2016-2017

Quality Improvement & Utilization Management Program Evaluation

Prepared and Submitted by

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1. Introduction

1.1 Quality Improvement and Utilization Management Review Summary

The goal of the Children's Medical Services (CMS) Managed Care Plan Quality Improvement Program (QI Program) and Utilization Review Program (UM Program) is to assure high-quality care and services for our enrollees by aggressively seeking opportunities to improve the performance of our health care delivery system. This report is a summary of fiscal year 2016-2017 activities to monitor and improve both the health status and experience of our members. It highlights our successes, examines lessons learned, and outlines next steps.

The CMS QI Committee is the main forum for oversight of CMS's health care delivery system. It reviews and approves QI, Utilization Management (UM) policies and procedures, Risk Management (RM), clinical guidelines and studies by our Integrated Care Systems (ICS) and the activities of all ICS delegations for UM services. During 2016-2017, the QI Committee met quarterly. CMS maintains minutes of each QI meeting and submits them to the CMS Governing Body (GB) on a quarterly basis. Both ICSs hold quarterly QI meetings and members of the CMS Plan Central Office attend.

Improving Member Health-In July of 2016, CMS implemented a new program based on care coordination interventions to encourage members to seek recommended care as measured by the Healthcare Effectiveness Data and Information Set (HEDIS). During the year, we have continued to look for ways to make interventions more effective and find new opportunities for improvement. With the launch of the new "Performance Measurement" program for care coordination, we were successful in expanding member awareness and education regarding thirty-two (32) separate areas addressed in the required HEDIS measures. We continue to offer preventive health programs for all enrollees through our Chronic Conditions/Disease Management Program, Healthy Behaviors Program, and preventive dental care. Our Chronic Conditions/Disease Management Programs focus on improving the care of members with the chronic conditions of diabetes, sickle cell disease, attention deficient disorder (ADHD/ADD) and asthma. The Healthy Behaviors Program includes smoking/tobacco cessation, weight loss, and alcohol/substance abuse. The main goal of the Healthy Behaviors Programs is for members to experience an increase in their overall health and feel more in control of their lives. In December of 2016, we launched a new prenatal program to improve the overall member health during pregnancy through the first 6 weeks of the postpartum period. CMS also has a 24-hour Nurse Help Line that ensures access to timely clinical advice for our members on a 24/7 basis.

Health Education and Cultural and Linguistic Services-These principles are actively integrated into quality improvement activities. In making decisions about quality improvement interventions, we examine the demographic characteristics of our enrollee population to ensure delivery of culturally appropriate materials. We believe that health education is better for each enrollee

when provided by his or her care coordinator and care team in the enrollee's primary language. CMS provides educational materials in a wide-range of topic areas. We make materials available to our enrollees. Our website includes an education oriented enrollee newsletter. As a result of the CMS annual review, we have updated and improved our website to make it more user friendly and to contain newly developed materials.

We were pleased to announce the launch of a Person and Family Engagement Plan this year. For this plan, we included input from families that have lived the experience of a child with a chronic condition.

Improving Health Systems-To support improved quality, CMS continually explores new ways to collaborate with its providers to move to a population health-based model. CMS encourages communication with our providers and our care coordinators. In 2016-2017, we focused on developing and implementing strategies for care coordinators to assist with loop closure with providers. During 2016-2017, the QI committee had several "task force" workgroups to study various systems for improvement.

Ensuring Member Satisfaction- One of CMS's top goals is to offer "exemplary service" to our members and providers. Each year, CMS monitors member satisfaction through member surveys. Based on survey results, CMS implements programs aimed at improving satisfaction. For 2016-2017, this included an action series on improving well-child visits in the third, fourth, fifth and sixth years of life (W34). CMS, through our contracted ICSs, offers a Customer Service Department that helps enrollees understand and take full advantage of their plan benefits. Additionally, CMS monitors grievances on a quarterly basis to identify trends and problems, as well as gauge timeliness and regulatory compliance. Our goal is to provide excellent service and, at a minimum, meet the Agency for Health Care Administration (AHCA) standards for responding to and resolving grievances.

Provider Relations-CMS closely monitors the adequacy of its provider network to ensure that members have access to the care they need in a timely manner. Clinical quality monitoring is also critical to CMS's success. Our ICSs review a sampling of our primary care providers (PCP) to ensure compliance with criteria from AHCA and accrediting agencies. Each year, CMS measures provider satisfaction and uses the results to improve the quality of care offered.

