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Evaluation of the Kentucky Health Care Partnership Program: A Comparison of the Managed Care Experiences in Regions 3 and 5

Final Report

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EVALUATION OF THE KENTUCKY HEALTH CARE PARTNERSHIP PROGRAM: A COMPARISON OF THE MANAGED CARE EXPERIENCES IN REGIONS 3 AND 5

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Abstract

In 1995, Kentucky began implementing a Medicaid managed care demonstration, *The Kentucky Health Partnership Program*. Under this unique initiative, the state encouraged its health care providers to form regional partnerships to serve the Medicaid population. Rather than contact with existing commercial managed care plans, the State planned to contract with eight regional partnerships. Each would be responsible for providing comprehensive health care coverage to their respective Medicaid beneficiaries.

Ultimately, only two regions, Region 3 and 5, which include the states' two major population centers (Louisville and Lexington), successfully formed managed care partnerships and were contracted by the state. However, Region 5 decided to dissolve its partnership in 1999.

Using information collected from personal interviews with state officials, plan representatives, providers, and advocates, as well as administrative and survey data, this analysis compares the experiences of Regions 3 and 5 in order to understand why one partnership remained in operation, while the other decided not to renew its contract after its second year of operation.

The authors identify a variety of financial, organizational, and administrative factors contributing to different outcomes in Regions 3 and 5 and offer recommendations to other states considering implementing Medicaid managed care programs.

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CHAPTER 1
INTRODUCTION

1.1 Background

In Fall 1995, the State of Kentucky began implementing a unique managed care initiative that encouraged the State's health care providers to form their own regional managed care organizations to serve the Medicaid population. Approved by the Centers for Medicare & Medicaid Services (CMS)[1] as an amendment to Kentucky's 1115 waiver, the Kentucky Health Care Partnership Program was designed to move nearly all Medicaid beneficiaries into a system of capitated managed care.[2] Rather than contract with existing commercial managed care organizations, the Kentucky Department of Medicaid Services (DMS), divided the State into eight services areas and requested that public and private providers collaborate to form regional managed care partnerships. Each partnership would then contract with the State to provide comprehensive health care to the Medicaid beneficiaries in their respective service areas. With the exception of a small group of exempt beneficiaries,[3] Medicaid recipients would be required to enroll in their regions' partnership plan. In other words, they would not be able to choose among multiple managed care plans nor would they have the option of remaining in fee-for-service (FFS) Medicaid.

Ultimately, only two regions, Region 3 and Region 5, which include the state's two major urban areas (Louisville and Lexington), successfully formed managed care partnerships and were contracted by DMS. The regions began enrolling members into their plans in November 1997. While both plans experienced initial start-up problems, Region 5's had more difficulty sustaining itself, and in November 1999, it decided to dissolve its partnership. As described later in this report, there was substantial provider discontent in Region 5 related to reimbursement under the partnership. The partnership felt it would not be able to maintain its provider network without increasing provider payments. However, they were unable to negotiate the capitation rate increase they considered necessary to support these higher provider payments because the State contended it would not be able to maintain budget neutrality. In the face of the potential dissolution of its provider network, the Region 5 partnership chose to cease operations. The region reverted back to a FFS system of reimbursement under the State's primary care case management (PCCM) program, Kentucky Patient Access and Care (KenPAC).[4]

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1 Formerly the Health Care Financing Administration (HCFA).

2 Medicaid beneficiaries excluded from the Partnership program include: eligibles in nursing facilities or psychiatric facilities for extended stay, eligibles served under the home and community-based waivers, and eligibles who must spend down to meet eligibility income criteria.

3 Medicaid beneficiaries excluded from the Partnership program included: eligibles in nursing facilities or psychiatric facilities for extended stay, eligibles served under the home and community-based waivers, and eligibles who must spend down to meet eligibility income criteria.

4 KenPAC was originally established in 1986 under a 1915b waiver. In July 2000, DMS began implementing an enhanced version of KenPAC in Region 5 and the 6 regions of the State that never contracted with DMS under the partnership initiative.

State officials, plan representatives, and providers identified a variety to organizational, financial, administrative, and political factors that they believed contributed to the Region 5 partnership's demise. This analysis considers these factors, comparing the different partnership experiences in Regions 3 and 5. It was designed to understand why one partnership remains in operation, while the other decided not to renew its contract with the State after its second year of operation. Much of the information presented in this report was collected during a site visit conducted in Kentucky on October 2-6, 2000. During this site visit, interviews were conducted with State officials as well as providers, plan representatives, and advocates from Regions 3 and 5. Analyses of administrative and survey data provided by DMS are also presented.

