

Managed Health Services

QI Program Executive Summary

1(a) Summary

The objective of the 2008 Annual Program Evaluation is to provide a systematic analysis of Managed Health Services' (MHS) performance and to define meaningful and relevant quality improvement activities for 2009. The MHS Board of Directors, Chief Executive Officer, Medical Director, and the Senior Management Team provides oversight of the health plan's quality, utilization, and operational quality improvement functions. The Annual Evaluation and Annual Work Plans are reviewed and approved by the Senior Executive Quality Improvement Committee (SEQIC), Clinical and Service Quality Improvement Committee (CASQIC), and Utilization Management Committee (UMC) before going to the Board of Directors for final review and approval. These entities serve as the foundation for making recommendations, taking action, and ensuring follow-up for effectiveness associated with the adopted recommendations.

In late 2007 and on into early 2008, MHS changed its approach to quality improvement. The purpose of the change in strategy was to actively involve the entire organization with the responsibility of improving the quality of care and services delivered to its members and providers. The organization-wide approach to improvement began with the decentralization of quality improvement activities from the Quality Improvement (QI) department to key clinical and service related departments. The QI department, while still performing core functions such as quality referral investigations and medical appeals, now coordinates and monitors progress on QI activities performed in other departments such as preventive health, chronic disease management and EPSDT outreach.

Also in late 2007 and early 2008, MHS drafted and adopted a Utilization Management Program as an addendum to the 2007 Quality Improvement/Utilization Management Program. Effective utilization management activities had always been an integral component of MHS' clinical operations and quality management programs but never formally adopted as a separately described comprehensive program until 2007.

Throughout 2008, the QI department and MHS remained focused and committed to this new structure for quality improvement. One of the hallmarks of this 'entire plan' quality integration was an integrated quality and marketing plan that espoused the philosophy that best marketing practice involves the marketing of preventive health and established medical best practices. And, although this plan-wide intense focus on quality was not seen markedly in the 2008 HEDIS[®] reporting year (RY) results (2007 dates of service); early indications of HEDIS[®] 2009 results (2008 dates of service) are positive and encouraging that the plan has changed direction and is headed in the right direction.

1(b) Accomplishments and Improvements

The areas of accomplishment and improvement of which MHS are most proud are the following:

- Throughout 2008, MHS departments worked actively in a spirit of collaboration on many integrated, interdepartmental, quality-based committees inclusive of the Grievances and Appeals workgroup, Preventive Health Advisory Council (PHAC), CAHPS workgroup, HEDIS[®] workgroup, Asthma Disease Management oversight, Behavioral Health improvement workgroup, and many more. These committees made many robust changes and implemented several interventions that have proven effective already or are showing great promise to positively affect RY2009 HEDIS[®] rates.
- Grievance and Appeals Turn-Around-Time (TAT) rates were abysmal at the beginning of calendar year (CY) 2008. Appeal Level 1 average TAT in March was 53 business days (BD) and the Appeal Level 2 average TAT, 36 BD; and, not even tracked until April, the Grievance average TAT was 73 BD. Beginning in May, the QI department charted a new course that began with extreme optimization of the entire work process (inclusive of root cause analysis), adding new staff and an Grievance and Appeals Manager, and custom building and implementing a Grievance and Appeals software tracking and reporting application. From July through December 2008, the team boasted a sustained improvement with average TATs of less than 20 BD. December TATs for Grievances, Appeal Level 1, and Appeal Level 2 cases were 17 BD, 8 BD, and 7 BD respectively. The Office of Medicaid Policy and Planning (OMPP) removed MHS from its corrective action plan for Grievance and Appeals in late 2008 after being convinced of a successful intervention that led rapidly to a marked and sustained improvement.
- Prenatal and Postpartum Care. MHS rates for prenatal and postpartum care continue to reflect the exemplary care coordination that MHS members receive in the perinatal period. Both the RY2008 Prenatal Timeliness rate of 89.84% and the Postpartum Care rate of 66.41% exceed the NCQA Quality Compass Medicaid National Benchmark 75th percentile rate.
- Immunizations. MHS has made great strides in improving the immunization rates of both its child and adolescent members over the past four years. From RY2007 to RY2008, MHS increased its rates significantly for Combination 2 and Combination 3 immunization measures respectively. For Combination 2, MHS increased its immunization rate from 55.47% to 61.31% ($p = .04$); and for Combination 3, an increase from 46.23% to 55.96% ($p=.003$) was realized. MHS continued robust outreach to members regarding the importance of childhood vaccinations throughout 2008, making more than 50,000 calls to members by the Quality Outreach Team, sending post cards to members on their birthdays, and holding Kindergarten Roundup and Healthcheck Day events.
- Women's Health. MHS began intensive ramp-up of its QI programs for women's health in 2008. Although a transition and planning year, MHS began in late 2008 partnering with facilities to provide Mammography Day events in which MHS booked the facility and scheduled members in the surrounding area who had not

received a mammogram. MHS is proud to note an increase in RY2008 HEDIS® breast cancer screening rates from 34.84% to 36%.