Care Coordination Services-CMS is a unique plan in that each member receives care coordination services. Each CMS enrollee receives care coordination services from a nurse or social worker. Care Coordination is viewed as the link connecting members and families to the most appropriate services at the most appropriate time. Care Coordination has always been core to nursing practice. It is one of the traditional strengths of the nursing profession. Most care coordination performance measures are process measures that capture a small but important part of care coordination activities. Care Coordinators are the "voice" of our health plan. Care Coordinators provide the ongoing relationships necessary for successful connections among our enrollees,

providers and community resources. It is the Care Coordinator's relationship with the enrollee and the continuous education, interventions, and bidirectional communication with the enrollee and the enrollee's family that enable CMS's success in achieving quality performance. Care Coordinators share accountability in ensuring that performance measures are met. It is imperative that Care Coordinators understand CMS's performance measures and continually educate and document progression toward compliance with these measures.

At CMS, we take pride in the many ways we collaborate with our members and provider network to improve quality and access to care. We follow the Plan-Do-Study-Act (PDSA) model for improvement; since it is not always clear what is the best way to achieve a goal, we pilot interventions, measure the outcomes, and then revise our approach accordingly.

1.2 Quality Leadership

The CMS Quality Improvement Committee (QI Committee) is the main forum for oversight of CMS's QI, UM, and RM programs. The QI Committee meets quarterly and members include physician and administrative representatives. The QI Committee reviews the QI activities, UM activities, RM reports, Cultural and Linguistic Services, Healthy Behaviors Programs, Chronic Conditions/Disease Management Reports, Provider Relations, Grievances and Appeals, Fraud, Waste, and Abuse Activities, Area Office Oversight and Performance Measures, Title XIX Contract Updates, Pharmacy Report, ICS monitoring on behalf of CMS, Enrollment and Eligibility, and the Program for All-Inclusive Care for Children (PACC).

All CMS policies and procedures and clinical guidelines are reviewed every two (2) years or more frequently, if necessary. CMS maintains minutes of each QI Committee meeting and reports them to the CMS GB on a quarterly basis.

<u>QI Committee Membership</u>

- Governing Board Representatives and CMS Executive Leadership
    - Cheryl Young
    - Andrea Gary
    - Kelli Stannard
    - Mansooreh Salari, M.D., F.A.A.P.
- Central Office Members
    - Angela Renken
    - Alana Balsters
    - LaNesha Palmer
    - Melissa Dancel
    - Patricia Trom
    - Sue Whittington
    - Tamara Zanders
    - Anthony Redman

    - Otis Forston
    - Sara Miller
    - Marcus Richartz
    - Cindy Smith
    - Drew Richardson
    - Joni Hollis
    - Charlotte Moon
- ICS Members
    - Don Fillipps, MD, FAAP-Ped-I-Care
    - Jennifer Barry-Ped-I-Care
    - Marc Grasley-Ped-I-Care
    - Holly Estep-Ped-I-Care
    - Lupe Rivero-Community Care Plan (CCP)
    - Alex Fabano-CCP
    - Miguel Venereo, M.D., FACOG, CPPS-CCP
    - Maria Jam-Crease-CCP
    - Amy Pont-CCP
    - Michael Alvarez-CCP
    - Susan Ragazzo-CCP
    - Natalia Penalver-CCP
    - Tonya Barnes-CCP
    - Juliet Duncan-CCP
- MED3000 Member
    - Carla Davis

2. Improving Member Health

Our goal is to be among the top Medicaid Health Plans for getting the right care at the right time, as determined by HEDIS measures required by AHCA. CMS has multiple programs to encourage members to seek care, and every year we continue to look for ways to make our interventions more effective. For example, we support population health at the provider and the care coordination level. We encourage provider adherence to quality care measures through education and office site visits.

In addition, we are highly committed to improving the health of members with chronic conditions. To that end, CMS is continuously providing education and training to the Care Coordination Team to enhance our offerings in the Chronic Conditions/Disease Management resources and education to enrollees. In December 2016, we launched our Prenatal Program to achieve the goal of improving the quality of maternity care, improving birth outcomes, and providing continuity of care for high risk pregnant enrollees.