1.2 Description of Kentucky's 1115 Waiver

Approved by CMS in October 1995, Kentucky's Health Care Partnership Program had three broad objectives: 1) to improve access and quality of care for Medicaid beneficiaries; 2) to stabilize growth in Medicaid costs; and 3) to emphasize primary care and prevention. The State expected each of its regional partnerships to be a capitated risk-bearing entity (907 KAR 1:705). Each partnership was also required to have a governing board comprised of a broad cross-section of providers and include a licensed HMO or integrated service delivery network. (Appendix A includes a comprehensive list of partnership criteria mandated by Kentucky state regulation.)

DMS conducted separate rate negotiations with each partnership to determine monthly capitation payments. Within each region, different rates were developed for five eligibility categories: AFDC/TANF, SOBRA, children in foster care, SSI eligibles with Medicare, and SSI eligibles without Medicare. Partnerships were responsible for covering most acute care services, laboratory and x-ray, pharmacy, home health, dental, and vision care. However, long-term care services were excluded from the partnerships' benefit package. (See Appendix B for a complete list of covered and excluded services).

If a region failed to form a partnership that was acceptable to the State or if the partnership was dissolved or terminated, the State reserved the option to contract with multiple managed care organizations (for-profit or not-for-profit) within that region beginning January 1, 1999. The potential for the State to open up the regions to competitive bidding from all interested managed care organizations served as an incentive for each region's providers to collaborate in the formation of a partnership. Initially, this stimulated action on the part of providers who wanted to avoid commercial managed care entities from entering the State's Medicaid market and exercising control of health care services.

State regulations indicated that the partnerships would be implemented incrementally beginning with the two regions that included the State's major urban areas: Region 3, which included Louisville/Jefferson County and surrounding counties, and Region 5, which included Lexington/Fayette County and surrounding counties. (See ***Figure 1-1***.) Both the Region 3 partnership, Passport Health Plan, and the Region 5 partnership, Kentucky Health Select (KHS) began enrolling members in November 1997. While Passport continues managing health care for Region 3 Medicaid beneficiaries,[5] KHS decided in November 1999 to discontinue serving as the

5 By January 2003, Passport's enrollment had reached 123,700.

Region 5 partnership. By the end of June 2000, all KHS enrollees were transitioned back into KenPAC, the State's PCCM program, leaving Passport as the only partnership operating in Kentucky. (See Appendix C for a timeline of partnership implementation.)

By Fall 2000, Kentucky had decided to abandon its plans to implement partnerships in other regions of the State. After an unsuccessful solicitation of commercial bidders to serve the Medicaid population in one or more of the remaining seven regions, the State decided to implement an enhanced version of its PCCM program, KenPAC.

1.3. Overview of the Region 3 and Region 5 Partnerships

The State required partnerships to abide by regulatory criteria governing areas such as the composition of their boards of directors, financial solvency, and benefit package (see Appendix A). At the same time, DMS hoped that each partnership would be responsive to regional needs and provided partnerships with considerable flexibility in how they choose to organize, manage, and finance their plans. ***Table 1-1*** summarizes some of the organizational and reimbursement differences between Regions 3 and 5.

1.3.1 The Region 3 Partnership

The Region 3 partnership emerged from a collaboration of the University of Louisville's Medical School, a group of Louisville-based hospitals (Jewish Hospital Healthcare Services, Norton Healthcare, and University Medical Center), as well as the region's primary care centers. The Region 3 plan, known as Passport Health Plan, was established through a three-party contract between the Commonwealth of Kentucky, the Region 3 Partnership Council, and University Health Care, Inc. (UHC).

The Region 3 Partnership Council serves as the governing body of Passport Health Plan, while UHC is the risk-bearing entity. The Region 3 Partnership Council is comprised of a Board of Directors with 27 seats representing the region's Medicaid providers and consumers. The Partnership Council operates through a structure of 13 committees and subcommittees that oversee various aspects of health care access, management, and quality. They involve a total of 204 committee members, including 23 plan members and member advocates.

