served by the new delivery system. Previously, these enrollees had been served by two distinct delivery systems. In 7 of the 8 regions, a large number of enrollees were served through a fee-for-service arrangement with a primary care case management component (KenPAC). KenPAC provided monthly payments to primary care providers (PCPs) to manage patient care for an assigned group of patients. However, while theoretically their PCP was responsible for referrals to most specialty services, the degree to which primary care providers actually coordinated care for assigned patients under KenPAC was not routinely monitored by the state or rigorously evaluated.

The second delivery system operated in Jefferson county and 15 surrounding counties (Region 3). Region 3 has been served through a risk-based managed care arrangement since the state began the Kentucky Health Partnership Program demonstration in 1995. This region has continued to operate under a separate CMS waiver. After some initial start-up problems and well-publicized management issues that emerged in 2010, Passport—the health plan serving the region under the waiver until the end of 2012—stabilized and was reported to be viewed positively by most providers and other stakeholders. However the waiver will expire at the end of 2012 and the region was opened to new bidders shortly after the period covered in this report.

The 1995 Partnership program was intended to result in a statewide managed care program phased into different regions incrementally as set out in state regulations. However, a second region of the state (Region 5), which also began serving Medicaid patients through a risk-based arrangement through the demonstration, experienced problems (particularly with regard to physician reimbursement) and a decision was made to dissolve it by 1999. By fall 2000, the state abandoned plans to continue implementation of state-wide risk-based managed care.

**Figure 1: Map of Regions**



Kentucky's most recent implementation of state-wide risk-based managed care comes when national insurance companies are expressing heightened interest in expanding their Medicaid managed care business. This increased interest is likely due to the promise of a new marketplace created by the Affordable Care Act (ACA). If Kentucky takes up the Medicaid expansion option for uninsured adults, the state could add an estimated 288,000 enrollees to the risk-based managed care program under Medicaid.<sup>4</sup> Learning from the implementation of risk-based managed care is important in planning for this potential expansion of managed care in the state.

The report that follows is the first of a series of reports that will come during a three year evaluation of Kentucky Medicaid managed care implementation. The evaluation is being

conducted for the Foundation for a Healthy Kentucky by The Urban Institute and its subcontractors, the University of Kentucky and Georgia State University. In this report, we provide a comprehensive overview of the state of implementation as of mid-2012 based on our case study analysis, conducted about eight months after the state began enrolling beneficiaries in risk-based managed care state-wide. Subsequent reports will track the implementation of risk-based managed care since mid-2012 and will incorporate input from focus groups with beneficiaries, as well as quantitative findings that describe changes in patient outcomes that have resulted from Medicaid managed care.

## Methods

The report is based on a review of documents, including contracts with health plans, and a series of interviews with state agency staff, Medicaid plan staff, providers, advocates, and state legislators. Provider informants varied with respect to their place of employment (representing major hospital systems, critical access hospitals, community health centers, and private practice), as well as their function (for example, health care providers and financial staff). Semi-structured interviews were conducted in person in the central (Lexington/Louisville/Frankfort), eastern (Hazard), and western (Bowling Green and Madisonville) regions of the state between June 11<sup>th</sup> and 15<sup>th</sup>, 2012, utilizing protocols that were designed for each informant type.

Interviews were conducted in all three regions 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 a longstanding provider shortage, though a large proportion of providers who practice in the area have historically accepted Medicaid patients. Western Kentucky has lower rates of provider participation in Medicaid. A small number of follow-up interviews were conducted by telephone shortly after our site visit. Interview notes were transcribed, and then coded and analyzed using NVIVO (a qualitative research software program). All respondents were assured of anonymity and encouraged to provide an honest assessment of the implementation process to date—including successes and challenges. Table 1 shows the number of interviews by type of respondent. Appendix A provides a list of interviewees.



**Table 1: Interviews by Type of Respondent**

| <b>Interviewee Type</b> | <b>Number of Respondents</b> |
|-------------------------|------------------------------|
| State Official          | 2                            |
| Health Plans            | 4                            |
| Providers               | 15                           |
| Advocates               | 4                            |
| State Legislator        | 1                            |
| <b>Total</b>            | <b>26</b>                    |

In order to provide a description of provider networks, the evaluation team conducted an analysis of each contracted plans' June 2012 provider directory. This analysis represents the networks at a point in time based on the information that was available, understanding that provider networks are in flux. We discovered that the provider directories did not include some contracted providers, so the analysis relies on supplementary information. For example, one of the plans failed to include most of its pharmacies and dentists in the state directory, so this information was verified through their subcontractors' provider directories. We evaluated hospital networks across the state, but our analysis of primary care doctors, specialists, dentists and pharmacies focuses on three diverse and largely self-contained Kentucky markets: Hopkins County (Madisonville), Perry County (Hazard), and Warren County (Bowling Green)—three counties that we visited as part of our site visits and where we obtained information on the local health care delivery systems. Perry County is in the eastern region of the state, and Hopkins and Warren Counties are in the western part of the state. These counties were chosen to provide contrasting settings. For example, Warren County has a much larger Medicaid population than the other two, but has the smallest percentage of the total population on Medicaid (see table 2). One-third of Perry County's population is covered by Medicaid, while the figure is less than 20 percent in Hopkins and Warren Counties, a rough index of longstanding economic hardship in Eastern Kentucky compared with Western Kentucky.

**Table 2: County Population and Medicaid Enrollment (January 2012)**

| County  | Medicaid enrollment | Percentage of Total Population in Medicaid |
|---------|---------------------|--|
| Hopkins | 9,258               | 19.7%                                      |
| Perry   | 9,475               | 33.0%                                      |
| Warren  | 18,903              | 16.4%                                      |

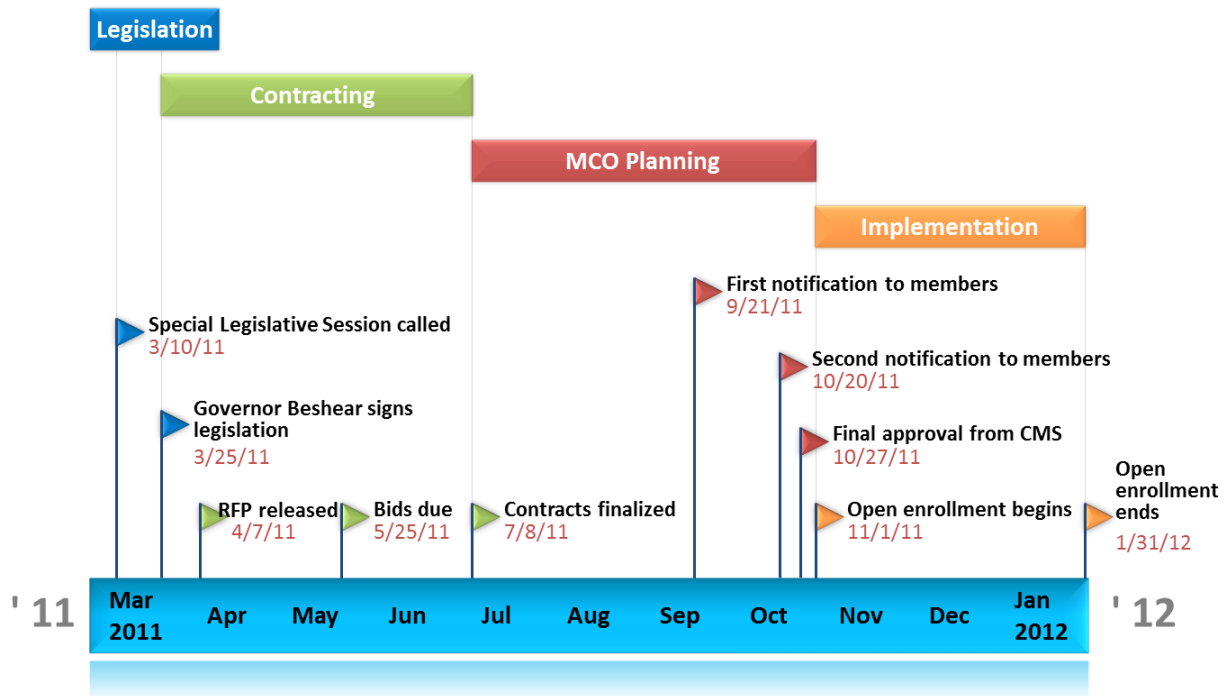
## **Implementation of the State-wide Managed Care Waiver**

By all accounts, the transition from Kentucky’s Medicaid Fee for Service (FFS) reimbursement approach to a risk-based managed care program was extremely rapid. In contrast to other states,<sup>5</sup> Kentucky chose to implement risk-based managed care for almost all Medicaid enrollees in all areas of the state (outside of Region 3) at the same time. This included rural areas and disabled and non-disabled beneficiaries. In addition, there were no “carve outs” for services such as behavioral, dental, and pharmacy services. Several informants told us that they believed that the upcoming election for Kentucky’s race for Governor was a primary contributing factor in the rapid implementation timeline. Facing a Medicaid budget deficit of \$100 million,<sup>6</sup> Governor Steve Beshear’s office saw the closing of this gap as a major issue that needed to be addressed before the November election and chose implementation of risk-based managed care as a way to address the shortfall. Thus, in the spring of 2011 Governor Beshear presented his budget to the legislature, which assumed an October 1 implementation date for state-wide risk-based Medicaid managed care and also assumed substantial savings. Implementation was subsequently postponed until November 1, 2011 (just one week prior to the Governor’s re-election), at the insistence of the Kentucky Hospital Association. The Hospital Association asserted more time was needed for hospitals to negotiate contracts with plans.

Figure 2 depicts the timeline for risk-based managed care implementation, with several key milestones indicated on the figure. The legislation that authorized the transition was passed in a special legislative session in March 2011. Soon after, state staff held a well-attended bidders’ conference, and then released a request for proposals (RFP) soliciting bids from managed care

plans. The state indicated that it might select plans for single regions, for multiple regions, or for the entire state. Consequently, bids were requested for multiple rate cells and by region.

**Figure 2: Implementation Timeline**



The proposals were due on May 25<sup>th</sup> and bids were received from seven plans: Amerigroup, AmeriHealth Mercy, Centene (Kentucky Spirit), Coventry, Meridian, United Healthcare, and WellCare. None of the plans that responded to the RFP had previously operated in Kentucky, except for AmeriHealth Mercy, which provides administrative support to the Passport plan in Region 3. Of these bidders, the state selected three: Centene (Kentucky Spirit), Coventry, and WellCare.

By the end of the first week of July 2011, contracts were finalized with these three managed care organizations. Each plan would serve the seven regions of the state not currently served by Passport. Selected plans were chosen based on a scoring process, which accounted for their likely technical performance, as well as their cost proposal.

All three plans are for-profit, national companies which serve a large number of Medicaid managed care beneficiaries in other states. Coventry's national patient base includes Medicaid managed care beneficiaries in nine states; it also serves commercial and Medicare beneficiaries in multiple states. Centene (branded locally as Kentucky Spirit) is a Medicaid-focused company, serving Medicaid managed care enrollees in 18 states. Lastly, WellCare focuses on enrollees of public programs, serving Medicaid and Medicare patients, with Medicaid enrollees in seven states.

The plans had only four months (early July to November 1) to establish operations in Kentucky. To prepare for the transition, plans needed to establish local offices; recruit and train staff; contract with local providers; upload automated data on new Medicaid members and providers into their systems; adapt their case management programs to the Kentucky environment; develop policies and procedures for beneficiaries and providers; educate Kentucky providers on managed care processes (such as claims submission); and market to potential Medicaid managed care enrollees.

## **Beneficiary Assignment to Plans**

Once the three health plan contracts were in place, the state assigned Medicaid enrollees to a plan (a process called auto-assignment) and sent a letter to all beneficiaries letting them know the plan to which they had been assigned. The letter indicated that members could change their plan within 90 days of the implementation date. Because of this process, auto-assigned enrollees account for a sizable proportion of the enrollment base of plans, with one plan reporting that, at the time of our interviews, 70 percent of their patient base had been auto-assigned to them.

The auto-assignment algorithm accounted for the enrollees' historical physician relationships, consistency of household members assigned to the same plan, and load balancing across plans. When this was taken into account, preference was given to the plan with the lowest premium. Because the auto-assignment took place before plans established contracts with all providers in their networks, the auto-assignment process was based on letters of intent to contract. This meant that at times beneficiaries were assigned to a plan based on a previous provider affiliation,

even though that provider did not ultimately sign a contract with the plan to which they were assigned.