2.1 Performance Measures

CMS has identified the need for additional care coordination education in meeting our HEDIS measurements. CMS is contracted with the Institute for Child Health Policy (ICHP). ICHP is responsible for CMS performance monitoring. Most data is collected from claims reports and chart reviews. Performance Measures will only be reflected in the claims data if Care Coordinators are successful in providing education and assistance to families toward meeting the measures. Care Coordinators are the key to enrollee compliance; therefore, Care Coordinators are familiar with the CMS performance measures and continually address the measures with families. All performance measures have national benchmarks associated with each. The goal of CMS is to meet or exceed each national benchmark. With this goal in mind, CMS developed a Performance Measurement Desk Reference for Care Coordination. As a direct result of the evaluation of our current QI Plan, the CMS QI Work Plan was revised to reflect the new performance measures. Although each performance measure is important, CMS will pay particular attention to preventive care including immunizations and well-child visits and dental services.

2.2 Nutrition and Physical Activity

CMS has included yearly education regarding the area of nutrition and physical activity, as well as chronic disease management/healthy behaviors into our program. We are currently working on improving our health education resources for care coordinators to use for family education.

Addressing the obesity epidemic is a top priority for CMS. CMS offers a Healthy Behaviors Program available to all enrollees for weight reduction and management.

2.3 Health Risk Assessment (HRA)

New enrollees receive a Medical History questionnaire with their new member materials from the ICS. The ICS forwards this completed questionnaire to the appropriate CMS Area Office and the PCP once it is received back from the enrollee. This questionnaire is used to assist the care coordinator in assessing the enrollee's health risk. In addition to this questionnaire, the care coordinator completes an initial and annual HRA that includes:

- Family History
- Social History
- Past Medical History
- Past Surgical History
- CMS Acuity Tool

CMS continuously makes every effort to assess member needs and provide them with precise care and services. Information from these assessments is used to provide appropriate care coordination services to all enrollees.

2.4 Nurse Help Line

Our ICSs contract with CareNet, a nurse help line that is available 24 hours per day, 7 days per week. CMS advises enrollees to use the Nurse Help Line in the following situations:

- Medical advice
- Health information
- Answer questions about your health
- Advice about a sick child
- Information about pregnancy
- Questions regarding the need to go to an emergency room

CMS added monitoring of the Nurse Help Line to the QI Plan in 2016-2017. To further the CMS monitoring, in 2017-2018 the ICSs are reporting on monthly statistics from each ICS Care Net service and the following will be reported to the QI Committee on a quarterly basis:

- Total # of calls
- Type of call (enrollment or clinical)
- Date of Area Office notification if a clinical call

Each Area Office will be monitoring the care coordination enrollee follow-up if the call was a clinical call. The Area Office will report this data on a quarterly basis.

2.5 Chronic Conditions/Disease Management

Through analysis of the enrollees served, CMS has developed a Chronic Conditions/Disease Management Program. This program serves children with the following chronic conditions:

- Asthma
- ADHD/ADD
- Diabetes
- Sickle Cell

The goal of the program is that members may experience an increase in their overall health and may feel more in control of their lives. Through these programs, health education materials related to the chronic condition are distributed, strategies for disease management are discussed and implemented, and medication adherence is monitored. CMS unveiled a Care Coordinator Portal to serve as a central repository for all approved educational materials to assist with these programs.

During the 2016-2017 year, we did onsite education for these programs during the Quality & Practice Management area office reviews.

For the 2017-2018 year, CMS is pleased to be participating in a special QI project, the Florida Asthma and Tobacco Cessation Learning and Action Network (LAN). Leadership for this special QI initiative is led by the National Institute for Children's Health Quality (NICHQ) and the Florida Department of Health. Over the next year, our CMS team will work with other MMAs and with asthma management and quality improvement experts to test new ideas and share and implement strategies that will lead to sustainable system change for CMS, providers and beneficiaries. The overall goal of the project is improving asthma control in children ages 5-18 years. It will be exciting to see the results of the year-long project in September 2018.

3. Health Education, Cultural, & Linguistic Services

Health education and cultural and linguistic competency principles are actively integrated into CMS's QI activities. As part of decisions about QI interventions, CMS examines the demographic characteristics of its member population.

3.1 Health and Wellness Programs

CMS has established programs to encourage healthy behaviors. Each program has defined educational goals and objectives. CMS has established the following Healthy Behaviors Programs:

- Medically approved smoking/tobacco cessation program
- Weight loss program
- Medically approved alcohol and substance abuse recovery program

As part of the QI initiatives to promote population health and preventive care and management, CMS has established a Prenatal Care Coordination Program. This program was started in December of 2016. A centralized Prenatal Care Coordination Specialist works together with members and providers to achieve the goal of improving the quality of maternity care, improving birth outcomes, and providing continuity of care for high risk pregnant enrollees.