UHC is a risk-bearing HMO that was licensed in January 1997. It was created for the specific purpose of providing Medicaid services to Region 3 beneficiaries. The University of Louisville Medical School Practice Association is the majority investor in UHC with 51 percent ownership. The three major hospitals in Louisville (Jewish Hospital Healthcare Services, Norton Healthcare, and University Medical Center, Inc.) each own 13 percent of UHC. The remaining ten percent of UHC is owned by the Louisville-Jefferson County Primary Care Association, which is comprised of the region's two FQHCs (Family Health Center, Inc., and Park DuValle Community Health Center, Inc.), the Jefferson County Health Department, and the University of Louisville Primary Care Center.

In December 1996, UHC contracted with AmeriHealth Mercy Health Plan, based in Philadelphia, to perform administrative services for the partnership including claims processing, member and provider services, implementation of a medical management information system, case management, and health education.

Figure 1-1
Kentucky Medicaid Health Care Partnership Managed Care Regions

Table 1-1
Summary of the Region 3 and Region 5 Managed Care Partnerships Characteristics

	Region 3	Region 5
Plan Name	Passport Health Plan	Kentucky Health Select (KHS)
Governing Body	Region 3 Medicaid Partnership Council	Central Kentucky Regional Provider Entity (CKRPE)
Risk-Bearing Entity	University Health Care, Inc. (UHC, Inc.) HMO created by providers in 1997 to serve the Region 3 partnership. Majority Owner: University of Louisville Medical School PracticeAssociation (51%).	CHA HMO, Inc. HMO created by providers in 1995 Majority Owner: University of Kentucky Hospital (51.93%)
Membership Size	110,000 members (August 2000)	67,000 members (January 2000)
Coverage Area	16 counties Includes Jefferson County (Louisville)	21 counties Includes Fayette County (Lexington)
Administrative Responsibilities	Contracted to AmeriHealth Mercy Health Plan based in Philadelphia, PA.	Retained by CHA HMO, Inc.
PCP Reimbursement	Capitated payments for primary care adjusted for age, sex, and eligibility. FFS reimbursement for EPSDT services.	Current Medicaid fee schedule with a 20 percent withhold.
Hospital Reimbursement	Current Medicaid fee schedule with a 10 percent withhold.	Current Medicaid fee schedule with a 20 percent withhold.
Specialist Reimbursement	105% of current Medicaid fee schedule with a 10 percent withhold.	Current Medicaid fee schedule with a 20 percent withhold.

NOTE: KHS disenrolled its 67,000 members between January 1, 2000 and June 30, 2000.

1.3.2 The Region 5 Partnership Organization

The partnership in Region 5 began with a February 1996 meeting of representatives from the Fayette County Health Department and the University of Kentucky (UK) Hospital. This group was subsequently expanded to include urban and rural providers, health departments, FQHCs, pharmacists, home health agencies, and consumers. The Region 5 plan, Kentucky Health Select (KHS), based in Lexington, executed a contract with the State to serve as the region's partnership entity in September 1997.

KHS existed under an operating agreement between the Central Kentucky Regional Provider Entity (CKRPE) and CHA HMO, Inc. (CHA) and served as the region's partnership for two years. CKRPE, the governing body of KHS, oversaw the partnership's financing as well as provider and medical management. Its 25-member Board of Directors included a variety of providers and consumers. CHA is a commercial HMO that was created in 1995 by a consortium of providers and served as the partnership's risk-bearing entity. UK Hospital owns 51.9 percent of CHA. The minority owners include: UK Appalachian Regional Health Care (23.45%), St. Luke's Hospital (14.9%), Our Lady of Bellefonte Hospital (4.27%), Patti A. Clay Hospital (3.1%), Mary Chiles Hospital (1.7%), and Rockcastle County Hospital (0.8%).

KHS operated with five standing committees, each responsible for a different aspect of the region's health care delivery system: credentials, utilization management, pharmacy and therapeutics, quality and access, and quality management and improvement. Rather than contract administrative services to an administrative services organization (ASO), the Region 5 partnership retained those functions, which were performed by its partner HMO, CHA.

1.4 Overview of Report

This report examines a variety of factors that contributed to the differing experiences in Regions 3 and 5. Chapter 2 compares population characteristics in Regions 3 and 5 including differences in each region's overall population and Medicaid population. This chapter also examines differences in the region's health care service delivery systems. In Chapter 3, we consider financing issues. Here we examine the process that DMS used to negotiate capitation rates with each plan, and we compare rates across the two regions. In addition, we look at the different ways that each plan chose to reimburse their providers. Chapter 4 examines administrative and management issues. In this chapter, we consider how the partnerships' organization and staffing decisions impacted their ability to respond to administrative needs and develop positive public relations with providers and key political players. Chapter 5 summarizes the Kentucky partnership experience and presents lessons learned that may be of value to other states considering a similar approach to Medicaid managed care.