- Access and Availability. MHS added 435 providers to the network in 2008 and facilitated the availability of specialty care through focused contracting in areas where members have limited choice. MHS met 100% of the State required access requirements for PMPs and 95% for specialty providers. MHS is extremely proud to report that RY2008 heralded a benchmark year for the plan's performance on both the Call Answer Timeliness (CAT) and Call Abandonment (CAB) rates. Both rates were greater than the respective 2008 NCQA National Medicaid 75th percentile benchmark rates. The CAT measure boasted a highly significant increase ($p < .001$) from RY2007 with an RY2008 rate of 89.5%. The CAB measure performance did not significantly change from RY2007, for the RY2008 rate of 1.54% indicated a sustained stellar performance by the member services team.
- Over- and Under-utilization Monitors. MHS utilization statistics, when compared to national benchmarks, indicate an appropriate use of services in the key areas of Ambulatory and Maternity Services.
- 2008 Child and Adult CAHPS (satisfaction survey). For the Child CAHPS survey, MHS' ratings exceeded the 2008 NCQA Quality Compass National Medicaid 75th percentile benchmarks in the categories of Getting Care Quickly, How Well Doctors Communicate, and Rating of Specialist. The rating exceeded the 50th percentile benchmark for the Rating of Healthcare category. For the Adult CAHPS survey, MHS ratings exceeded the 50th percentile benchmarks for almost every category (Customer Service, Rating of Health Care, Rating of Personal Doctor, Rating of Specialist, Rating of Health Plan); and, exceeded the 75th percentile benchmarks for Getting Needed Care and Getting Care Quickly categories.
- Employee Turnover. MHS effectively reduced its employee turnover rate by 11.29% in 2008 compared to 2007. MHS' turnover rate in 2007 was 45.49%, and in 2008 was decreased by more than 10 percentage points to 34.20%.

1(c) Strengths of MHS' QAIP and UM Programs

- Practitioners and Senior Management actively participate in QI and Advisory Committees.
- Programs' design/re-design permits flexibility to serve the multiple needs of the organization.
- Promote multi-disciplinary and interdepartmental participation in quality improvement activities.
- Use language, ethnicity, and cultural information to focus activities on typically underserved populations.
- Promote collaboration with community health centers, community agencies, and governmental agencies for improving care and service to Indiana's Medicaid population.

1(d) Case Management

- Transitioned 160 catastrophic members to more appropriate care (demonstrating potential cost savings of 4.8 million dollars)
- Maintained an inpatient readmission rate of < 2% for the year (1.22% actual)
- Completed a gap analysis for NCQA Case Management/Disease Management standards and initiated process to revise all policies/procedures to meet 2010 NCQA standards

1(e) Utilization Management

- Sustained the medical/surgical admit/1000 member ratio at 26 for the 2008 year (compared to a 2007 year end ratio of 27 admits/1000 members)
- Completed a gap analysis for NCQA UM standards and initiated process to revise all policies/procedures to meet 2010 NCQA standards
- Analyzed plan over- and under-utilization of ENT procedures using 2008 Quality Compass scores for HEDIS[®] and implemented a prior authorization process for identified, potentially over-utilized services mid year 2008
- Preliminary internal audit results for 2008 demonstrate a marked improvement in documented discharge planning for inpatient admissions (only 2 of 30 cases identified by internal audit in 2008 vs. 17 of 30 cases in 2007).

1(f) Referral Specialists

- Referral Specialists achieved an abandonment rate of <5% for most of 2008 despite understaffing due to membership growth and turnover.

1(g) Pharmacy

- Intense oversight occurred of asthma controller medications for over/under utilization.
- Preliminary 2009 HEDIS[®] results for asthma are demonstrating an improvement in utilization.
- Generic drug utilization increased in 2008 from 75% to 77.14%.
- The Restricted Card Program was revised in 2008, resulting in an increase in enrollment of eligible members to greater than 350, from an enrollment of 65 members prior to the program being revised.

1(h) Lessons Learned

- Interventions for preventive care outreach must be implemented in the beginning of the measurement year to have the best chance to impact rates.
- Members must be reminded frequently and through varied media to receive their wellness benefits.
- Encounters and claims data must be supplemented by rigorous medical record review to adequately assess the quality of care delivered to members for priority initiatives.

- Diabetes initiatives require an aggressive approach and comprehensive scope to affect the majority of the population served.
- Ready access to data and reporting is critical to keeping a finger on the pulse of any changes in the quality of healthcare provided at the population level, and, to effectively evaluate interventions.
- Provider performance feedback is essential to changed practice patterns.
- Proactive identification, recruitment, and training of staff for anticipated membership growth is essential to provide service and meet performance goals as new members join the Plan in significant numbers
- Staff training and ongoing development are essential to improvement in employee satisfaction, member satisfaction, and provider satisfaction.

1(i) Opportunities for Improvement and Areas of Focus in 2009

- Adult female preventive screenings – breast, Chlamydia, and cervical cancer
- Childhood immunizations – EPSDT
- Well-child visits and adolescent well care – 0-15 months, 3-6 years, 12-21 years of life
- Diabetic A1c, LDL, nephropathy screenings, and retinal eye examinations
- Use of appropriate medications for people with asthma
- Maternal care – prenatal, postpartum, and high risk
- Behavioral health – depression, ADHD, and follow-up after hospitalization
- Emergency Department visits
- Employee satisfaction/retention
- Provider satisfaction
- Credentialing and delegated credentialing
- QI referral investigations
- Physician medical record-keeping practices
- Retention of Referral Specialist staff