Prenatal care coordination is a collaborative set of interventions and activities, including assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services that address the health care and preventive service needs of pregnant and postpartum enrollees through communication and available resources to promote quality, cost effective outcomes.

Prenatal care coordination is outcome-focused, with an emphasis on improving birth outcomes through reducing the rate of preterm birth, and monitors the pregnant Medicaid population and prenatal service delivery system using data, telephonic conversations, and communication with providers. Prenatal care coordination applies systems and information to improve care and assist enrollees in becoming engaged in a collaborative process designed to manage medical, social, and behavioral health conditions more effectively. Prenatal care coordination will be used to establish a baseline for assessing the adequacy of our enrollee's access to prenatal care in the CMS program.

3.2 Promoting Cultural Competency and Language Access

Cultural Awareness Training

Cultural and Linguistic Training is provided with initial and annual training for all staff in order to work effectively with individuals and families from different cultural and ethnic backgrounds. Cultural and linguistic training provides equal access and quality health care to our enrollees. This training is also on the CMS website for providers.

Language Access

All CMS staff have access to a Language Line for serving enrollees who do not speak English as their primary language and who might not understand the English language at a level that permits them to interact effectively.

Studies across the demographics served indicated that CMS letters needed to be interpreted in the Haitian Creole and Spanish languages. Versions of all approved letters for these languages are posted for the CMS staff to access.

CMS will continue to develop and add health education materials for the outreach and promotion of culturally-matched materials.

4. Improving Health Systems

CMS works through our ICSs to conduct four (4) annual Performance Improvement Projects (PIP). Each ICS assumes the lead on two (2) PIPs. The CMS PIPs focus on the following four domains:

- Behavioral Health Re-Admission Rates
- Improving Call Center Timeliness
- Improving the Rate of Child and Adolescent Preventive Dental Care
- Well Child Visits in First 15 Months of Life

Behavioral Health Re-Admission Rates

The topic for this PIP is reducing the behavioral health re-admission rates to a mental health facility (institution, hospital, or other inpatient facility) for children enrolled in CMS. Behavioral health care costs are among the largest category of costs among CMS clients. Within the behavioral health cost category, rates of admissions and re-admissions have historically risen more rapidly than other behavioral health services, these needs are difficult to address by our current Children's Medical Services (CMS) Nurse Care Coordinators, who attend to the needs of all enrolled children. Our Quality & Practice Management Social Work Consultant works with the Care Coordinators, our ICSs, and Concordia, our Managed Behavioral Health Organization (MBHO), to assist in the care and provision of services for this population.

Improving Call Center Timeliness

The Member Services Call Center is an essential function for maintaining both provider and enrollee satisfaction with a health plan. The call center is the place where most crucial customer interactions take place. The call center's effectiveness and efficiency of operation is a key ingredient to the overall success of an organization. Delays in answering calls may be a barrier to access and availability for enrollees as providers potentially refuse to see them. Providers' dissatisfaction or frustration may induce termination from the plan, furthering enrollees' dissatisfaction and increasing disenrollment as members follow providers to other health plans. The Agency Health Care Administration (AHCA) – Florida Medicaid Quality in Managed Care includes the HEDIS measure - Call Answer Timeliness as part of the reporting requirement for HEDIS 2016 (CY2015).

Improving the Rate of Child and Adolescent Preventive Dental Care

Among the many dental conditions affecting children, dental caries (tooth decay) is the preeminent concern in the context of Medicaid services because of their substantial prevalence in the low-income population. Tooth decay continues to be the single most common chronic

disease among U.S. children, despite the fact that it is highly preventable through early and sustained home care and regular professional preventive services. CMS recognizes the importance of proper, timely dental care, especially among children with special needs.

Well Child Visits in the First 15 Months of Life

As part of its efforts to encourage preventive health care, CMS complies with the Florida Statute on child and adolescent health care and the recommended periodicity schedule for child health screening schedules, including six or more "well-child" visits in the first 15 months of life. This study seeks to increase the proportion of eligible members who are receiving six or more well-child visits during the first 15 months of life.

Some of the Care Coordination Performance Measures served as leading measures to help increase the PIPs performance.