CHAPTER 2
POPULATION AND SERVICE DELIVERY DIFFERENCES

This chapter explores differences in the populations and health service delivery systems in regions 3 and 5. We examine two aspects of population. First, we consider sociodemographic differences between Regions 3 and 5. Second, we compare the overall size and distribution of the regions' Medicaid enrolled populations. Regional population might have potentially influenced the success or failure of the partnerships in a few different ways. Plans that are able to spread their fixed administrative costs over a larger enrollee base benefit from economies of scale relative to smaller plans. In addition, plans may find it easier to provide health care coverage in a region with a high concentration of residents living in urban areas. A plan with a diffuse population would require a more geographically dispersed provider network, which is more difficult for a plan to develop and manage. Finally, differences in the distribution of Medicaid enrollees across eligibility categories may have advantaged one region over the other. Although each partnership negotiated eligibility category-specific capitation rates based on historical cost data provided by DMS, there were errors in the cost data for SSI eligibles and pharmaceuticals (discussed in Chapter 3). While these miscalculations impacted both regions, they could have disproportionate effect across regions if plan members were distributed differently across eligibility categories.

We also considered differences in the regions' health service delivery systems that may have contributed to the partnerships' success. One would expect a region with a large supply of health care professionals and facilities to be well positioned to establish a comprehensive network to serve its members. A partnership serving a region with less developed delivery system would need to expend considerably more energy building a provider network by soliciting plan involvement from a relatively smaller pool of providers.

2.1 The General Populations of Regions 3 and 5

Regions 3 and 5 include Kentucky's largest urban centers, Louisville and Lexington. Region 3 is located in the northern central portion of Kentucky and shares a border with Indiana. It includes the State's largest city, Louisville, which is in Jefferson County, as well as 15 additional counties. The region includes 1.04 million people or 27 percent of the State's population. Its 16 counties range in population from 6,823 in Trimble County to 675,551 in Jefferson County. The majority of the region's population (64.8 percent) resides in Jefferson County (Kentucky State Data Center, 1995).

Region 5 is located east of Region 3 in central Kentucky. It includes the city of Lexington, located in Fayette County, and the State's capitol, Frankfort, which is in Franklin County. The region is home to 720,094 Kentuckians (18.6 percent of the State's population) spread across 21 counties. The counties range in population from 6,957 (Nicholas County) to 241,728 (Fayette County), and 33.6 percent of the region's population resides in Fayette County (Kentucky State Data Center, 1999).

Characteristics of each region's population, as well as the State's population, are shown in ***Table 2-1***. Both regions are more densely populated than the State as a whole. However, Region 3 is geographically smaller (4,705 versus 6,324 square miles) and more densely

populated then Region 5 (221 versus 114 residents per square mile). While the two regions' populations have a similar age distribution, Region 3 had a higher percentage of minority residents, 15 percent compared to 9 percent in Region 3 and 8 percent of the State population.

Table 2-1
Population and Geographic Characteristics, Regions 3 and 5 and Statewide

Characteristic	Region 3	Region 5	Statewide
POPULATION			
Total Population, 1995	1,042,101	720,094	3,867,511
Percent Population Change (1980-1995)	6	4	14
Percent Over Age 64, 1990	13	12	13
Percent Under Age 18, 1990	25	24	25
Percent Minority, 1990	15	9	8
Percent at or Below 100% Poverty Level, 1990	14	16	19
Percent at or Below 200% Poverty Level, 1990	33	36	40
Percent AFDC Recipients, 1995	4	4	5
Percent on Food Stamps, 1995	10	10	13
Percent on WIC, 1995/1996	2	3	3
Percent Medicaid Enrolled, 1996	10	11	14
GEOGRAPHY			
Square Miles	4,705	6,324	39,649
Population Per Square Mile, 1995	221	114	97

