



2015

Quality Improvement & Utilization
Management Program Evaluation

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) 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 2015 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 2015, 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.

Improving Member Health-CMS manages several interventions to encourage members to seek recommended care as measured by the Healthcare Effectiveness Data and Information Set (HEIDIS). We continue to look for ways to make interventions more effective and find new opportunities for improvement. As a result of these efforts, CMS will be launching a new “Performance Measurement” program for care coordination. We offer preventive health programs for all enrollees. Our Chronic Conditions/Disease Management Programs focus on improving the care of members, including diabetes and asthma. A 24-hour Nurse Help Line ensures access to timely clinical advice for our members. These efforts have been successful to date.

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.

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.

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 2015, 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) in order 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-*Each CMS enrollee receives care coordination services. Care Coordination is viewed as the link connecting patients 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 the 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 the 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 partner 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 contains 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 and Abuse Activities, Area Office Oversight and Performance Measures, Title XIX Contract Updates, Pharmacy Report, ICS monitoring on behalf of CMS, 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.

QI Committee Membership

- Governing Board Representative
 - Melissa Vergeson
- CMS Executive Leadership
 - Chery Young
 - Andrea Gary
 - Kelli Stannard
 - Mansooreh Salari, M.D., F.A.A.P.
- Central Office Members
 - Angela Renken
 - Michele Burnette
 - Chrishonda Jenkins
 - Patricia Trom
 - Savetra Robinson
 - Patrice Miller
 - Otis Forston
 - Sara Miller
 - Charlotte Roe
- ICS Members
 - Dr. John Nackashi, PhD, M.D.-Ped-I-Care
 - Jennifer Barry-Ped-I-Care
 - Lupe Rivero-SFCCN
 - Alex Fabano-SFCCN
 - Miguel Venereo, M.D., FACOG, CPPS
 - Maria Jam-Crease-SFCCN
 - Amy Pont-SFCCN
- 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.

In addition, we are highly committed to improving the health of members with chronic conditions. To that end, CMS started work in 2015 to enhance our offerings to include Chronic Conditions/Disease Management resources and education to 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. 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 has developed a new Performance Measurement Desk Reference for Care Coordination. As a direct result of the evaluation of our current QI Plan, the CMS QI Plan is being revised to reflect the new performance measures. Training for Area Offices is planned for the new fiscal year. Although each performance measure is important, CMS will pay particular attention to preventive care including immunizations and well-child visits, dental services, HIV and prenatal care.

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 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 Care Net, 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 is adding Nurse Help Line to the QI Plan in 2016. CMS will be requesting 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 Asthma and Diabetes

Through analysis of the enrollees served, CMS has developed an asthma and diabetes Chronic Conditions/Disease Management Program. Through these programs, health education materials related to both asthma and diabetes are available. CMS is currently working on a Care Coordinator “Dash Board” to serve as a central repository for all approved educational materials available as a result of QI evaluations.

2.6 HEDIS Results

Results of our QI program will be measured by our HEDIS results for reporting year 2015 due to the fact that CMS has only been a plan since August of 2014 and we did not have complete data for the reporting year of 2014. As mentioned earlier, CMS is concentrating on care coordination performance measures to assist with meeting and surpassing our benchmark goals.

3. Health Education, Cultural, & Linguistic Services

Health education and cultural and linguistic competency principles are actively integrated into CMS's QI activities. In order to make 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 of chronic conditions, CMS has established the following Chronic Conditions/Disease Management Programs:

- Diabetes
- Asthma
- Sickle Cell Anemia
- ADD/ADHD

Although these programs are still in their early stages, CMS plans to examine the data from 2015 and develop interventions to increase the enrollment and measure satisfaction with all health and wellness programs.

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.

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 in 2016 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.

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 plan. The Agency Health Care Administration (AHCA) – Florida Medicaid Quality in Managed Care added the HEDIS measure - Call Answer Timeliness as part of the reporting requirement for HEDIS 2015 (CY2014).