In order to gain the most from our PIP studies, we consulted with another state's plan to get insights on best practices.

5. Improving Member Experience

Experience surveys assist us in evaluating the quality of service our members receive from CMS and from our provider network.

5.1 Measuring Member Satisfaction

CMS believes that member experience and outcomes of children with special health care needs, and the satisfaction of their parents, are important indicators of these children's health and the quality of services they receive.

The Institute for Child Health and Policy (ICHP) at the University of Florida is contracted with the State of Florida Department of Health (DOH) Office of CMS Plan to fulfill this evaluation role. A National Committee for Quality Assurance (NCQA)-certified vendor is used to administer surveys to statewide members. Eligibility requirements mandated that enrollees had:

- An age of 21 years or younger as of December 31st of the reporting year
- Current enrollment at the time the sample is drawn
- Continuous enrollment for at least the last 6 months
- No more than one gap in enrollment of up to 45 days during the measurement year
- Prescreen Status Code, where the member has claims or encounters during the measurement year or the year prior to the measurement year. The Prescreen Status Code indicates the child is likely to have a chronic condition

Per contract specifications, NCQA methodologies were utilized. A list of all eligible members [per the criteria above] was supplied to the NCQA-certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) vendor for survey administration. In turn, a sample was pulled based upon NCQA guidelines. Multi-modal (mail and phone) administration of the survey was employed per NCQA guidelines. Eligible participants were contacted in five waves:

- Day 1: First questionnaire packet and cover letter mailed to recipients.
- Day 10: Post Card Reminder mailed to recipients.
- Day 35: Second questionnaire packet and cover letter mailed to recipients
- Day 45: Second post card reminder mailed to recipients
- Day 56: Telephone follow-up for non-respondents.

For the 2015-member survey, ICHP surveyed the entire state to meet the CAHPS criteria. Members had to meet the other requirements to be eligible for the sample pool.

A total of 1,650 Title IXX parents and guardians of children aged one to 19 years were identified as the eligible sample. A total of 538 respondents completed the survey.
Key findings include:

- **Getting Needed Care** increased three percentage points over the previous year and is not only above the national average, but also exceeds the 90th percentile benchmark.
- **Getting Care Quickly** increased four percentage points over the previous year and is well above the national average of 93 percent.
- Scores remained consistent from the previous to the current year for the core composite of **How Well Doctors Communicate**. The score remained steady at 93 percent and the percentage of respondents indicating the child has a personal doctor remained at 95 percent.
- The **Health Plan Information and Customer Service** composite scores for the population exceeded the national average of 68 percent with scores for CMS at 89 percent.
- The overall rating for **Child's Health Care** was slightly higher than the national average at 69 percent and increased four percentage points over the previous year.
- The overall rating for **Child's Personal Doctor** rounded to 74 percent, which is the national average.
- The overall rating for **Child's Health Care** was 78 percent and was not only above the national average, but surpassed the 90th percentile benchmark.
- The overall rating for **Child's Health Plan** was several percentage points higher than the national average, and increased seven percentage points over the previous year.
- The global proportion for **Getting Prescription Medicine** for the population not only exceeded the national average, but also surpassed the 90th percentile benchmark.
- The global proportion for the composite **Getting Specialized Services** for the population rose six percentage points over the previous year, from 68 percent to 74 percent.
- Considerably more respondents reported trying to access special medical equipment and devices or special therapy for a child than in the previous year, with both items showing a nine percent increase in attempted access.
- The global proportion for the composite **Personal Doctor Who Knows Child** remained consistent with the previous year at 89 percent.
- While the global proportion for **Getting Needed Information** did not meet or exceed the score achieved the previous year, it remains well above the national average at 92 percent.
- The composite score for **Coordination of Care** fell three percentage points from the previous year with this score at 78 percent.
- Considerably more respondents than the previous year reported needing their child's health provider to contact a school or daycare about the child's health and that their child received care from more than one kind of provider or used more than one kind of health care service. Both items increased by 11 percentage points.

- The overall score for the population for **Shared Decision Making** was 86 percent and rose four percentage points over the previous year.

During the 2016-2017 year, CMS implemented strategies for increasing awareness of the random survey to boost the response rate. CMS increased satisfaction awareness by adding an announcement to the CMS Plan website. CMS has also redesigned the website to make it easier to find information about covered services, announcements, and quality information.