Due to its lower overall capitation rates, Kentucky Spirit was initially assigned the largest number of enrollees, over 200,000 members just after auto-assignment. During the 90 day switching period, many enrollees changed their enrollment from Kentucky Spirit to Coventry or WellCare. Table 3 shows enrollment by plan just after we conducted interviews. As of July 9, 2012, the Cabinet's figures<sup>7</sup> show that Kentucky Spirit had 26.5 percent of Medicaid beneficiaries in the 7 regions, Coventry had 44.8 percent, and WellCare had 28.7 percent. Plans reported that there was significant churning of membership. One plan reported that in a given month, they would lose and then gain approximately 12,000 members. This churning was reportedly complicated by a high number of retroactively assigned members as compared to other markets served by the health plans.

**Table 3: Medicaid Managed Care Enrollment (July 9, 2012)**

| Medicaid Managed Care Plan | Enrollment (#) | Enrollment (%) |
|----------------------------|----------------|----------------|
| KY Spirit                  | 137,923        | 26.5%          |
| Coventry                   | 233,679        | 44.8%          |
| WellCare                   | 149,433        | 28.7%          |
| <b>Total Enrollment</b>    | <b>521,035</b> | <b>100.0%</b>  |

Variation in provider networks caused some members to switch plans, but it was not the only motivation. In order to entice enrollees to join their plan, the plans offered a variety of incentives, such as free diapers and free strollers. Provider informants reported that this sometimes resulted in a beneficiary switching plans in order to obtain more than one incentive package, leading to confusion about which plan the person was enrolled in and which plan to bill for services.

*“In the waiting room, patients would talk to each other and discover this. So, during the time switching was allowed they would switch to get both sets of incentives!” (Provider)*

Another critical incentive determining enrollment patterns was that Coventry, uniquely among plans, initially did not charge any copays. It is plausible that this may have caused some patients with health problems to switch from Kentucky Spirit or WellCare to Coventry.

After enrollees were assigned to plans, the state sent an eligibility file to each health plan. When plans received a new eligibility file, they then called new members to conduct a health risk assessment, answer their questions, and help them choose a primary care provider (PCP). If the enrollee could not be reached or did not choose a PCP, the plan assigned one.

Although the state focused on auto-assigning members to plans that included their PCP, mix-ups in the process of plans assigning enrollees to providers were reported. Providers complained that their patients were sometimes assigned to inappropriate primary care providers. For example, they mentioned that children were assigned to OB/GYNs, or that others were assigned to pain care doctors or providers who had passed away. These anecdotes suggest that some provider assignments were made before plans had finalized the list of providers who were in their networks.

## **Provider Networks**

One aspect of implementation that was particularly difficult under the time constraints was the establishment of provider networks. While plans were required to have begun developing a network when preparing their proposal, this generally involved signing “Letters of Intent” (LOIs) with selected providers which did not specify final contract terms (including, critically, payment rates). This was further complicated because the plans had not operated in Kentucky and did not have established statewide networks.

The following analysis describes the overlap in provider networks for the three health plans as of June 2012. The analysis has some implications for access to care, since a beneficiaries’ access to services from a non-contracted provider is limited.<sup>8</sup> However, the analysis does not address access to care more broadly, particularly whether an adequate number of providers of all types participate in Kentucky’s Medicaid program in all areas of the state.

## *Hospitals*

As of June 2012, 68 out of the total 93 hospitals in the state (73 percent) contracted with all three plans, while 23 (25 percent) contracted with only two plans, and 2 hospitals—Methodist Hospital in Henderson County and Russell Hospital in Russell County—contracted with only one plan.

Since the time of the analysis, Coventry’s hospital network has been in transition, as the plan has tried to drop, amend, or terminate contracts with several hospitals and systems. Thus, these data likely overstate the extent of overlap in the hospital networks across the three plans at the current time.

Both plans and providers reported that the key to building successful provider networks was to successfully contract with local hospitals. One informant said,

*“There are many primary care providers who may be signed up with one or two health plans and not the third. That reason may be because of what the local hospital did. If the hospital didn’t contract with a particular plan, then the doctors are going to look to that and say, ‘I can’t send my patients to the local hospital, what’s the point of me being contracted with that plan?’ ... That’s really driving which plans they’re signing up with”.* (Provider)

The quick implementation timeline created contracting problems that were reported most prominently by hospitals, who felt they were asked to sign too quickly, and that the contracts contained language that didn’t apply to them.

*“There seemed to be provisions in there that weren’t applicable to the state of KY or were in violation of Kentucky law.”* (Provider)

Some of these issues were not fixed before November 1, and hospitals began working with only a LOI. In some cases, the LOI did not ultimately lead to a contract, due to an inability to agree on provider payment rates. For example, Kentucky Spirit was ultimately unable to sign a contract with Appalachian Regional Healthcare (ARH), an important provider of health care services in eastern Kentucky.

Contracting issues between ARH and two plans, Coventry and Kentucky Spirit, appear frequently in media accounts.<sup>9, 10</sup> ARH is a prominent not-for-profit health system, which operates ten hospitals, multi-specialty physician practices, home health agencies, and retail

pharmacies. The ARH facilities are dominant in the counties they serve, offering most of the obstetrical, cardiology, oncology, and behavioral health services. Kentucky Spirit did not contract with ARH due to failed rate negotiations, and Coventry has sought to end its contract. While geo-access reports produced by the state and Coventry indicate that there are other facilities within the required contractual distance for Medicaid beneficiaries in the eastern region and deemed Coventry's network adequate, the mountainous terrain and challenging roads in the region make access less timely than mileage alone suggests.<sup>11</sup> Thus, questions have been raised about the adequacy of the networks of these two plans in the eastern region.

### ***Primary Care Providers***

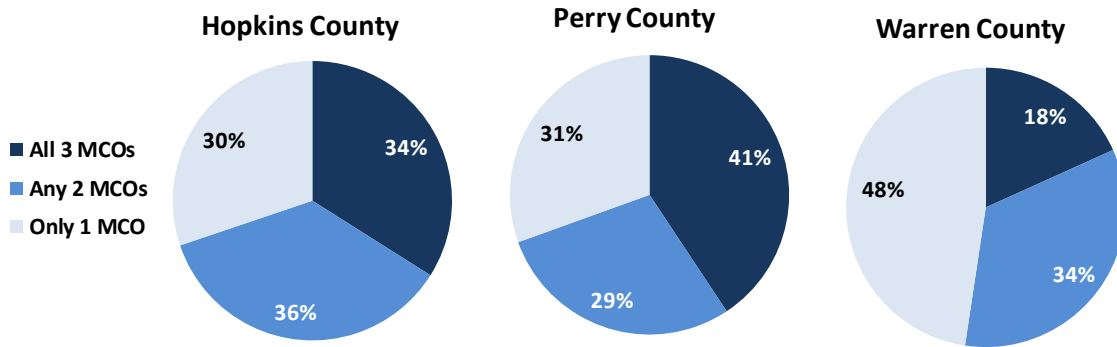
PCPs in the three markets that we studied have different patterns with regard to plan participation. It is not common in any county for PCPs to contract with all 3 plans. This has implications for access to PCPs for Medicaid beneficiaries who previously could change providers more easily.

An important consideration for PCPs in determining the plan(s) with which to contract was the reimbursement rate the plan was offering. Once a provider determined with which plan(s) to contract, they could encourage their patients to switch to the contracted plans during the ninety day open enrollment period. For example, some primary care providers were able to use this leverage with the plans to negotiate a higher per visit payment. Some providers who understood that the KenPAC program would no longer exist reportedly negotiated a monthly case management fee, similar to what they had received under the KenPAC program.

In Perry County, with its high proportion of Medicaid beneficiaries, 41 percent of PCPs participated in all three plans as of June, 2012, compared to 34 percent in Hopkins County and 18 percent in Warren County (see figure 3). Differences in market dynamics in the three counties make Warren County PCPs less reliant on Medicaid, which permits providers to be more strategic when contracting with plans.



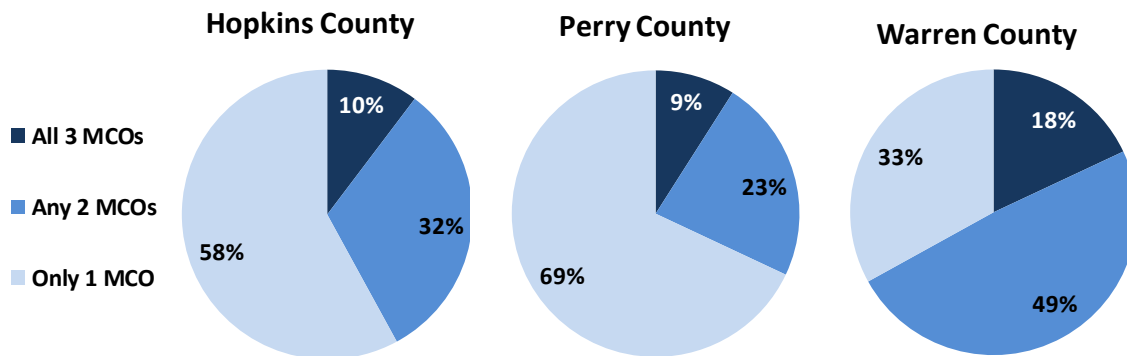
**Figure 3: Overlap in Primary Care Providers**



### *Specialists*

Even fewer specialists have contracts with all three plans. As with PCPs, 18 percent of specialists in Warren County contract with all three plans. In contrast, a very small percentage contract with all three plans in the other two counties (9 percent in Perry County and 10 percent in Hopkins County—see figure 4).<sup>12</sup> However, each plan’s listing includes some specialists whose primary practice site is in another county, or even another state, and who may see patients in the listed county once or twice a month.<sup>13</sup> In any case, the data suggest potential access issues with specialty care for some beneficiaries.

**Figure 4: Overlap in Specialists**



The availability of providers whose primary office is out-of-state or who are infrequently available may help to explain the discrepancy between plans and provider views of specialist

networks. Most plans did not think that contracting with specialists was particularly difficult, though some PCPs noted difficulty finding specialists to whom to refer their patients. One health plan said,

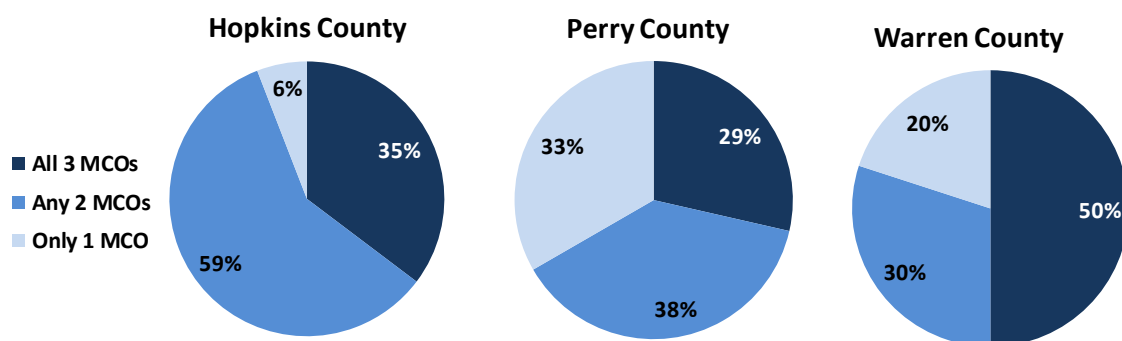
*“To meet network adequacy, we can contract with out-of-state providers when we are dealing with border counties. That has helped us meet some of the network requirements. PCPs and specialists have not been a challenge for us at all. We’ve done well contracting with those providers.” (Plan)*

This perspective was surprising to the authors, who have studied Medicaid managed care in other states, and have found that Medicaid plans often have difficulty contracting with a sufficient number of specialists in rural areas.<sup>14</sup>

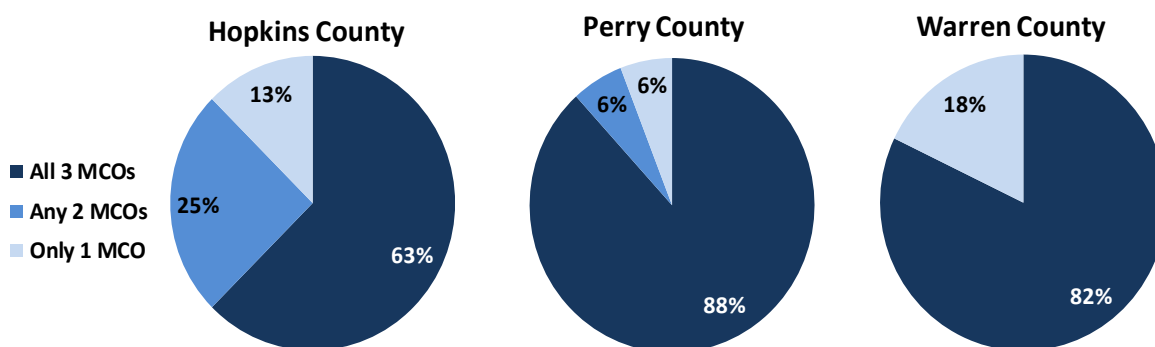
### ***Dental and Pharmacy***

We analyzed pharmacy and dentist participation in the same three counties (see figures 5 and 6). Pharmacists and dentists are more likely to participate in all three plan networks. While dentists are more likely than PCPs to contract with all three plans, informants told us that there are not enough dentists serving Medicaid patients in the state, suggesting ongoing dental access problems that existed before managed care implementation.