NOTES:
Population estimates for 1995 were developed by the Kentucky State Data Center, University of Louisville.
Population change used the US Bureau the Census 1980 Decennial Census data.
Percent Minority is based on the US Bureau of the Census, 1990 Decennial Census.
Poverty levels were based on the US Bureau of the Census, 1990 Decennial Census.
AFDC is the Aid to Families with Dependent Children program, now called Temporary Assistance for Needy Families (TANF).
Percent of AFDC Recipients reflects the total number of adult and child recipients in calendar year 1995 as a proportion of the area's population.
Percent of Food Stamps reflects the average number of food stamp recipients as a proportion of the area's population for the period July 1994 through June 1995.
WIC is the Women-Infant-Children nutritional supplement program.
Percent on WIC is the average number of WIC recipients for two typical months (10/95 and 4/96) as a proportion of the area's population.
Percent of Medicaid eligible is the total number of persons enrolled in Medicaid (as of the January 1996, Kentucky Medicaid Summary Report) as a proportion of the area's population.
Population density was based on 1995 population estimates.

SOURCE: University of Kentucky, Center for Rural Health. *County Profiles in Health*. A report prepared by the Good Samaritan Foundation, Inc. June 1997.

In the years preceding partnership implementation, the two regions had similar proportions of their populations enrolled in social welfare programs. According to the 1990 census, both regions had proportionately fewer people at or below 100 percent of the federal poverty level than the statewide average (19 percent), although Region 3 had a smaller percentage than Region 5 (14 percent versus 16 percent). In 1995, four percent of each region's population received AFDC, while 10 percent of each region's population received Food Stamps. At the same time, two percent of Region 3's residents were enrolled in the WIC program, and three percent of Region 5's residents received WIC support. As of January 1996, 14 percent of the population statewide was enrolled in Medicaid. Regions 3 and 5 had slightly lower Medicaid enrollment, 10 and 11 percent of their populations respectively.

2.2 Medicaid Beneficiaries

2.2.1 Total Medicaid Enrollment

Table 2-2 compares Medicaid beneficiaries in Region 3 and 5 for 1997 and 1999. These data represent the annual total number of unique Medicaid enrollees in each region including those individuals who were exempt from enrollment in the partnerships (e.g., the institutionalized, spend-down, and home and community-based waiver populations).[6] The data show differences in the size and composition of the Medicaid populations in the two regions. Region 3 has a larger Medicaid eligible population than Region 5. In 1997, the number of unique Medicaid beneficiaries in Region 3 was 165,673, while Region 5 had only 109,888 beneficiaries. Of these beneficiaries, 40 percent from Region 3 were AFDC eligible, while 36 percent from Region 5 were AFDC eligible. Region 5, in contrast, had a slightly higher proportion of SSI-eligibles recipients than Region 3. SSI eligibles with Medicare comprised 15 percent of Region 5 beneficiaries, but only 12 percent of Region 3's eligibles. Region 5 also had a slightly higher percentage of SSI eligibles without Medicare (14 percent versus 12 percent).

Medicaid enrollment declined over time in both regions by nearly 4 percent. By 1999, Region 3 had 159,750 Medicaid beneficiaries, while Region 5 had 105,736. The decrease in the total number of beneficiaries between 1997 and 1999 is largely due to a decline in the number of AFDC/TANF beneficiaries in both regions. In Region 3, the number of AFDC/TANF beneficiaries fell 19 percent, compared to 23 percent in Region 5. These decreases coincided with the State's implementation of welfare reform. The number of SSI enrollees with Medicare also fell in both regions (by 5-7 percent) while enrollment in all other categories grew. As a result of these changes, the AFDC/TANF population comprised a decreasing share of Medicaid enrollees in both regions.

6 The State was unable to provide partnership enrollment by eligibility for the same periods.

Table 2-2
Medicaid Beneficiaries in Regions 3 and 5 by Eligibility Category, 1997 and 1999

Region 3

	1997		1999		1997-1999
Eligibility Category	Region 3	% of Region	Region 3	% of Region	**% Change**
AFDC/TANF	67,036	40.5%	54,138	33.9%	-19.2%
KCHIP	NA	NA	2,463	1.5	NA
Foster Care	2,783	1.7	2,992	1.9	7.5
SOBRA	42,406	25.6	45,596	28.5	7.5
SSI without Medicare	20,248	12.2	21,880	13.7	8.1
SSI with Medicare	19,280	11.6	18,303	11.5	-5.1
Other	13,820	8.3	14,378	9.0	4.0
Total	**165,573**	**100.0**	**159,750**	**100.0**	**-3.5**