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.

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 patient 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), our CMS vendor for member satisfaction surveys uses a National Committee for Quality Assurance (NCQA)-certified vendor to administer surveys to statewide enrollees.

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:

- Wave 1: Initial survey is mailed.
- Wave 2: A thank you/reminder postcard is mailed four to ten days after the initial questionnaire.
- Wave 3: A replacement survey is mailed to non-respondents approximately 35 days after the initial questionnaire.
- Wave 4: A thank you/reminder postcard to non-respondents is mailed four to ten days after replacement questionnaire.
- Wave 5: Telephone interviews are conducted with members who have not responded to either survey mailing. Telephone follow-up began approximately 21 days after the replacement survey is mailed.

For the 2014 member survey, ICHP surveyed Medicaid members in Broward and Duval counties to meet the CAHPS criteria. Members had to meet the other requirements to be eligible for the sample pool.

A total of 1,030 respondents completed the survey with an overall response rate of 28 percent. Key findings include:

- High levels of satisfaction with care
- CMS Plan met benchmarks for (1) health plan information and customer services and (2) getting needed information
- CMS Plan was just below benchmarks for (1) how well doctors communicate and (2) child's specialist.

CMS has proposed strategies for increasing awareness of the random survey to boost the response rate. CMS is increasing satisfaction awareness by adding an announcement to the CMS Plan website. CMS has 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. 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 will be adding 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 CAHPS 5.0 survey for Title XIX CMS enrollees.

The CMS provider satisfaction survey was approved by AHCA in September 2014 and mailed and/or emailed to the CMS providers in March 2015.

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 SFCCN were supplied by CMS in January 2015. ICHP was e-mailed an Excel file containing the provider contact information [including ICS] from CMS. From the directory provided, each entry was checked for validity. Entries with the following were eliminated:

- Non-named provider
- Health Practices

After removing the invalid entries, remaining provider listings were assessed for quality. Any address that was listed as a PO Box was evaluated and corrected. Any provider with multiple addresses was further evaluated for duplication. When necessitated, health practices were contacted to verify provider mailing addresses. Following data quality checks, providers with e-mail contacts were entered into Research Electronic Data Capture (REDCap). Dummy e-mail addresses were created for providers with no e-mail on file to facilitate the generation of a unique link to the online survey modem.

In March 2015, providers from both Ped-I-Care and SFCCN were sent a satisfaction survey [by mail and email].

CMS started operating statewide on August 1, 2014. ICHP administered the provider satisfaction survey in March 2015. Of the 3,364 providers sampled, 264 providers completed the satisfaction survey (approximately 8%).

Key findings of the survey include:

- 87 percent of providers are currently accepting new patients, which is an increase from 2013
- Agreement levels for all survey items exceeded 60%
- The greatest level of disagreement identified by providers were related to claims processing and complaint resolution representatives helpfulness

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 **South Florida Community Care Network (SFCCN)** 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 **SFCCN** 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 and Waiver Programs

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

CMS works with federal waiver programs such as the HIV/AIDS Waiver Program and the Home and Community Based Services Waiver for the Developmentally Disabled.

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, CMS is in the process of developing a new guide and Area Office QI monitors related to our HEDIS performance measures. This is 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 is currently in development. This phase involves the Business Objects (B.O.) reports that are being 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 will be incorporated into the QI Plan.

Phase three (3) will begin as soon as phase two (2) is completed and will involve education and training for our Area Offices and the development of tracking tools for evaluation and comparison of reports for the QI Committee.

CMS is responsible for assuring that there is comprehensive care coordination for all enrollees.

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.

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, Director of Managed Care Administration, Director of Managed Care Operations and the CMS Plan Medical Director. The CMS Central Office Quality Improvement Coordinator 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 CMS QI program include the following:

- Review and evaluation of the QI program description, QI work plans 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 2016 for our QI Program.