**Figure 5: Overlap in Dentists**



**Figure 6: Overlap in Pharmacies**



## Plan Capitation Rates

Per-member-per-month (PMPM) rates are paid to the plans by Medicaid; plans then pay providers according to negotiated rates. The rates (PMPM) were developed by the plans and reviewed by the state's contracted actuary, PricewaterhouseCoopers.

Rates were developed in a three-phase process.<sup>15</sup> First, each plan developed its own rates based on experience in other states and the data book provided by the state. Independently, actuaries with PricewaterhouseCoopers developed a range of rates that they believed would be adequate to accomplish the goals of managed care. Lastly, negotiations took place between the plans and the state.

In the first phase, each health plan developed proposed rates by region and by demographic rate cell. Rates were developed using a data book provided by the state that was based on 2009 and 2010 fee-for-service Medicaid experience. Each plan also considered their experience with Medicaid in other states in developing rates. Separate bids were developed for each of the three contract years (2012, 2013, and 2014).

PricewaterhouseCoopers developed an actuarially sound range of rates, in accordance with federal law (42 CFR 438.6(c)).<sup>16</sup> The plans were not informed of the rate ranges before they

developed their initial cost proposals. PricewaterhouseCoopers contends in their report that plans were informed during negotiations whether their bids were within the actuarially sound rate range, but a plan indicated to us that they were not informed of the rate range. The PricewaterhouseCoopers rates were developed using fee-for-service Medicaid data, and adjusted for expected savings, as well as the administrative expense for plans operating in the Kentucky market (projected at 8 to 11 percent). The rates included assumptions that savings would be achieved through reducing unnecessary care, increasing preventive care, and shifting care to more appropriate types and venues. The actuaries assumed that some provider types would be paid higher reimbursement than fee-for-services rates, so plans could meet network adequacy requirements. Savings were expected to accrue in the first period of the contract, with modest improvements in subsequent years.

Some key informants believed that the managed care organizations may have underbid their contracts with the state (see table 4). Reasons may include the following:

- The plans may have thought that short-term losses in the state would lead to long-term gains, because their market positions would strengthen with the Affordable Care Act's Medicaid expansions and health benefit exchange;
- The plans may have received incomplete data from the state. One plan stated that the rate data that they were given to construct their bid contained inaccuracies. We were told that Passport had a similar problem with their initial state data in the 1990s;
- Rates were determined before provider network contracting was finalized, so plans did not yet have full and accurate information about provider reimbursement rates.

Table 4 shows that rates vary across the three plans. The rates in the table are provided as an illustration. A full list of rates for the first year of the contract is in Appendix B. In general, WellCare negotiated the highest capitation rates, with Coventry following, and with Kentucky Spirit negotiating the lowest rates.

**Table 4: Initial Contracted Rates for Year One for Selected Rate Cells by Plan, Region One**

| Rate Cell                 | Per Member Per Month \$ |                 |          |
|---------------------------|-------------------------|-----------------|----------|
|                           | Coventry                | Kentucky Spirit | WellCare |
| <b>Non-SSI</b>            |                         |                 |          |
| Age 6-12                  | \$145*                  | \$132           | \$143    |
| Age 13-18                 |                         |                 |          |
| Female                    | \$249                   | \$240           | \$259*   |
| Male                      | \$185                   | \$192           | \$198*   |
| Age 40+                   |                         |                 |          |
| Female                    | \$522                   | \$500           | \$550*   |
| Male                      | \$512                   | \$569           | \$602*   |
| <b>SSI (Non-Medicare)</b> |                         |                 |          |
| Age 6-18                  | \$477                   | \$506           | \$566*   |
| Age 45+                   |                         |                 |          |
| Female                    | \$950*                  | \$891           | \$936    |
| Male                      | \$868*                  | \$816           | \$862    |
| <b>Dual Eligible</b>      |                         |                 |          |
| Female                    | \$102                   | \$117*          | \$107    |
| Male                      | \$90                    | \$105*          | \$96     |

Note: \* Indicates the highest rate of the three plans for a particular rate cell.

Published financial reports of the three plans show that each lost money on the Medicaid market in Kentucky in the first two quarters following implementation of managed care in Medicaid (see table 5). One might think that, in a market where all plans are losing money, the health plan with the lowest rates would lose the most. However, it is Coventry that has the highest medical loss ratio (MLR). This means, for example, that in quarter 1 of 2012, Coventry spent about \$1.20 to pay for the medical care of their enrollees, for every dollar that they were paid by the state.

**Table 5: Medical Loss Ratio by Plan**

|                 | Coventry | KY Spirit | WellCare | Passport | Total  |
|-----------------|----------|-----------|----------|----------|--------|
| <b>2011, Q4</b> | 116.6%   | 103.2%    | 102.5%   | 98.6%    | 104.6% |
| <b>2012, Q1</b> | 120.7%   | 104.3%    | 103.9%   | 99.4%    | 108.1% |

Source: Citi Investment Research and Analysis

Coventry contends that its losses are attributable to its sicker membership. It is plausible that by waiving co-pays and contracting with a broad provider network, Coventry attracted sicker enrollees.

The problem is compounded because the lower capitation rates negotiated by the state with Kentucky Spirit gave them less flexibility to pay providers above the prevailing Medicaid fee-for-service rates. Thus, they could not compete with the other plans in establishing a broader provider network. Consequently, many Kentucky Spirit enrollees chose to re-enroll with one of the other plans during the open enrollment period. The Medicaid beneficiaries who disenrolled from Kentucky Spirit are likely to have been disproportionately sicker, and heavier utilizers of health care, leaving Kentucky Spirit with those who had been auto-assigned to them by the state and shifting higher risk patients to the other plans.

To remedy this situation, plans pressed the state to begin risk-adjusting the capitation rates, as had been planned and negotiated prior to implementation. The state implemented risk-adjustment on April 15, 2012. This resulted in an increase in capitation rates for Coventry and WellCare, and a decrease for Kentucky Spirit. The state has used a nationally-recognized risk-adjustment model to implement risk adjustment, the CDPS Rx model.<sup>17</sup> This model uses diagnosis codes from claims data to determine the risk profiles of the plans' enrollment base.

## **Provider Reimbursement and Special Issues with Cost-Based Providers**

There is no public information available on what plans are paying providers. The state generally imposes no restrictions on what plans can pay their contracted providers, and the rates are subject to negotiations between plans and providers. We were told that generally plans are paying at previous fee-for-service rates, or slightly more, although there are exceptions. The fact that some providers did not sign contracts due to disputes about reimbursement rates suggests that there is variation in what plans are paying some providers.

Some providers are paid an interim rate by plans and these providers expected their rates to be regularly reconciled by the state. For example, Rural Health Clinics (RHCs) and Federally

Qualified Health Centers (FQHCs) are reimbursed a prospective rate while Critical Access Hospitals (CAHs) are reimbursed on a cost basis. These types of providers do not need to negotiate rates with the health plans, as their rates are predetermined.

Delays in reimbursement adjustments have resulted in cash flow issues for these providers. Reconciliation was delayed because the providers were not receiving timely data on the number and amount of claims needed to file for the adjustments. An interim solution was developed whereby the state issued monthly checks based on an estimated number of claims from previous years' data while they develop the capacity of the claims system. To date, the state has not issued a plan to reconcile claims using actual claims data. Some informants expressed concern that they may never recover their losses associated with this problem from the early implementation period.

*“Some payments are being received, though sometimes they are questionable. One of the big problems is that certain organizations are supposed to be made whole by the state and that isn't happening. You've got (providers) that have gone into reserves. They are getting much less money even though the promise was that this wouldn't happen.”*  
(Provider)

## **Utilization Management, Prior Authorization and Claims Denials**

In our interviews with providers we heard that utilization was tightly managed by the plans, which resulted in frequent denial of claims, especially early in the implementation period. Providers noted that a burdensome prior authorization process also slowed claims payment. These problems are reflected in the number of times providers we interviewed mentioned these issues (see table 6). These factors have caused deterioration in the financial situation of many providers since November, 2011, in spite of similar or even enhanced payment rates under the managed care arrangement. The deterioration is also in part due to the termination of the KenPAC program, which had paid a \$4 per-member-per-month case management fee to many clinics and physicians.

Prior authorization requirements have also reportedly led to new administrative barriers for providers, and late claims payment. Providers often complained about the amount of information

that the plans requested of them, and the antiquated modes (“snail mail”, fax) for delivering this information. Their complaints were elevated to the state level, and the Senate Health and Welfare Committee held a hearing to address the hundreds of emails they received.<sup>18</sup> The State Auditor, Adam Edelen, reviewed health plan information and concluded that plans did not have adequate information systems, staffing or communication processes in place.<sup>19</sup> Plans expressed concerns about the methods used by the auditor to derive the recommendations, indicating that the auditor did not directly review plan systems or processes.

**Table 6: Provider Mentions of Managed Care Issues (n= 15)**

| <b>Issue</b>                         | <b>Number of Provider Informants<br/>Who Mentioned the Issue</b> |
|--------------------------------------|--|
| Administrative Hassles               | 9  |
| Slow Prior Authorization Process     | 8  |
| Unclear Prior Authorization Criteria | 5  |
| Coding Issues                        | 5  |
| Plan Staff is Unhelpful              | 4  |

These administrative issues have led to an increase in suspended claims, a major financial issue for some providers. For example, two primary care providers that we interviewed stated that, at the time of our discussion in June, they had unpaid claims dating back to November. They contrasted such delays with the Kentucky Medicaid FFS system, which was reported to have been a timely payer of claims.

*“They didn’t pay as much money, but they paid and they paid quickly.” (Provider)*

*“Our suspended claims have increased 925 percent since the plans began operations in Kentucky. We are talking millions that haven’t been released because of the plans.” (Provider)*

Administrative problems are worsened by the number of claims that providers need to appeal in this new environment, often resulting in a state fair hearing. For example, one hospital reviewed data from quarters 1 and 2 of 2011 and quarters 1 and 2 of 2012 and found that the number of denials subject to appeal went up 84 percent over that time period.



Kentucky Medicaid has historically used Interqual criteria<sup>20</sup> to determine whether or not to admit a patient to an inpatient hospital. Interqual criteria are an industry standard for determining medical necessity. Although the plans confirmed that Interqual criteria were still being used to make utilization management decisions, there was a perceived change in the application of the criteria. Providers noted that many decisions being issued by the plans did not seem to be consistent with the criteria, which they had become familiar with over time. This caused confusion regarding how they would be paid for their services

*“We have some questions about whether (the plans) are making good decisions regarding care, because we have some sick patients who have been denied. We have standard criteria that we use to determine whether someone should be admitted, these are standard criteria that lots of hospitals use. I don’t know if they are using different criteria or what.” (Provider)*

Providers also complained that plans had begun to base payment decisions on information not available to the provider at the time of admission.

*“In the past if it met inpatient criteria, it would be approved by Medicaid. With the plans you have to send a complete medical record to prove the authorization.... When a patient is admitted you don’t have the benefit of knowing the entire stay at that point, but the plans will have the benefit of that information.” (Provider)*

Some providers were simply frustrated because of the lack of communication regarding why a claim was denied.