Region 5

	1997		1999		1997-1999
Eligibility Category	Region 5	% of Region	Region 5	% of Region	**% Change**
AFDC/TANF	39,215	35.7%	30,373	28.7%	-22.6%
KCHIP	NA	NA	1,532	1.4	NA
Foster Care	1,544	1.4	1,768	1.7	14.5
SOBRA	28,380	25.8	30,409	28.8	7.2
SSI without Medicare	15,120	13.8	16,325	15.4	8.0
SSI with Medicare	16,177	14.7	15,092	14.3	-6.7
Other	9,452	8.6	10,237	9.7	8.3
Total	**109,888**	**100.0**	**105,736**	**100.0**	**-3.8**

NOTES:
Estimates represents annual number of unique Medicaid eligibles.
Estimates include eligibles who were exempt or received a waiver from the Partnership program.
Kentucky's KCHIP Medicaid expansion using federal CHIP funding began in July 1998.

SOURCE: Kentucky Department of Medicaid Services, Medicaid eligibility files, 1997 and 1999.

2.2.2 Geographic Distribution of Enrollees

Table 2-3 shows Medicaid beneficiaries in Regions 3 and 5 comparing enrollees in each region's major urban county (Jefferson and Fayette) to the rest of the region. Similar to Table 2-2, these are annual counts of unique Medicaid eligibles and include individuals who were enrolled in the partnerships as well as any beneficiaries who remained in FFS Medicaid. These data show a major difference in the concentration of the two regions' populations in urban areas. In 1997, the year both partnerships were implemented, 64 percent of Region 3 beneficiaries were located in Jefferson county, while only 25 percent of Region 5 Medicaid eligibles resided in Fayette County. By 1999, the regions' population had not shifted substantially. Jefferson County accounted for 65 percent of Region 3's Medicaid eligibles, and Fayette County included 25 percent of Region 5's Medicaid population.

The disparity in urban concentration is consistent across all eligibility categories. In 1997, as much as 69 percent of Region 3's AFDC/TANF population (the largest eligibility category) resided in Jefferson County compared to 28 percent in Region 5 that resided in Fayette County. During the same year, the category with the lowest concentration of eligibles in Jefferson County was the SOBRA population at 57 percent, whereas 22 percent of Region 5's SOBRA beneficiaries were in Fayette County. In Region 3, 59 percent of the SSI beneficiaries on Medicare were in Jefferson County, compared to 23 percent of Region 5's dually eligible population in Fayette County.

2.2.3 Beneficiary Satisfaction

Researchers at the University of Kentucky (UK) conducted three mail surveys of Medicaid beneficiaries to collect basic utilization and satisfaction information before and after the implementation of Kentucky's Partnership program (Hager and Talbert, 1998, 1999, 2000).[7] Baseline data were collected in 1997 in the months immediately preceding the implementation of the Region 3 and 5 partnerships. Two additional surveys were conducted during the post-managed care period, one survey in 1998/1999[8] and a second in 2000. All three surveys were based on a random sample of Medicaid beneficiaries stratified by Medicaid region and eligibility category.

Table 2-4 shows beneficiary reporting of their satisfaction with Medicaid for 1997 and 1998/1999.[9] Beneficiaries were asked to rank their satisfaction on a five point scale, with lower values indicating higher levels of satisfaction and a decrease across years indicating increased satisfaction. We used the Wilcoxon rank sum test (Mann-Whitney U) to test differences in satisfaction between 1997 and 1998/1999. Table 2-4 shows beneficiaries across the State were

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7 UK researchers also conducted surveys of provider satisfaction in 1999 and 2000 (Hager and Talbert 1999; Hager and Talbert 2000). Due to the surveys' low response rates (28 percent statewide for 1999) and the small number of providers reporting at the regional level, we do not present the provider survey findings in this report.

8 Most of the responses for this survey were returned to researchers at UK in December 1998 and January 1999 (Hager and Talbert, 1999).

9 Comparable results were not available for 2000.

generally satisfied with the Medicaid program. While there were statistically significant increases in dissatisfaction in both of the partnership regions following the implementation of managed care, the same trend is observed in the non-managed care regions. Satisfaction with Medicaid for children did not change over time in either in Region 3 or Region 5. Satisfaction for children in the non-managed care regions increased over time, although it was only marginally significant ($z < 0.1$). Some of the increase in adult dissatisfaction may be an artifact of the survey design. For this particular question, UK researchers reversed the order of possible responses for half of its respondents in its 1998/1999 survey. The survey researchers reported that this accounted for a portion of the decline in adult satisfaction (Hager and Talbert, 1999).