6. Provider Relations

6.1 Provider Network Access Monitoring

CMS closely monitors the adequacy of our provider network to ensure that our enrollees have access to the care they need in a timely manner and PCP wait times. CMS has a stable network of PCPs that is more than adequate to care for our enrollees. Regulatory requirements set forth in our AHCA contract guide our accessibility standards. CMS also regularly monitors the number of physicians in our network in specialty areas that our enrollees access to ensure network adequacy.

CMS works to ensure that our enrollees have access to a primary care provider who speaks their language or who has access to interpretation services.

CMS, through our contracted ICSs, works to review selected contracted PCPs at their sites. Site reviews and visits include on-site inspection, interviews with site personnel and chart reviews. Reviewers use reasonable evidence available during the review to determine if practices and systems on site meet survey criteria. Corrective action is implemented if a site review reveals critical deficiencies. The medical record portion of the review evaluates areas of chart format, documentation, continuity, coordination of care, and preventive care. Physical accessibility of PCP sites is assessed as well as compliance with language and interpretation services.

The ICSs share the results of audits with the CMS QI Committee. All audit deficiencies are followed up throughout the year until resolved. CMS added some review questions for Health Education and Wellness during the fiscal year 2016-2017.

6.2 Provider Satisfaction Survey

Annually, CMS conducts a Provider Satisfaction Survey to gather information about network provider issues and concerns with CMS and our services. CMS provider surveys are sent to both PCPs and specialist within our network.

The intent of the provider survey is to determine healthcare providers' level of satisfaction with CMS. ICHP, on behalf of CMS, oversees the administration and evaluation of the survey for Title XIX CMS enrollees.

The CMS provider satisfaction survey was approved by AHCA in March 2017 and subsequently mailed and/or emailed to the CMS providers later that month.

Purposes

The purposes of this report are to describe provider satisfaction within the following categories:

- Relations and Communication and Clinical Management Processes with the ICS
- ICS Authorization Processes
- ICS Complaint Resolution Process
- CMS Clinical Management Processes
- CMS Claims Payment and Processing
- CMS Care Coordination and Care Management

Data Collection and Evaluation Methods

A list of providers within both Ped-I-Care and CCP were supplied by CMS in January 2017. ICHP was e-mailed an Excel file containing the provider contact information from CMS. From the directory provided, each entry was checked for validity. Entries with the following were eliminated:

- Name of a Medical Home
- Name of pharmacy, clinic or specialist who would not be able to give sufficient feedback such as a surgical anesthetist

After removing the invalid entries, remaining provider listings were assessed for quality. Any provider entries with multiple identical addresses were further evaluated for duplication. All remaining provider addresses were then verified using internet resources for accuracy. An initial random sample of 1,200 was selected for further validation. Of these 1,200, a total of 103 provider entries were eliminated due to inappropriate specialty type and 263 provider entries were eliminated due to inability to verify the address. A random sample of the remaining 834 providers was pulled, resulting in a random selection of 800 unique providers. These providers were entered into REDCap™, a secure electronic data capture tool. Mock email addresses were created for providers with no email, or with only an administrative email on file, to facilitate generation of a unique link to the online survey tool.

In March 2017, 800 providers from both Ped-I-Care and CCP were sent a satisfaction survey by mail and email. A total of 146 surveys were returned, resulting in a response rate of 18 percent.

Key findings of the survey include:

- 92 percent of providers are currently accepting new patients, which is an increase from 87 percent in the last survey.
- Overall, providers are highly satisfied with their relationship with the ICS as well as the clinical management processes.
- The strongest amount of agreement was shown for having a positive relationship with the ICS.
- As a whole, respondents were highly satisfied with the ICS authorization process.
- Overall levels of satisfaction with the ICS authorization process decreased from the last survey. The greatest decrease was in the number of providers who found the number of authorizations denied to be appropriate. Even given the decreases in satisfaction levels over the previous year, over 70 percent of respondents indicated satisfaction with each aspect of the authorization process included in the survey.
- The complaint resolution process was rated quite positively by providers. The highest level of satisfaction was for the reasons given for denials.
- Providers were very highly satisfied with the CMS Plan's clinical management processes. Providers most strongly agreed with CMS Plan's involvement.
- A significant majority of providers showed a high level of satisfaction with CMS claims payment and processing. The highest level of satisfaction was in claims being processed according to the contract, with 88 percent of respondents responding favorably. The greatest amount of dissatisfaction among respondents was with the processing of claims without error, at 26 percent.
- Providers were highly satisfied with care coordination and case management, responding in agreement to the survey items with a range from 82 to 85 percent. Providers strongly agreed that care coordinators provide excellent service and that care coordination and care management are satisfactory.