*“The claim may just say ‘didn’t meet criteria for admission’”. (Provider)*

*“The prior authorization algorithm is not transparent.” (Provider)*

Uncertainty regarding the claims authorization decisions made by plans caused some providers to speculate that the plans did not have clear decision criteria of their own. Providers noted that they received inconsistent information depending on whom they spoke with at a plan. This was true of denials and prior authorizations.

*“We get different answers on the same drug depending on who we talk to when we call. You can talk to (the plan) three times and get three different answers.” (Provider)*

Denials were also a by-product of inconsistent coding standards. Plans and providers alike noted that coding and payment policies led to problems, as providers were relying on longstanding Kentucky coding mechanisms, while the plans were relying on the coding schemes that they used in other states. For example, providers had billed for office care visits in 15 minute increments under the old system, but the plans expected them to bill once for the total amount of time that they spent with the patient. Another provider gave an example of specific modifiers that are used in Kentucky and how they were misinterpreted by the plans,

*“A modifier of 25 is on an office visit if you do something other than just an office visit. If you do an immunization, a strep test, etc. It’s an indicator that you have done something else. When I used the modifier for (a health plan) in March and April, they paid it. Now they are saying that they will be paying for a well visit and an office visit, so they reduced the well visit by 50 percent. That’s not what that means.” (Provider)*

This problem is evidence of communication difficulties between plans and providers early in the implementation of risk-based managed care.

*“When we call the health plans, they don’t really know how to communicate with us or how to communicate with each other. We are having problems learning which codes we need to use.” (Provider)*

Much of the increased burden resulted from a manual prior authorization process. Providers complained that the plans’ electronic systems did not perform at the level of the systems to which they had grown accustomed. Some complained that the plans were inappropriately reliant on mail and fax, and that tracking payment had grown more difficult.

*“You ought to be able to status claims and look at anything. Traditional Medicaid is a model. The claims that went last week would have been in the payment cycle, so I could know what was going to deny and pay next week. I could fix the denial before it ever hit the system. (In the new system) you can’t even view claims very well.” (Provider)*

Although providers were generally discouraged about the prior authorization process, one informant noted that initially Passport had similar issues with lack of payment and the compatibility of claims systems, lending hope to the possibility that these issues will be resolved over time.

## Special Issues with Behavioral Health and Pharmacy

### *Behavioral Health*

Kentucky has chosen to “carve-in” behavioral health services into risk-based managed care, directing responsibility for payment and management of those services to the plans. A major reason for choosing to do so was to promote integration of behavioral health services and physical health services which is important given that many Medicaid enrollees have dual diagnoses. However, Coventry and Kentucky Spirit have subcontracted out these behavioral health services to “sister companies,” MHNet Behavioral Health (Coventry) and Cenpatico (Kentucky Spirit).

Providers in the behavioral health community noted many of the same issues as other providers. Most notably, they experienced slow claims payment, inconsistent answers from the plans, confusion regarding payment and the criteria that plans were using, and disruptions in patient prescriptions (explored in the next section). Beyond these more generalized implementation issues, informants discussed problems that were specific to behavioral health. While all informants favored integration of behavioral and physical health services, providers and advocates were dissatisfied with the plans’ progress in achieving that integration.

Providers also expressed concern that the subcontracts used by Coventry and Kentucky Spirit interfered with the goal of integration. Some said that, in spite of the carve-in, there is little care coordination between behavioral and physical health, resulting in a situation where neither the prime nor the subcontractor wants to pay for certain behavioral health claims.

*“A patient will come in with a condition and have a behavioral health diagnosis imbedded within a medical diagnosis, and we have one firm who is trying to kick that claim over to their behavioral health sub(contract)or... If it’s admitted into a medical diagnosis than you need to treat it that way.” (Provider)*

Another feature of Kentucky’s behavioral health system is that the majority of behavioral health services covered by Medicaid are billed through the Community Mental Health Centers (CMHCs). CMHCs are quasi-governmental agencies, established in statute since 1966, that receive both state and federal funding. They offer a range of services, including psychology,

psychiatry, substance abuse treatment and supports for individuals with mental health and intellectual/developmental disabilities. Plans must contract with these agencies.

There is a widespread perception among informants that CMHCs have not been adequately funded over time, and consequently providers of physical health services have difficulty finding adequate behavioral health resources for their patients.

*“In almost every staff meeting there is a discussion of how to get our patients to the appropriate behavioral health provider.” (Provider)*

*“It was an excellent system, but then it started to deteriorate.” (Provider)*

Providers and advocates acknowledge chronic difficulty in providing appropriate step-down services for patients leaving inpatient facilities (especially children) who are not sick enough to need inpatient services, but are not well enough to be treated as an outpatient. The Impact Plus program of outpatient services has ameliorated the problem for children to some extent. Legislation passed in 2010 established a more intensive level of psychiatric residential treatment facilities and when fully implemented may also ease the problem by creating step down care for children in Kentucky. Plans complained that the necessary services to adequately serve these populations were not present in Kentucky, but advocates expressed concern that any new facilities would not be well-supported by the Medicaid program under managed care. One program run by the North Key Community Mental Health Center, had provided these step-down services for children, but has been closed since the implementation of Medicaid managed care. Advocates contend that this is due to financial and care restrictions imposed by the plans.

## ***Pharmacy***

All three plans expect to achieve significant cost savings by better coordinating enrollee medication and curbing over-prescribing.

*“We pulled a list of 800-900 members who had an average of 30 prescriptions per month; some members had as many as 60 prescriptions.” (Plan)*

In order to achieve these goals, the plans have developed a preferred drug listing (or formulary), which gives preference to low-cost drugs. Providers are expected to prescribe from that list for

beneficiaries enrolled in the particular plan. A provider who wants to prescribe something that is not on the list must request prior authorization. This approach, while common in Medicaid managed care programs, has led to claims denials and frustration among providers who are not accustomed to working with multiple formularies.

*“We begged Medicaid to have a common formulary. The fact that they are all so different is a problem.” (Provider)*

*“Patients who have been on stable therapy for years are being told that they need to try as many as 6 other medications before they can get their current medications approved.” (Provider)*

*“Recently, we tried to change a patient’s medication because [that person] was having a reaction to a drug. The pre-authorization was denied because they hadn’t maxed out their current medication.” (Provider)*

The issue of prior authorization for existing prescriptions seems to be particularly difficult for providers, because they were assured that the drugs that had previously been prescribed would be grandfathered in.

*“We were told that endocrinology meds were grandfathered in, but that did not include diabetes. We were told that cardiovascular meds were grandfathered, but that did not include hypertension. Nothing was really grandfathered in... I asked who is making the decisions regarding what medications are related to what body system. The person I spoke to said that he was not a clinician so he did not know.” (Provider)*

*“They were supposed to have grandfathered people on medications. They changed it on day 1.” (Advocate)*

## **Case Management**

Providers, plans, advocates, and the state all expressed support for the idea that managed care has the potential to improve care coordination for Medicaid beneficiaries. Plans have more resources at their disposal than the state—nurses, data analysts, and community outreach workers—who can work with individual Medicaid beneficiaries to improve their health and health behaviors. Plan case managers can counsel those with chronic illnesses to receive necessary preventive care and adhere to medications. They can assist with poverty-related issues, such as lack of

transportation, that interfere with patients' medical appointments. They can use claims to identify emergency room "frequent-fliers" or those who take multiple medications that interact adversely. Done effectively, these initiatives could both improve the quality of care and reduce its cost.

In the state of Kentucky, it is too soon to evaluate the three new plans' case management programs. The three plans are contractually required to hire case managers, conduct health risk assessments for new members, and develop a care plan for members with special health care needs. However, during our interviews we obtained little detail on their actual activities.

Providers who commented on the issue uniformly agreed that to date they had not seen much evidence of care coordination for patients, with a few exceptions. For example, providers and other informants did note plans were providing health risk assessments, that plans called patients to encourage them to receive annual physicals, and that educational materials had been sent to some of their patients with chronic illnesses.

Two obstacles to the development of good case management programs were identified by respondents: a dearth of potential employees with managed care experience in the state and beneficiaries' lack of experience with managed care concepts.

*"We have a patient who has... legitimate problems, but she'll come in for her big toe one day, or because her ear is hurting. So we called the health plan and they said they had the perfect program, case management. She can call her case manager to see if what she is showing up for is really something that she needs care for. But, she has to agree to it... She still shows up the next day." (Provider)*

## **State Monitoring of Access and Quality**

States are required by the federal government to evaluate plans' performance as it pertains to quality and access to care for Medicaid beneficiaries. To comply with this requirement, the state of Kentucky included quality and access requirements in their contracts with the plans.

However, at the time of our visit there was little progress reported in implementing quality and access programs due to the early stage of implementation and the strain on staff resources due to the implementation issues mentioned above.

Contractual access requirements include:<sup>21</sup> minimum PCP-to-enrollee ratios, minimums for appointment wait times, and maximum driving times for enrollees to reach categories of providers. The Kentucky standards shown in table 7 are fairly typical among large Medicaid managed care states.<sup>22</sup> However, there is some controversy in the state regarding whether these standards are being properly enforced. For example, in *Appalachian Regional Healthcare vs. Coventry Health and Life Insurance Company*, Judge Karl Forester questioned the validity of geo-access reports produced by the state and Coventry to verify adequacy of networks.<sup>23</sup>

**Table 7: Kentucky Access Standards**

| Appointment Wait Times |                    | Maximum Number of Enrollees to Each PCP | Required Geographic Proximity for PCPs |                              |
|------------------------|--------------------|---|--|------------------------------|
| Routine Care (days)    | Urgent Care (days) |   | Urban Areas (miles/ minutes)           | Rural Areas (miles/ minutes) |
| 30                     | 2                  | 1500                                    | 30                                     | 45                           |

The Health Care Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) are commonly used by states to examine their plans' effectiveness. The HEDIS data measure health care utilization and outcomes. The CAHPS data measure patient satisfaction with their plan, providers and their health care. Kentucky plans are contractually required to collect and report both types of data annually (with the first data set to be reported in summer, 2013).

Plan contracts specify which HEDIS measures should be collected by plans. Selected measures indicated in the contracts include measures of physical activity, nutrition, heart disease and stroke, tobacco use, substance abuse, alcohol use, oral health, access to health services, family planning services, sexually transmitted disease services, behavioral health screening, environmental health, and disability. The plans' performance is to be evaluated on a subset of these measures, which are to be determined collaboratively by the state and the plans. At the time of our visit, required HEDIS measures had not yet been determined.

The state requires plans to submit approximately 100 different monitoring reports regularly. Originally, the state had conceived a list of 125 different reports, but they have limited their request in order to optimize the plans' resources, as well as their own. (See Appendix C for the original list of reports.) Still, plans expressed the opinion that the amount of required reporting was burdensome and questioned its value. In addition, advocates reported that the information from the reports is not easily accessible, and that it is unclear how reports are being used. The authors requested nine of the active reports, but were only able to gain access to four. Reports pertaining to subcontractor monitoring, quality improvement activities, performance improvement plans, grievances and appeals, and provider changes in networks were considered to be proprietary and were not provided to us.

The state issued a Request for Proposals on April 25th, 2012, soliciting a new External Quality Review Organization (EQRO), which will be responsible for conducting an annual review of the quality of services provided by the plans. The EQRO will have broad responsibilities such as conducting two quality of care studies per year on topics to be determined collaboratively with the state and plans; reviewing the completeness and quality of claims/encounter data; and auditing the degree to which the plans meet contracted access requirements.<sup>24</sup> The responses were due on June 15th, and on August 31, the state awarded the contract to IPRO.

## **State Capacity to Oversee Medicaid Managed Care**

In general, undertaking an overhaul of the Medicaid delivery system and overseeing its implementation effectively demands a different set of skills from state staff than those needed for administering a fee-for-service Medicaid program.<sup>25</sup> Ideally, the staff overseeing this transition should have Medicaid managed care experience, and should view their role in the transition process as an active one. It is important for any state undergoing such a transition to convert from, for example, overseeing FFS providers and paying claims to regulating and overseeing the work that is being done by plans. The development of an effective working relationship between the state and the plans is critical; if the plans fail, providers and beneficiaries are negatively affected. For example, it is important that state staff act as an intermediary between plans and providers, and ensure that plans are in compliance with their contracts with the state. A staff that



is experienced with fee-for-service reimbursement may need further training in order to fulfill their new role effectively.