Table 2-3
Medicaid Beneficiaries in Regions 3 and 5 by Eligibility Category and County, 1997 and 1999

Region 3	**1997**			**1999**		
Eligibility Category	Jefferson	Other[a]	% Jefferson	Jefferson	Other[a]	% Jefferson
AFDC/TANF	46,391	20,645	69.2%	39,089	15,049	72.2%
KCHIP	0	0	0.0	1,473	990	59.8
Foster Care	2,028	755	72.9	2,175	817	72.7
SOBRA	24,218	18,188	57.1	26,824	18,772	58.8
SSI without Medicare	13,355	6,893	66.0	14,336	7,544	65.5
SSI with Medicare	11,341	7,939	58.8	10,645	7,658	58.2
Other	8,419	5,401	60.9	8,739	5,639	60.8
TOTAL	105,752	59,821	63.9	103,281	56,469	64.7
Region 5	**1997**			**1999**		
Eligibility Category	Fayette	Other[b]	% Fayette	Fayette	Other[b]	% Fayette
AFDC/TANF	10,864	28,351	27.7%	8,859	21,514	29.2%
KCHIP	0	0	0.0	280	1,252	18.3
Foster Care	747	797	48.4	814	954	46.0
SOBRA	6,296	22,084	22.2	6,833	23,576	22.5
SSI without Medicare	3,521	11,599	23.3	3,823	12,502	23.4
SSI with Medicare	3,798	12,379	23.5	3,412	11,680	22.6
Other	2,499	6,953	26.4	2,706	7,531	26.4
TOTAL	27,725	82,163	25.2	26,727	79,009	25.3

NOTES:
Estimates represent the annual number of unique Medicaid eligibles.
Estimates include eligibles who were exempt or received a waiver from the partnership program.
[a] Includes the remaining 15 counties in Region 3.
[b] Includes the remaining 20 counties in Region 5.

SOURCE: Kentucky Department of Medicaid Services, Medicaid eligibility files, 1997 and 1999.

Table 2-4
Average Medicaid Satisfaction Rating
(5-Point Scale: 1 = Very Satisfied, 5 = Very Dissatisfied)

	Pre-Managed Care (1997)	Post-Managed Care (1998/1999)
Region 3		
Adult	1.58	2.21 ***
Children	2.57	2.00
Region 5		
Adult	1.44	1.80 ***
Children	2.15	1.95
Non-Managed Care Regions		
Adult	1.54	1.79 ***
Children	2.30	1.80 *

NOTES:
Ratings were coded 1=Very Satisfied, 2 = Somewhat Satisfied, 3 = Neither Satisfied or Dissatisfied
4 = Somewhat Dissatisfied, 5 = Very Dissatisfied.
Wilcoxon rank sum test (Mann-Whitney U Test) was used to test differences between the 1997 and 1998 ratings.
*** z significant at <.01 level.
** z significant at <.05 level
* z significant at <.1 level

SOURCE: RTI analysis of data from 1997 and 1998-1999 *Kentucky Assessment of Medicaid Recipient Satisfaction Surveys* conducted by Hager and Talbert (1998 and 1999).

2.3 Health Service System Delivery Characteristics

Table 2-5 shows baseline health service delivery system characteristics for Regions 3 and 5 and the entire State. In 1995, both regions had similar population to physician[10] ratios with Region 3 at 352 residents per physician and Region 5 at 357 residents per physician, substantially lower than the statewide ratio of 500. Regions 3 and 5 also had a lower ratio of population to PCPs than the rest of the State, 1,523 and 1,521 respectively, compared to the statewide ratio of 1,784. Based on the Center for Rural Health's assumption that each PCP can serve 1,500 patients, the proportion of unmet primary health care needs in the two regions is low, two percent in Region 3 and one percent in Region 5, relative to 16 percent statewide.