Regardless of these gains, there is still opportunity for improvement in all areas. Items with the greatest levels of dissatisfaction were the speed with which complaints are addressed (31 percent), the number of authorizations denied being deemed appropriate (30 percent), and claims being processed without error (26 percent).

In summary, with a higher response rate than seen in the previous year, providers showed a high level of satisfaction in their interactions with the ICS and with CMS Plan. Areas in which resources would best be used for improvement are the complaint resolution process, the ICS authorization process, and claims payment and processing.

7. Care Management Services

7.1 Utilization Management

The CMS UM philosophy and approach are geared toward providing CMS enrollees high quality and cost effective health care. The UM program is designed to achieve congruence with goals of enrollees' and providers' satisfaction, efficiency, and effectiveness. CMS has partnered with **Ped-I-Care** and **Community Care Plan (CCP)** to authorize CMS services when provided to CMS enrollees**.** These partners make the determination to approve a service based on review of submitted information and a determination of medical necessity. **Ped-I-Care** and **CCP** each support CMS in different areas of the state. CMS, through our contracted entities, includes physician involvement in all aspects of the UM program.

The overall scope of the plan is to establish a planned and systematic process to effectively and efficiently maintain the promotion and delivery of high quality health care to all enrollees. Through our ICSs, procedures are in place to support the major components of the UM program such as timely authorization of prescribed health services and to ensure the needed services are rendered in the most appropriate and cost-effective setting in accordance with the enrollee's coverage benefits. Consistent application of review criteria for authorization decisions is used throughout the state by each ICS. Each ICS will consult with the requesting provider when appropriate to coordinate the services to be rendered.

Each ICS reports UM data to the QI Committee on a quarterly basis.

7.2 Coordination of Care with Community Agencies

CMS members requiring specialty care are referred to specialists who provide these services. Members may also receive services from many agencies in the community with which CMS refers via the CMS Quality Enhancement Program. Some of these community programs include Early Start, Women, Infants, and Children (WIC), Community Behavioral Health Services, and numerous family support groups. CMS recently streamlined access to the CMS Managed Care website to provide enrollees with additional information regarding community programs.

7.3 Care Coordination Services

Each enrollee in CMS is assigned a care coordinator who is either a registered nurse or a social worker. Quality care coordination is an integral part of achieving our goals as an organization. Care coordination in CMS provides families and children with special health care needs an opportunity to grow in an environment that is responsive and supportive to their individual needs. Care coordination is an ongoing process which repeats the cycle of assessment, planning, implementation, monitoring and evaluating for each new concern. The overarching goal of

quality care coordination is to empower the client and family to effectively navigate through the health care system including community resources. Standardization of care coordination practices is essential because it makes the care coordination process more responsive to quality improvement interventions. Care coordination for CMS is performed in accordance with all CMS policies and procedures.

As a result of our CMS QI Annual Evaluation, during the year 2016-2017, CMS completed development of a new guide and Area Office QI monitors related to our HEDIS performance measures. This was a three (3) phase process.

Phase one (1) was the development of a Performance Measurement Care Coordination Desk Reference. In this desk reference, care coordinators can find the following for all thirty-two (32) performance measures:

- Overview of Measure
- Care Coordinator Responsibilities
- Performance Measure Monitoring

Phase one was completed on February 29, 2016.

Phase two (2) started on March 3, 2016 and was completed in May of 2016. This phase involved the Business Objects (B.O.) reports that were developed in order to measure each monitor and developing the actual monitoring tool for each Area Office to use to evaluate the compliance with the performance measure. Once completed, these reports and monitoring tools were incorporated into the QI Plan.

Phase three (3) started as soon as phase two (2) was completed and involved education and training for our Area Offices and the development of tracking tools for evaluation and comparison of reports for the QI Committee. The program was launched on July 1, 2016.

The CMS GB is responsible for reviewing the QI, UM, and RM Plans on an annual basis. The GB receives quarterly updates from the QI Committee and reports on Care Coordination.

7.4 Area Office QI Program Evaluations

Each area office completed an Annual Quality Improvement Program Evaluation for the year 2016-2017. The areas evaluated included:

- Committee Structure and Accountability
- Yearly Goal Status Review
- Overall Effectiveness of the QI Program, and
- Opportunities for Improvement, Challenges, and Barriers.