Kentucky did have experience overseeing Medicaid managed care in Region 3 since the mid-nineties. However, their previous experience was with one plan, which had experienced past problems with a lack of state oversight.<sup>26</sup> Some of the important functions were contracted out. For example, the Department of Insurance oversaw the regulation of Passport. Now the state staff is responsible for overseeing three additional plans in seven more regions, which is undoubtedly a challenge to staff resources. Furthermore, given the rapid transition to risk-based managed care, retraining did not occur broadly for state Medicaid staff in Kentucky prior to implementation.

As the state adds new staff with managed care experience, its collective knowledge base will improve, and over time Kentucky state staff will be better prepared to undertake a wider range of monitoring tasks. For example, a new branch of 10 people dedicated to managed care oversight has been formed (with six existing staff and four new staff). In addition, the new Medicaid commissioner, Lawrence Kissner, was appointed on July 1, 2012, and has 17 years of experience with managed care.<sup>27</sup> The Medicaid managed care oversight branch is charged—among other functions— with receiving and analyzing reports from the plans. The Cabinet is still deciding how to best utilize information obtained from the reports in order to provide feedback to MCOs, identify areas that may need improvement, and determine best practices.

The Cabinet's task is complicated by their new role overseeing insurers, which has been done by the Kentucky Department of Insurance in the past. Charging an agency which has no experience overseeing insurers with this new responsibility may have exacerbated problems caused by the short implementation timeline. For example, patient protections that were included in other health insurers' contracts were not included in the Medicaid managed care contracts. Proposed legislation to remedy the gap (HB 566) led to a hearing, but the legislation was not passed.

## Developments since the Evaluation Site Visit

Since June, 2012, the implementation of Medicaid managed care has continued. Our evaluation team has continued to monitor the progress of Medicaid managed care in Kentucky, and future reports will reflect these updates. Based on further review of documents and information from the evaluation staff based in Kentucky, we summarize some of the key events that have occurred since June 2012 that likely will have substantial effects on the Medicaid managed care program in Kentucky:

- The second round of open enrollment began on August 20<sup>th</sup>, in which beneficiaries were allowed to switch plans. It is unclear to date how much switching there has been across plans and what the resulting enrollment will be by plan.
- The state issued an RFP in June (with bids due in late July) for plans to provide risk-based managed care services in Region 3 (previously served exclusively by Passport). Contracts were awarded to the following plans: Coventry, Humana, Passport, and WellCare.
- Over the summer months, Coventry notified some providers that it intends to cancel its contracts with them, including most notably contracts with several hospitals: ARH, Kentucky One Health (which includes Jewish Hospital, Frazier Rehab Institute, St. Mary's, and St. Josephs), King's Daughters Medical Center, and Baptist Healthcare.
- There was turnover in Coventry's leadership team shortly after our site visit.
- Aetna, a large commercial managed care organization with increasing public sector enrollment, agreed to acquire Coventry<sup>28</sup> in August 2012. While the overall motivation for the acquisition is national in scope (in preparation for ACA implementation), it also has implications for Kentucky. In particular, Aetna has about 90,000 commercial enrollees in Kentucky, which means that they have already established relationships with some providers. As yet, it is unclear how this will affect Kentucky Medicaid.
- The Cabinet is conducting an assessment by outside consultants concerning how to further reorganize the Medicaid staff to provide improved management of the risk-based managed care program and oversight of health plans.

- Judge Karl Forrester has issued rulings concerning the controversy with Coventry and its contract with ARH. He ordered that the contract remain in place until November 1, 2012.
- Kentucky Spirit has signaled its intent to terminate its contract in July 2013, one year prior to contract expiration and withdraw from the Kentucky market.<sup>29</sup>

In the coming year, the evaluation team will conduct telephone interviews with key informants to update our information on the status of implementation. In addition, we will conduct focus groups with beneficiaries in spring 2013, in order to receive beneficiary opinions of how Kentucky Medicaid managed care has affected their health care access and quality.

## **Observations**

This report has described the implementation of risk-based Medicaid managed care in seven regions of Kentucky over the one-year period from the time the RFP soliciting plan participation was released in late May, 2011, up through the evaluation site visit in June, 2012. In addition, the report provides background information on the time period leading up to the RFP, as well as a brief summary of key events since the site visit.

The report is based on document review and information and opinions from interviews with a select group of key informants. Importantly, we did not speak directly to Medicaid beneficiaries during this phase of the study, although we spoke with patient advocates. In addition, the findings are from a relatively short period, just after risk-based managed care began. With these limitations in mind, below we highlight some major implementation issues that we identified in our study, including those requiring further attention as the state continues to move forward with risk-based Medicaid managed care.

### ***Speed of Implementation***

The implementation period in Kentucky was short. While it is too late to change the process, by all accounts the four- month implementation period led to a number of implementation issues that could have been avoided with more time, and may be ameliorated as more time passes. Also, the short period helped to minimize the potential political opposition to the change. It is

possible that, given strong provider opposition to Medicaid managed care, the change would not have occurred without a quick timetable. If plans and providers can adapt to the new environment administratively and financially, and if coordination of patient care improves, the early difficulties may be overcome. However, if some of the issues that we highlight below continue without necessary attention and resources, risk-based Medicaid managed care in Kentucky may fail, as it did in Region 5 earlier in the history of Kentucky risk-based managed care,<sup>30</sup> or as it did in Tennessee did with their first venture into Medicaid managed care.<sup>31</sup>

### *Disruptions and Delays in Patient Care*

Prior authorization requirements under managed care caused delayed patient care and the introduction of plans' formularies resulted in denials for prescription drugs. These denials affected patient care when their previous medication was changed or coverage was denied, and advocacy groups like the Kentucky Mental Health Coalition, Kentucky Youth Advocates, Kentucky Equal Justice Center, and Kentucky Voices for Health have been documenting these stories. One advocate told us a story of a paranoid schizophrenic with bipolar disease.

*“Getting him his medication and keeping him on them is unbelievable. He was doing well through a year ago. (One day after Medicaid managed care was implemented) he went to his usual pharmacy with his usual prescription, and they told him to come back the next day. He never came back. He was off the medications for four months because part of his mental illness (makes him paranoid of taking drugs).” (Advocate)*

Outside of the areas of pharmacy and mental health, we did not hear of other major disruptions to the receipt of patient care, though we may hear more when we speak with beneficiaries directly. Information from the providers and patient advocates with whom we spoke suggests that most providers continued to provide their patients with a comparable health care experience to that which they would have received under fee-for-service. However, while there is considerable effort to maintain the prior standard of care, providers are simultaneously dealing with what is reportedly much more burdensome administrative requirements and many have been unable to hire additional staff.

*“Many of the providers I’ve talked to have said that they’ve spent so much time on this that they are not spending as much time with patients.” (Advocate)*

Delays in care also occurred due to prior authorization and other reasons described above. Other examples of ways in which access may have been disrupted include: beneficiary confusion about Medicaid managed care and uncertainty about which providers they could see; incomplete and inaccessible provider directories; and discontinuity in beneficiary care due to cancelled contracts between providers and plans. In 2013, focus groups with beneficiaries will augment the findings in this report with beneficiaries' direct perspective on patient care issues.

### ***Lack of Staff Capacity and Experience***

Because risk-based managed care grew substantially in Kentucky, in the first year of implementation there has been a shortage of personnel with managed care experience, particularly at the state and plan levels. In attempting to recruit new staff, the state faces a two-fold challenge: the lack of individuals with such experience in the state and the inability to add new positions due to budget limitations. In the case of the plans, none of the three had operated in Kentucky before, and rapidly had to set up a new operation in the state. In many cases, plans were not able to recruit local staff with managed care experience, leaving them with two options: either to bring in people from outside the state without experience in Kentucky; or to hire local staff with little managed care experience. While more time would not have eliminated this problem altogether, it would have allowed for more re-training of staff.

### ***Lack of Communication between Major Partners***

The major partners in the implementation of risk-based Medicaid managed care are the state, the plans, the providers, and the beneficiaries. In order for the system to function properly, all major partners must work effectively together. However, in Kentucky at the time of the site visit there were a number of signs that the partnership was not functioning well in many respects, and indeed there was evidence of an adversarial relationship, largely due to the financial stress that the state, plans, and providers were under.

The interviews revealed a lack of communication about the many details—large and small—necessary for a smooth transition to risk-based managed care. For example, providers did not always know in which plan their patients were enrolled, and what the rules were for formularies, prior authorization, and claims submission. Some providers did not have ready access to

knowledgeable plan staff who could answer questions accurately and smooth out the inevitable “glitches.”

A critical area where plans were dissatisfied with the level of communication, was in the way that the state provided plans with the information that was needed to achieve “actuarially sound” rates. While we did not audit the process directly, we were told that data were not complete and up-to-date for all services. Specifically, we were told that for some services (for example mental health services provided by state agencies) the reimbursement may not have been thoroughly documented in claims files.

While again we do not yet have the beneficiary perspective, it is likely that the communication problems directly affected beneficiaries as well. For example, in studying provider networks, we discovered that web-based provider directories were sometimes inaccessible or inaccurate. This would affect a beneficiary’s ability to find a PCP or the PCP’s ability to refer their patient to a specialist in their patient’s plan.

### ***Desire by State to Achieve Cost Savings***

It is thoroughly understandable that in the current fiscal environment there is a strong desire and necessity to achieve state budget cost savings. Achieving such savings through improved care coordination and a reduction in unnecessary services has been successfully accomplished in other state Medicaid programs through the adoption of managed care. However, such changes in the way care is provided take time, through changes in procedures and provider and beneficiary behavior. When savings are a primary motivation for risk-based managed care, there is pressure to select the lowest bidders and to force savings in the first year. At the same time, among national proprietary plans that are attempting to grow their Medicaid business and that want to be in a position to provide services to new Medicaid enrollees under the ACA, there is a temptation to bid low, in order to add large numbers of new beneficiaries regardless of how difficult it may be initially to provide care within the capitation rate.

Past experience cited above has shown that when cost savings are the driving force for implementing risk-based Medicaid managed care, problems can arise, notably fiscal distress on the part of both plans and providers. Given our preliminary findings, this may be what has

happened in the first year of Kentucky's state-wide risk-based managed care program. Plans will not continue to participate if they lose money, nor will providers, which could lead to disruptions in patient care if plans and providers exit. It could also lead to the loss of some of the generally-recognized benefits that managed care conveys such as care coordination, improved outcomes, and cost predictability.<sup>32</sup>

### ***Lack of Structure to Oversee Quality and Access Monitoring***

When the state delegates the operation of its Medicaid program to private health plans, as has now occurred in Kentucky, it is the state's responsibility to monitor those plans to assure that they meet the terms of their contracts, including provider access requirements (for example, meeting the contracted standards for accessibility laid out earlier in this report) as well as determining the quality of care provided. With the incentives under risk-based managed care, there is particular concern that some services may be underprovided by managed care plans. However, at the time of the site visit, there was little publicly-available evidence that monitoring was occurring. This is a critical issue, particularly given the cost savings that were imposed on the system in the first year, potentially translating to service limitations. While a large number of reports are required from plans, placing a large burden on stressed staff, at this point it is unclear whether and how the reports are being used for plan monitoring and associated quality oversight. It is a positive step that the state is choosing an External Quality Review Organization, and judicious use of that organization may result in more effective monitoring.

### ***Behavioral Health Care Provider Capacity***

One of Kentucky's behavioral health policies predates the adoption of risk-based managed care. It requires Medicaid beneficiaries to obtain most of their behavioral health care from a limited number of providers that are part of a state-wide network of Community Mental Health Centers (CMHCs). This may have been a reasonable policy in the early years of Medicaid in the late 1960's and the 1970's when the network was well-funded. However, we heard that since that time, as Medicaid enrollment and the associated demand for services has grown, there has not been a concomitant expansion in funding and, thus, in the supply of services through the CMHCs. It is somewhat unusual to have all behavioral health "carved in,"<sup>33</sup> as is the case in

Kentucky. The “carve in” approach can be beneficial if there is adequate access to behavioral health services, and if there is a close linkage between primary care and behavioral health care. However, currently this does not appear to be the case in Kentucky.

Plans indicate that the lack of a complete behavioral health continuum of care in Kentucky does not allow them to effectively manage that care in a cost-effective way in order to provide adequate care within the capitation rates. However, behavioral health advocates contend that intensive outpatient services have become further restricted in the managed care environment due to a lack of plan authorization and financial support for these services. This particularly affects some very high cost child and adolescent care, since there is greater demand for intensive outpatient services to substitute for inpatient hospitalizations, when appropriate. Inpatient hospitalizations are a covered Medicaid benefit for children, unlike adult inpatient mental health services, which are federally excluded by the Institutions for Mental Diseases (IMD) exclusion.

### ***Evolving Health Policy Environment***

Kentucky’s implementation of Medicaid managed care has come at a unique time for health policy nationally. As the state works through the challenges of implementing Medicaid managed care, a number of other important decisions face policymakers. The state must decide whether to implement the Medicaid expansion for adults under the ACA. Additionally, the development of the health benefits exchange authorized by the ACA is underway in Kentucky. The Governor has appointed an Exchange Advisory Board and an Executive Director for the Kentucky Health Benefit Exchange, and must submit a plan for the exchange to the U.S. Department of Health and Human Services by November 16, 2012.<sup>34</sup> The evaluation will continue to assess how Medicaid managed care is affected by these and other new developments.

### ***Moving Forward***

Based on these important implementation issues identified within the first year of the program, we recommend that the implementation partners consider the following steps in the coming year:

- Strong leadership from the Cabinet is critical to ensuring a well-functioning system. The Cabinet can play a prominent role in ensuring that their goals for managed care



are well-defined and well-executed, and that the terms of their contracts with plans are consistently enforced.

- The state's new Medicaid Commissioner has considerable experience in managed care. New state managed care staff will likely benefit from this expertise, and may also benefit from formal and informal training on managed care concepts. This could be accomplished through, for example: site visits to states that have longstanding experience with risk-based managed care; attending national meetings (for example, the National Academy of State Health Policy); attending seminars (in person or on-line); and the review of written materials. Key state staff could be assigned this responsibility and then could function as the local trainers on the ground, both for state staff and providers.
- Plans should have a mix of staff with Kentucky expertise and managed care expertise.
- A stronger collaboration, fostered by state staff, should be developed that assures regular communication among all the key partners (state, plans, providers, and beneficiaries or their advocates). In addition to regular meetings, there should be more information-sharing including, for example, developing a "dashboard" of information from reports from the plans that provides key information and is easily accessible by the public and key stakeholders.
- As the state builds up and trains its managed care staff, a strong core capacity should be developed in plan monitoring. In partnership with the EQRO, the state should define the HEDIS indicators, and begin collecting them from the plans in the coming year. As plans move towards NCQA certification, which the plans indicated they plan to do for their Kentucky lines of business, they will be required to collect the full HEDIS data set according to NCQA specifications. The state should also develop plans for CAHPS surveys for both children and adults. For example, they should determine who will do the survey and how often. The state should also consider mechanisms for assessing the adequacy of managed care plan networks and access to care, such as "patient audit studies" whereby state staff call providers, posing as patients, and request appointments in order to monitor which providers are seeing

new patients and the length of time it takes to obtain an appointment. These kinds of procedures for monitoring quality and access are standard in well-functioning risk-based Medicaid managed care programs. Problems that are uncovered should be shared with plans and providers as part of a collaborative, quality-improvement process. Over time the state may want to implement a “Pay for Performance” system whereby strong performance in particular areas is rewarded by enhanced capitation rates.

- It is apparent that all three plans operating Kentucky’s risk-based managed care program are in some degree of financial distress (see table 5), and Kentucky Spirit has announced their intended departure from Kentucky’s Medicaid program. The state should pay close attention to this issue, and use every source of data available (including plan reports) to assess the seriousness of the problem, in order to determine whether and to what degree, rates should be raised. It is the responsibility of the state’s contracted actuary to assure that the rates are “actuarially sound,” and to assist in determining the source of the financial difficulties that are uncovered.
- More attention should be paid to obtaining direct input from beneficiaries. This will occur if the state implements the CAHPS survey, as well as through the focus groups undertaken by our evaluation.
- Finally, consideration should be given to addressing problems in the behavioral health care system that the implementation of Medicaid managed care has highlighted and which are likely to grow as Medicaid enrollment expands in the coming years. While some of these issues could be addressed through stronger collaboration between the state and plans on improving access to appropriate behavioral health care for Medicaid beneficiaries, fundamental reform will require broader institutional and budgetary changes in both Medicaid and state-funded behavioral health services.

In the coming year, the evaluation will update this very early assessment with information obtained in focus groups from beneficiaries designed to capture their direct input. In addition, we will re-interview all key respondents by telephone to obtain updated information on implementation milestones and to determine the extent to which the issues outlined in this report

have been resolved and whether new issues have emerged. An analysis of quantitative data on access, utilization and cost of care will also be conducted. Through this process, and in future reports, we hope to provide an independent assessment of whether and how Kentucky's risk-based Medicaid managed care program is benefiting the most disadvantaged residents of the state by improving access to and quality of care, improving health outcomes, and reducing cost.

## Endnotes

- <sup>1</sup> Presentation by Secretary Audrey Haynes to the Interim Joint Committee on Health and Welfare. June 20, 2012.
- <sup>2</sup> Howell E, Palmer A and Adams, F. *Medicaid and Chip Risk-Based Managed Care in 20 States: Experiences Over the Past Decade and Lessons for the Future*. Washington, DC: Urban Institute, July 2012.
- <sup>3</sup> Commonwealth of Kentucky Solicitation Number RFP 758 1100000276.
- <sup>4</sup> Kenney G, Dubay L, Zuckerman S and Huntress M. "Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would not Be Eligible for Medicaid?" Washington, DC: Urban Institute, July 5, 2012.
- <sup>5</sup> Howell et al. *Medicaid and Chip Risk-Based Managed Care in 20 States*.
- <sup>6</sup> Avanbenshoten. "Beshear urges lawmakers to balance Medicaid budget." *Cincinnati.com blog*, January 19, 2011.
- <sup>7</sup> Data obtained from the Cabinet through Open Records Request.
- <sup>8</sup> According to the managed care contracts, a plan must pay out-of-network providers 90 percent of the FFS rate for covered services.
- <sup>9</sup> Boyd T. "Appalachian Regional Healthcare Suing Centene, Coventry Demanding Medicaid Managed Care Payments." *Insider Louisville*, April 19, 2012.
- <sup>10</sup> Estep B and Honeycutt Spears V. "Contractor Must Continue Paying for Services at ARH for 30 days, State Official Says." *Kentucky.com*, May 12, 2012.
- <sup>11</sup> *Appalachian Regional Healthcare v. Coventry Life and Health*, Civil Action 5:12-CV-114-KSF, U.S. District Court, Eastern District of Kentucky. <http://docs.justia.com/cases/federal/district-courts/kentucky/kyedce/5:2012cv00114/69776/67/0.pdf?1340278017>
- <sup>12</sup> Personal communication with one of the plans brought to light a host of potential errors in classification of specialists due to a mismatch between the Department for Medicaid Services' (DMS) list and that of the plan, so the reader should review these results with caution.
- <sup>13</sup> Personal Communication with University of Kentucky providers.
- <sup>14</sup> Howell et al. *Medicaid and Chip Risk-Based Managed Care in 20 States*.
- <sup>15</sup> PricewaterhouseCoopers, LLP. *Managed Care Expansion Data Book and Capitation Rate Ranges: Fiscal Years 2012, 2013, and 2014*.
- <sup>16</sup> Ibid.
- <sup>17</sup> The Revision of CDPS and the Development of a Combined Diagnostic and Pharmacy Based Risk Adjustment Model. [http://cdps.ucsd.edu/CDPS\\_Update.pdf](http://cdps.ucsd.edu/CDPS_Update.pdf)
- <sup>18</sup> Yetter D. "Executives Admit to Problems." Louisville, KY: *Courier- Journal*, February 16, 2012.
- <sup>19</sup> Kentucky Government Press Release. "Edelen Makes Recommendations to Improve Kentucky's New Medicaid Managed Care System." February 29, 2012.

- <sup>20</sup> For more information about InterQual Evidence-based Criteria go to [http://www.mckesson.com/en\\_us/McKesson.com/Payers/Decision%2BManagement/InterQual%2BEvidence-Based%2BClinical%2BContent/InterQual%2BEvidence-based%2BCriteria.html](http://www.mckesson.com/en_us/McKesson.com/Payers/Decision%2BManagement/InterQual%2BEvidence-Based%2BClinical%2BContent/InterQual%2BEvidence-based%2BCriteria.html)
- <sup>21</sup> Review of plan contracts.
- <sup>22</sup> Howell et al. *Medicaid and Chip Risk-Based Managed Care in 20 States*.
- <sup>23</sup> See Judge Forrester’s decision in *Appalachian Regional Healthcare et al. vs. Coventry Health and Life Insurance Company, et al.*
- <sup>24</sup> Cabinet for Health and Family Services, Department for Medicaid Services. “Strategy for Assessing and Improving the Quality of Managed Care Services.” 2011.
- <sup>25</sup> Lipson D. “Keeping Watch: Building State Capacity to Oversee Medicaid Managed Care Long-Term Services and Supports.” AARP Public Policy Institute, July, 2012.
- <sup>26</sup> LuAllen C. “Examination of Certain Policies, Procedures, Controls, and Financial Activity of University Health Care, Inc., dba Passport Health Plan, and its Affiliation with the University of Louisville and the Cabinet for Health and Family Services” Frankfort, KY: Auditor of Public Accounts, November, 2010. <http://www.khpi.org/blog/wp-content/uploads/2011/08/2010PassportHealthPlanreport.pdf>
- <sup>27</sup> A new Secretary of the Cabinet for Health and Family Services, Audrey Haynes, was also appointed on April 16, 2012.
- <sup>28</sup> Terlep S and Das A. “Aetna to buy Coventry in \$5.7 Billion Deal.” *Wall Street Journal*, August 20, 2012.
- <sup>29</sup> Kentucky Cabinet for Health and Family Services. “Kentucky Spirit Announced its Intent to Cancel Medicaid Managed Care Contract One Year Early.” Press Release, October 17, 2012. <http://chfs.ky.gov/news/Contract+Termination.htm>
- <sup>30</sup> Marton J, Yelowitz A and Talbert JC. “A Tale of Two Cities? The Heterogeneous Impact of Medicaid Managed Care.” Andrew Young School of Policy Studies Research Paper Series No. 11-28, June 1, 2011. <http://ssrn.com/abstract=1866389> or <http://dx.doi.org/10.2139/ssrn.1866389>
- <sup>31</sup> Chang C. “Evolution of TennCare Yields Valuable Lessons.” *Managed Care*, November, 2007.
- <sup>32</sup> Marton et al. “A Tale of Two Cities?”
- <sup>33</sup> Howell et al. 2012 study found that, of the 20 most established Medicaid managed care states, 13 had carved the service out.
- <sup>34</sup> Kaiser Family Foundation. *State Exchange Profiles: Kentucky*. <http://healthreform.kff.org/State-Exchange-Profiles/Kentucky> (accessed October 10, 2012).