Committee Structure and Accountability was consistent throughout all offices. Each office had a QI Chairperson and the committees had representatives from both clinical and non-clinical departments. All offices held QI meetings at least quarterly. Minutes were maintained for the meetings and QI, RM, and performance measurements were discussed during the meetings.

Yearly goal status varied among offices with the majority being above the established benchmark for each of the performance measures.

All offices rated the overall effectiveness of the QI program as excellent or highly effective.

Opportunities for Improvement identified included:

- Ensuring Care Coordinators were made aware of HEDIS measures and the importance of these measures and the importance of successfully documenting to show compliance in education for the measures;
- Raising awareness and focus on child health education and providing many opportunities for education and documentation principles;
- Providing great opportunities for improvement in all documentation;
- Sharing best practices among staff was noted;
- Seeing the benefit of follow-up in all areas of care coordination;
- Offering ways to provide improved outcomes to meet the needs of the members;
- Allowing open discussions about challenges from all departments and the chance to problem solve for long term solutions; and
- Determining that staff education was often more successful in small groups or individually.

Challenges noted included:

- Getting new staff oriented to the documentation principles;
- Adjusting member training and education to include all performance measures;
- Incorporating all education and training into the daily tasks of care coordinators; and
- Reviewing improved time management skills for staff.

Barriers Identified:

- Getting staff to see the value of the process;
- Finding inventive ways to assist those coordinators that are resistant to change; and
- Finding measures for Care Coordinators to focus on medical needs as well as preventive measures and preventive education.

In summary, conclusions from many of the offices indicated greater awareness by staff of needed documentation components, sharing of best practices among staff, greater refined education of

the workforce, and most importantly, the correlation of care coordination and positive health outcomes for our CMS members and families.

8. Conclusion

The CMS QI program remains committed to the monitoring and evaluation of quality and appropriateness of care provided to enrollees including, but not limited to, review of quality of care and service concerns, complaints and grievances, enrollee rights, adverse/critical events, enrollee safety and utilization review processes. CMS providers and enrollees are provided the opportunity to give input to the QI Plan through the annual satisfaction survey.

CMS's Governing Body continues to oversee and evaluate the QI program and the QI work plan at least annually. The role of CMS's Governing Body includes providing strategic direction to the QI program, as well as ensuring the QI plan is incorporated into operations throughout CMS. The Governing Body meets at least quarterly. Membership in the Governing Body includes, at a minimum, the CMS Director of the Office of Managed Care & Specialty Programs, Director of Managed Care Administration, Director of Managed Care Operations & Specialty Programs and the CMS Plan Medical Director. The CMS Managed Care Plan Director of Quality and Practice Management is responsible for reporting QI activities including Risk Management and Utilization Review information to the Governing Body. The Governing Body's responsibilities as related to the CMS QI program include the following:

- Review and evaluation of the QI program description, QI work plan and the annual evaluation;
- Review of reports from the QI program delineating actions taken and improvements made;
- Ensuring that the QI program and work plan is implemented effectively and results in improvements in care and service;
- Ensuring links between QI and all benchmarking activities are communicated to management and the provider network;
- Ensuring results of satisfaction surveys are distributed to providers, members and other relevant committees and staff throughout CMS.

CMS recognizes that QI is a team process and virtually all QI projects involve a team process. CMS is committed to an effective infrastructure, such as, leadership, and policies and procedures to organize and facilitate the work of the team. CMS is looking forward to the positive changes in 2017-2018 for our QI Program.

QI AND UM PROGRAM EVALUATION APPROVAL

Areas of responsibility include the Director, Office of CMS Plan & Specialty Programs, Director, Office of CMS Plan Administration, Director, Office of CMS Plan Operations & Specialty Programs.

Andrea Gary — 2/9/18

Andrea Gary
Director, Office of Children's Medical Services
Plan Administration

Date

Kelli Stannard — 2/6/18

Kelli Stannard, RN, BSN
Director, Office of Children's Medical Services
Plan Operations & Specialty Programs

Date

Cheryl Young — 2/21/18

Cheryl Young
Director, Office of Children's Medical Services
Plan & Specialty Programs

Date

GOVERNING BODY APPROVAL

Andrea Gary — 2/21/18

for Cheryl Young
CEO Children's Medical Services
Managed Care Plan
Governing Body Representative

Date