## Appendix A: List of Interviewees

| Organization  | Interviewee       | Title                                     |
|---|-------------------|---|
| <b>State</b>  |                   |   |
| Cabinet for Health and Family Services                                | Lisa Lee          | Director, Division of Provider Operations |
| Kentucky Auditor of Public Accounts                                   | Adam Edelen       | State Auditor                             |
| <b>Health Plans</b>   |                   |   |
| Centene (Kentucky Spirit)   | Jean Rush         | CEO                                       |
| Coventry  | Spencer Boyer     | VP of Network Development                 |
|   | Russell Harper    | Director of Government Relations          |
|   | Carol Muldoon     | VP of Operations                          |
|   | Michael Murphy    | CEO                                       |
| Passport  | Mark Carter       | CEO                                       |
|   | Jill Bell         | VP and Chief Communications Officer       |
| Wellcare  | Dora Wilson       | Chief Operating Officer                   |
|   | Cheryl Schafer    | Senior Medical Director                   |
| <b>Providers</b>  |                   |   |
| Appalachian Regional Hospital   | Rick King         | Chief Legal Officer                       |
| Danville Medical Specialists  | Matt Adams        | Administrator                             |
| Fairview Community Health Center                                      | Chris Keyser      | Executive Director                        |
| Hazard Clinic   | Annie Williams    | Practice Administrator                    |
|   | Stephanie Wooton  | Practice Administrator                    |
| Individual Physician's Office   | Donald Neel, M.D. | Physician                                 |
|   | Judy Hayden       | Administrator                             |
| Kentucky Association of Mental Health/<br>Mental Retardation Programs | Steve Shannon     | Executive Director                        |
| Kentucky Dental Association   | Michael Porter    | Executive Director                        |
| Kentucky Health Department<br>Association                             | Linda Sims        | President                                 |
| Kentucky Hospital Association   | Steve Miller      | Vice President of Finance                 |
|   | Nancy Galvagni    | Senior Vice President                     |
| Kentucky Medical Association  | Patrick Padgett   | Executive Vice President                  |
|   | Lindy Lady        | Medical Practice Advocacy Manager         |
| Kentucky Medical Services Foundation                                  | Peggy Halcomb     | Director of Business Operations           |
| Marcum and Wallace Hospital   | Susan Starling    | Chief Executive Officer                   |
|   | Della Deerfield   | Chief Financial Officer                   |
|   | Chastity Ware     | Chief Medical Officer                     |
|   | Kristy Canter     | Case Manager                              |

| <b>Organization</b>           | <b>Interviewee</b> | <b>Title</b>   |
|-------------------------------|--------------------|--|
| Trover Health System          | Bert Whitaker      | Chief Executive Officer  |
|                               | Robert Brooks      | Vice President of the Education and Research Foundation                        |
|                               | Randall Power      | Vice President of Clinic Operations  |
| University of Kentucky        | Edward Erway       | Chief Revenue Officer  |
|                               | Mark Birdwhistell  | Associate Vice President for Marketing and External Affairs and Chief of Staff |
| White House Clinics           | Stephanie Moore    | Chief Executive Officer  |
| <b>Advocates</b>              |                    |  |
| Advocacy Action Network       | Sheila Schuster    | Executive Director   |
| Kentucky Equal Justice Center | Rich Seckel        | Director   |
| Kentucky Voices for Health    | Jodi Mitchell      | Executive Director   |
| Kentucky Youth Advocates      | Andrea Bennett     | Senior Policy Analyst  |
| <b>State Legislator</b>       |                    |  |
| Kentucky Legislature          | Julie Denton       | Senator  |

## Appendix B: Approved Capitation Payment Rates, FY 2012

### WellCare of Kentucky, Inc.

#### YEAR 1 – OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2012

|                                    | Year 1   |          |   |          |          |          |          |          |
|------------------------------------|----------|----------|---|----------|----------|----------|----------|----------|
|                                    | 1        | 2        | 3 | 4        | 5        | 6        | 7        | 8        |
| <b>Families and Children</b>       |          |          |   |          |          |          |          |          |
| Infant (age under 1)               | 530.52   | 591.85   |   | 626.52   | 750.48   | 614.59   | 767.50   | 718.17   |
| Child (age 1 through 5)            | 120.78   | 107.22   |   | 134.78   | 138.98   | 110.19   | 138.82   | 162.09   |
| Child (age 6 through 12)           | 142.91   | 157.75   |   | 183.41   | 169.33   | 146.64   | 166.27   | 183.96   |
| Child (age 13 through 18) - Female | 259.40   | 260.69   |   | 281.86   | 290.16   | 251.15   | 253.93   | 280.68   |
| Child (age 13 through 18) - Male   | 198.33   | 234.32   |   | 229.85   | 226.83   | 185.80   | 175.45   | 195.96   |
| Adult (age 19 through 24) - Female | 586.92   | 530.21   |   | 534.88   | 615.68   | 569.32   | 563.17   | 562.65   |
| Adult (age 19 through 24) - Male   | 206.12   | 206.12   |   | 206.12   | 206.12   | 206.12   | 206.12   | 206.12   |
| Adult (age 25 through 39) - Female | 514.71   | 462.28   |   | 488.77   | 553.05   | 534.62   | 477.19   | 485.77   |
| Adult (age 25 through 39) - Male   | 461.83   | 331.65   |   | 370.30   | 390.30   | 390.04   | 303.99   | 338.13   |
| Adult (age 40 or older) - Female   | 549.61   | 468.42   |   | 564.84   | 610.56   | 571.42   | 643.55   | 561.12   |
| Adult (age 40 or older) - Male     | 601.88   | 567.30   |   | 506.25   | 666.02   | 684.37   | 554.68   | 485.86   |
| <b>SSI Adults without Medicare</b> |          |          |   |          |          |          |          |          |
| Adult (age 19 through 24) - Female | 564.34   | 570.45   |   | 628.28   | 549.54   | 517.94   | 578.39   | 551.72   |
| Adult (age 19 through 24) - Male   | 479.38   | 375.10   |   | 334.75   | 439.66   | 643.30   | 448.39   | 386.09   |
| Adult (age 25 through 44) - Female | 757.51   | 684.81   |   | 738.39   | 782.84   | 791.88   | 823.10   | 753.97   |
| Adult (age 25 through 44) - Male   | 485.87   | 517.03   |   | 559.44   | 673.97   | 651.29   | 548.25   | 590.72   |
| Adult (age 45 or older) - Female   | 935.76   | 990.67   |   | 965.78   | 1,033.15 | 1,014.44 | 1,026.77 | 1,061.82 |
| Adult (age 45 or older) - Male     | 861.60   | 886.59   |   | 818.06   | 965.61   | 989.97   | 816.28   | 859.56   |
| <b>Waiver Option</b>               |          |          |   |          |          |          |          |          |
| <b>Dual Eligible</b>               |          |          |   |          |          |          |          |          |
| All Ages - Female                  | 106.80   | 130.71   |   | 131.04   | 150.24   | 148.15   | 150.01   | 155.69   |
| All Ages - Male                    | 95.60    | 111.82   |   | 116.68   | 127.96   | 142.58   | 135.00   | 136.30   |
| <b>SSI Children</b>                |          |          |   |          |          |          |          |          |
| Infant (age under 1)               | 5,650.40 | 5,650.40 |   | 5,650.40 | 5,650.40 | 5,650.40 | 5,650.40 | 5,650.40 |
| Child (age 1 through 5)            | 468.56   | 518.72   |   | 625.89   | 888.00   | 945.34   | 642.41   | 631.04   |
| Child (age 6 through 18)           | 565.57   | 677.53   |   | 738.47   | 681.69   | 536.24   | 560.09   | 472.71   |
| <b>Foster Care</b>                 |          |          |   |          |          |          |          |          |
| Infant (age under 1)               | 1,474.72 | 1,474.72 |   | 1,474.72 | 1,474.72 | 1,474.72 | 1,474.72 | 1,474.72 |
| Child (age 1 through 5)            | 232.16   | 273.77   |   | 271.94   | 328.50   | 229.08   | 277.89   | 296.40   |
| Child (age 6 through 12)           | 453.14   | 611.61   |   | 611.64   | 525.51   | 401.00   | 468.02   | 466.74   |
| Child (age 13 or older) - Female   | 549.26   | 779.22   |   | 873.00   | 906.28   | 769.84   | 635.18   | 902.79   |
| Child (age 13 or older) - Male     | 1,083.40 | 1,031.39 |   | 782.42   | 733.69   | 760.85   | 605.29   | 771.03   |



# COVENTRY HEALTH AND LIFE INSURANCE COMPANY

## YEAR 1 – OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2012

|                                    | Year 1   |          |   |          |          |          |          |          |
|------------------------------------|----------|----------|---|----------|----------|----------|----------|----------|
|                                    | 1        | 2        | 3 | 4        | 5        | 6        | 7        | 8        |
| <b>Families and Children</b>       |          |          |   |          |          |          |          |          |
| Infant (age under 1)               | 540.85   | 530.73   |   | 582.49   | 597.07   | 539.77   | 577.07   | 576.37   |
| Child (age 1 through 5)            | 120.14   | 117.88   |   | 129.39   | 132.61   | 119.87   | 128.16   | 128.02   |
| Child (age 6 through 12)           | 144.75   | 142.06   |   | 155.90   | 159.84   | 144.52   | 154.49   | 154.27   |
| Child (age 13 through 18) - Female | 249.33   | 244.59   |   | 268.49   | 275.11   | 248.65   | 265.88   | 265.64   |
| Child (age 13 through 18) - Male   | 185.37   | 181.96   |   | 199.67   | 204.77   | 185.16   | 197.92   | 197.60   |
| Adult (age 19 through 24) - Female | 539.10   | 528.01   |   | 580.15   | 593.17   | 535.56   | 573.14   | 573.59   |
| Adult (age 19 through 24) - Male   | 193.97   | 190.89   |   | 209.15   | 215.23   | 194.94   | 208.10   | 207.21   |
| Adult (age 25 through 39) - Female | 474.05   | 464.57   |   | 510.27   | 522.12   | 471.60   | 504.54   | 504.63   |
| Adult (age 25 through 39) - Male   | 333.29   | 328.07   |   | 359.40   | 369.95   | 335.14   | 357.71   | 356.10   |
| Adult (age 40 or older) - Female   | 521.97   | 512.61   |   | 562.33   | 577.05   | 521.94   | 557.77   | 556.62   |
| Adult (age 40 or older) - Male     | 512.28   | 503.73   |   | 552.18   | 567.59   | 513.81   | 548.73   | 546.87   |
| <b>SSI Adults without Medicare</b> |          |          |   |          |          |          |          |          |
| Adult (age 19 through 24) - Female | 522.36   | 512.97   |   | 507.26   | 570.19   | 582.31   | 543.53   | 538.52   |
| Adult (age 19 through 24) - Male   | 395.15   | 388.05   |   | 383.73   | 431.33   | 440.50   | 411.17   | 407.37   |
| Adult (age 25 through 44) - Female | 709.16   | 696.42   |   | 688.66   | 774.09   | 790.56   | 737.91   | 731.10   |
| Adult (age 25 through 44) - Male   | 564.57   | 554.44   |   | 548.26   | 616.27   | 629.38   | 587.46   | 582.05   |
| Adult (age 45 or older) - Female   | 950.14   | 933.07   |   | 922.68   | 1,037.14 | 1,059.19 | 988.66   | 979.54   |
| Adult (age 45 or older) - Male     | 868.01   | 852.42   |   | 842.93   | 947.49   | 967.64   | 903.20   | 894.87   |
| <b>Waiver Option</b>               |          |          |   |          |          |          |          |          |
| <b>Dual Eligible</b>               |          |          |   |          |          |          |          |          |
| All Ages - Female                  | 102.42   | 122.07   |   | 123.45   | 138.99   | 142.58   | 139.49   | 144.47   |
| All Ages - Male                    | 90.21    | 107.51   |   | 108.73   | 122.42   | 125.58   | 122.85   | 127.24   |
| <b>SSI Children</b>                |          |          |   |          |          |          |          |          |
| Infant (age under 1)               | 4,242.23 | 5,039.36 |   | 5,522.82 | 5,878.51 | 4,829.08 | 4,583.58 | 3,995.12 |
| Child (age 1 through 5)            | 577.25   | 685.72   |   | 751.51   | 799.91   | 657.11   | 623.70   | 543.63   |
| Child (age 6 through 18)           | 476.88   | 566.49   |   | 620.84   | 660.82   | 542.85   | 515.26   | 449.11   |
| <b>Foster Care</b>                 |          |          |   |          |          |          |          |          |
| Infant (age under 1)               | 1,209.50 | 1,379.19 |   | 1,358.59 | 1,393.59 | 1,100.29 | 1,127.05 | 1,389.74 |
| Child (age 1 through 5)            | 223.26   | 254.59   |   | 250.78   | 257.24   | 203.10   | 208.04   | 256.53   |
| Child (age 6 through 12)           | 439.38   | 501.02   |   | 493.54   | 506.25   | 399.71   | 409.43   | 504.85   |
| Child (age 13 or older) - Female   | 678.77   | 774.01   |   | 762.45   | 782.08   | 617.49   | 632.50   | 779.92   |
| Child (age 13 or older) - Male     | 640.55   | 730.43   |   | 719.52   | 738.05   | 582.72   | 596.89   | 736.01   |

# KENTUCKY SPIRIT HEALTH PLAN, INC.

## YEAR 1 – OCTOBER 1, 2011 THROUGH JUNE 30, 2012

|                                    | Year 1   |          |   |          |          |          |          |          |
|------------------------------------|----------|----------|---|----------|----------|----------|----------|----------|
|                                    | 1        | 2        | 3 | 4        | 5        | 6        | 7        | 8        |
| <b>Families and Children</b>       |          |          |   |          |          |          |          |          |
| Infant (age under 1)               | 334.27   | 340.06   |   | 359.14   | 410.37   | 326.33   | 424.66   | 423.84   |
| Child (age 1 through 5)            | 116.34   | 101.92   |   | 127.97   | 136.43   | 104.09   | 129.66   | 152.86   |
| Child (age 6 through 12)           | 131.86   | 145.97   |   | 167.99   | 156.31   | 132.57   | 150.34   | 166.17   |
| Child (age 13 through 18) - Female | 240.25   | 241.12   |   | 256.22   | 267.12   | 226.04   | 225.74   | 252.04   |
| Child (age 13 through 18) - Male   | 191.51   | 229.54   |   | 216.59   | 217.04   | 173.79   | 159.56   | 176.74   |
| Adult (age 19 through 24) - Female | 533.82   | 472.16   |   | 488.70   | 543.15   | 496.16   | 492.31   | 496.91   |
| Adult (age 19 through 24) - Male   | 172.19   | 144.61   |   | 188.96   | 200.27   | 193.71   | 191.73   | 168.83   |
| Adult (age 25 through 39) - Female | 467.48   | 413.27   |   | 444.40   | 491.07   | 467.91   | 418.49   | 421.54   |
| Adult (age 25 through 39) - Male   | 433.27   | 305.40   |   | 347.15   | 358.48   | 351.86   | 271.89   | 296.02   |
| Adult (age 40 or older) - Female   | 500.43   | 416.49   |   | 502.07   | 534.56   | 493.94   | 547.50   | 467.94   |
| Adult (age 40 or older) - Male     | 568.50   | 512.55   |   | 465.82   | 599.82   | 594.67   | 473.15   | 416.09   |
| <b>SSI Adults without Medicare</b> |          |          |   |          |          |          |          |          |
| Adult (age 19 through 24) - Female | 563.86   | 560.63   |   | 597.40   | 525.90   | 513.59   | 549.09   | 506.23   |
| Adult (age 19 through 24) - Male   | 475.97   | 355.37   |   | 324.98   | 436.95   | 524.99   | 421.44   | 346.72   |
| Adult (age 25 through 44) - Female | 733.94   | 652.22   |   | 707.82   | 739.25   | 750.35   | 768.14   | 674.01   |
| Adult (age 25 through 44) - Male   | 476.03   | 499.40   |   | 547.05   | 656.73   | 649.12   | 520.16   | 540.73   |
| Adult (age 45 or older) - Female   | 890.57   | 935.36   |   | 895.65   | 960.19   | 948.33   | 926.40   | 924.77   |
| Adult (age 45 or older) - Male     | 816.14   | 858.44   |   | 771.16   | 936.59   | 971.95   | 751.90   | 762.22   |
| <b>Waiver Option</b>               |          |          |   |          |          |          |          |          |
| <b>Dual Eligible</b>               |          |          |   |          |          |          |          |          |
| All Ages - Female                  | 116.96   | 141.58   |   | 143.93   | 161.41   | 157.46   | 156.32   | 163.33   |
| All Ages - Male                    | 104.85   | 120.30   |   | 126.91   | 134.50   | 150.14   | 141.21   | 140.34   |
| <b>SSI Children</b>                |          |          |   |          |          |          |          |          |
| Infant (age under 1)               | 3,177.99 | 2,983.31 |   | 4,121.55 | 5,643.79 | 4,272.65 | 4,529.93 | 3,819.84 |
| Child (age 1 through 5)            | 447.02   | 510.66   |   | 598.05   | 957.40   | 976.76   | 606.79   | 609.28   |
| Child (age 6 through 18)           | 505.72   | 608.15   |   | 662.98   | 627.05   | 479.66   | 487.10   | 420.16   |
| <b>Foster Care</b>                 |          |          |   |          |          |          |          |          |
| Infant (age under 1)               | 771.05   | 460.03   |   | 714.09   | 1,500.06 | 633.34   | 1,080.50 | 1,961.72 |
| Child (age 1 through 5)            | 221.07   | 251.18   |   | 242.08   | 334.45   | 215.85   | 268.19   | 276.24   |
| Child (age 6 through 12)           | 404.25   | 521.39   |   | 510.44   | 464.97   | 336.59   | 404.02   | 402.02   |
| Child (age 13 or older) - Female   | 484.55   | 702.52   |   | 784.14   | 861.75   | 700.02   | 572.29   | 839.60   |
| Child (age 13 or older) - Male     | 918.60   | 934.73   |   | 709.02   | 688.57   | 703.20   | 560.55   | 697.03   |

## Appendix C: Initial List of Potential Managed Care Plan Reports

| Report # | Report Name  |
|----------|--|
| 1        | NAIC Annual Financial Statement  |
| 2        | Audit/ Internal Control  |
| 3        | NAIC Quarterly Financial Statement   |
| 4        | Executive Summary  |
| 5        | Enrollment Changes by Quarter  |
| 6        | Member Requested Change in PCP Assignment  |
| 6        | Member Requested Change in PCP Assignment (Annual)                                 |
| 7        | PCP Requested Change in Member Assignment  |
| 7        | PCP Requested Change in Member Assignment (Annual)                                 |
| 8        | MCO Initiated Change in PCP Assignment   |
| 8        | MCO Initiated Change in PCP Assignment (Annual)                                    |
| 9        | PCPs with Panel Changes Greater than 50 or 10%                                     |
| 9        | PCPs with Panel Changes Greater than 50 or 10% (Annual)                            |
| 10       | Narrative for the MCO Reports #s 6-8   |
| 11       | Call Center  |
| 12       | Provider Network File Layout   |
| 12A      | GeoAccess Network Reports and Maps   |
| 13       | Access and Delivery Network Narrative  |
| 14       | Denial of MCO Participation (Quarterly)  |
| 15       | Subcontractor Monitoring   |
| 16       | Summary of Quality Improvement Activities  |
| 17       | Quality Assessment and Performance Improvement Work Plan                           |
| 18       | Monitoring Indicators, Benchmarks, and Outcomes                                    |
| 19       | Performance Improvement Projects   |
| 20       | Utilization of Subpopulations and Individuals with Special Healthcare Needs        |
| 21       | MCO Committee Activity   |
| 22       | Satisfaction Survey(s)   |
| 23       | Evidence Based Guidelines for Practitioners  |
| 24       | Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death |
| 25       | Overview of Activities   |
| 26       | Credentialing and Re-credentialing Activities During the Quarter                   |
| 27       | Grievance Activity   |
| 28       | Appeal Activity  |
| 29       | Grievances and Appeals Narrative   |
| 30       | Quarterly Budget Issues  |
| 31       | Potential or Anticipated Fiscal Problems   |
| 32       | Enrollment Summary   |
| 33       | Utilization of Ambulatory Care by Age Breakdown                                    |
| 34       | Utilization of Emergency and Ambulatory Care Resulting in Hospital Admission       |
| 35       | Emergency Care by ICD-9 Diagnosis  |
| 36       | Home Health Utilization  |
| 37       | Utilization of Ambulatory Care by Provider Type and Category of Aid                |
| 38       | EPSDT Special Services   |
| 39       | Monthly Formulary Management   |
| 46       | Systems Development and Encounter Data   |
| 47       | Claims Processing Timeliness/ Encounter Data                                       |
| 48       | Organizational Changes   |
| 49       | Administrative Changes   |
| 50       | Innovations and Solutions  |
| 51       | Operational Changes  |
| 53       | Prompt Payment   |
| 54       | COB Savings  |

| <b>Report #</b> | <b>Report Name</b>  |
|-----------------|---|
| 55              | Medicare Cost Avoidance   |
| 56              | Non-Medicare Cost Avoidance   |
| 57              | Potential Subrogation   |
| 58              | Original Claims Processed   |
| 59              | Prior Authorizations  |
| 60              | Original Claims Payment Activity  |
| 61              | Denied Claims Activity  |
| 62              | Suspended Claims Activity   |
| 63              | Claims Inventory  |
| 64              | Encounter Data  |
| 67              | Provider Credentialing Activity   |
| 68              | Provider Enrollment   |
| 69              | Termination from MCO Participation  |
| 70              | Denial of MCO Participation   |
| 72              | Medicaid Program Violation Letters and Collections  |
| 73              | Explanation of Member Benefits  |
| 74A             | Medicaid Program Lock-In Reports/ Admits Savings Summary Table  |
| 74B             | Medicaid Program Lock-In Reports/ Rolling Annual Calendar Comparison  |
| 74C             | Medicaid Program Lock-In Reports/ Member Initial Lock-In Effective Dates  |
| 75              | SUR Algorithms  |
| 76              | Provider Fraud Waste and Abuse  |
| 77              | Member Fraud Waste and Abuse  |
| 78              | Quarterly Benefits Payment  |
| 79              | Health Risk Assessments   |
| 80              | Provider Changes in Network   |
| 81              | Par and Non-Par Provider Participation  |
| 82              | Status of all Subcontractors  |
| 83              | Member TPL Resource Information   |
| 84              | Quality Assessment and Performance Improvement Project  |
| 85              | Quality Improvement Plan and Evaluation   |
| 86              | Annual Outreach Plan  |
| 87              | DMS Copied on Report to Management of any Changes in Member Services Function to Improve the Quality of Care Provided or Method of Delivery |
| 88              | Absent Parent Canceled Court Order Information  |
| 89              | List of Members Participating with the Quality Member Access Advisory Committee   |
| 90              | Performance Improvement Projects Proposal   |
| 91              | Abortion Procedures   |
| 92              | Performance Improvement Projects Proposal   |
| 93              | EPSDT CMS - 416   |
| 94              | Member Surveys  |
| 95              | Provider Surveys  |
| 96              | Audited HEDIS Reports   |
| 97              | Behavioral Health Adults and Children   |
| 98              | Behavioral Health Pregnant and Postpartum   |
| 99              | Behavioral Health Intravenous Drug Users  |
| 100             | EPSDT for Behavioral Health Populations   |
| 101             | Behavioral Health Evidence Based Practices  |
| 101A            | Behavioral Health and Wellness  |
| 102             | Behavioral Health and Chronic Physical Health   |
| 104             | Behavioral Health Expenses PMPM   |
| 105             | Unduplicated Number of Adults and Children/ Youth Received Services under 907 KAR 3:110   |
| 106             | Behavioral Health Pharmacy for all MCO Members- Adults and Children   |
| 107             | Behavioral Health Capacity  |
| 108             | Unduplicated Number of Adults and Children/ Youth Received PRTF- Level I and Level II   |

| <b>Report #</b> | <b>Report Name</b>  |
|-----------------|---|
| 109             | Unduplicated Number and Percentage of Adults and Children/ Youth Readmitted to PRTF   |
| 110             | Behavioral Health Services by Procedure   |
| 111             | Unduplicated Number and Percentage of Adults with SMI   |
| 112             | Unduplicated Number and Percentage of Adults with SMI and Children/ Youth with SED Received with Co-occurring Mental Health Abuse Disorders |
| 113             | Unduplicated Number and Percentage of Children/ Youth with SED Therapy or Family Functional Therapy   |
| 114             | Unduplicated Number and Percentage of Children/ Youth with SED who were assessed for Trauma History   |
| 115             | Unduplicated Number of Adults and Children/ Youth of their Caregivers Received Peer Support Service   |
| 116             | Unduplicated Number and Percentage of Pregnant and Post-partum women with Substance use Disorders Received First Treatment within 48 hours  |
| 117             | Unduplicated Number and Percentage of Children/ Youth Discharged from PRTF  |
| 119             | Behavioral Health Statistics Improvement Project Adult Survey   |
| 120             | Behavioral Health Statistics Improvement Project Child Survey   |
| 121             | Unduplicated Number of Adults and Children/ Youth with Behavioral Health Diagnosis' with PCP  |
| 122             | Unduplicated Number of Children/ Youth with Behavioral Health Diagnoses Received Annual Wellness Check/ Health Exam                         |
| 123             | Unduplicated Number of Adults and Children/ Youth General Behavioral Health Diagnosis and Chronic Physical Health Diagnosis                 |
| 124             | Unduplicated Number of Adults and Children/ Youth with Regular use of Tobacco Products  |
| 125             | Unduplicated Number of Adults and Children/ Youth Screened for Substance Use Disorder in Physical Care Setting                              |

\* Some reports were assigned a number and then deactivated, but may be re-activated at a later point. These reports were omitted from this list.