10 Physicians include both primary and specialist care physicians.

Table 2-5
Baseline Health Service Delivery System Characteristics, Region 3 and 5

Health Service Characteristic	Region 3	Region 5	Statewide
Population Per Physician, 1995	352	357	500
Population Per PCP, 1995	1,523	1,521	1,784
Percent Unmet Need for Primary Health Care	2	1	16
Population Per Dentist, 1996	1,343	1,319	1,694
Population Per Primary Care Dentist, 1996	1,613	1,698	2,055
Population Per Physician Assistant, 1995	29,774	6,487	16,388
Population Per Nurse Practitioner, 1995	7,663	6,546	8,850
Health Department Visit Rate/1,000 Persons, 1995	647	1,025	1,000
Number of Hospital Beds, 1994	4,442	2,965	15,557
Population Per Hospital Bed, 1994	232	240	246
Number of Rural Health Clinics, 1995	5	6	48
Number of Community Health Centers, 1996	9	3	29
Percent of Population in HPSA, 1996	15%	23%	26%

NOTES:
Physician estimates were based on annual license renewal form information collected by the Kentucky Board of Licensure in 1995.
Physician data reflect the location of the physician as reported on their license form, which may be different for their practice location.
PCP estimates were calculated by the Kentucky Cabinet of Health Services, Primary Care Branch and represent FTE equivalents.
PCPs include family practice, general internal medicine, ob/gyn, and general practice physicians
Unmet need calculations assume that each PCP can serve 1,500 individuals.
Dentist estimates are based on annually updated database maintained by the University of Kentucky, College of Dentistry, 1996.
Physician Assistant estimates were obtained from the Kentucky Board of Medical Licensure.
Nurse Practitioner estimates were reported by the Kentucky Board of Nursing.
Health Department and hospital utilization data are maintained by the Kentucky Cabinet for Health Services
Number of Rural Health Clinics are reported by the DHHS Office of the Inspector General.
Lists of Community Health Centers are maintained by the Kentucky Primary Care Association
HPSAs Health Professions Shortage Area. Data reflect shortages as of July 1996 as reported by the Kentucky Cabinet for Health Services.

SOURCE: University of Kentucky, Center for Rural Health. *County Profiles in Health.* A report prepared by the Good Samaritan Foundation, Inc. June 1997.

Region 5 had a larger supply of physician assistants with 6,487 residents per physician assistant relative to 29,774 in Region 3. While Region 3 had substantially more hospital beds than Region 5 (4,442 versus 2,965), the ratios of population to hospital beds were nearly equal, with Region 3 at 232 and Region 5 at 240, similar to the statewide ratio of 246. Region 3 included 5 Rural Health Clinics (RHCs) in 1995, while there were 6 RHC's in Region 5. And, in 1996, Region 3 had three times more Community Health Centers than Region 5 (9 versus 3). While 26 percent of the State of Kentucky resides in a Health Professional Shortage Area (HPSA), only 15 percent of Region 3's population lives in a HPSA, while 23 percent of Region 5 lives in a HPSA.

2.4 Implications of Population and Health Service Delivery Differences

Regions 3 and 5 had similar baseline health service delivery system characteristics, and both had greater capacity to provide health care than rest of the State. At the same time, the regions had population differences that may have contributed to differing partnership outcomes. In particular, Region 3 has a larger Medicaid population than Region 5. In addition, Region 3 had proportionately more AFDC/TANF eligibles on its Medicaid rolls than Region 5, and its beneficiaries were more concentrated in a single urban county.

Partnership enrollment data reflect the differences between the two regions' pools of Medicaid enrollees. Passport reported that in March 1998, it enrolled 95,000 members[11] (Passport, 2000). This was 10,000 below the State's initial projection of Passport enrollment, reflecting the decreasing number of AFDC/TANF eligibles following welfare reform. In comparison, KHS enrolled roughly 63,000 members in April 1998 (French, *et al*., 1999). KHS's initial enrollment was also lower than the State's projection of 71,000 members. In July 2000, when KHS was phasing out, its membership had reached 67,000. By August 2000, Passport's membership reached 110,000 (Passport, 2000). During the course of our site visit, plan representatives indicated that lower than projected enrollment early on in the Partnership program put both plans at a financial disadvantage because there was a smaller enrollee base over which fixed costs would be spread. Similarly, interviewees in both regions speculated that the smaller number of enrollees in KHS may have made it more difficult for the plan to survive.

In addition to differences in the size and geographic distributions of their Medicaid populations, Regions 3 and 5 had different population distributions across eligibility categories. Region 3 had proportionately more AFDC/TANF beneficiaries than Region 5, and proportionately fewer SSI eligibles. Both partnerships contended the capitation rates for the SSI population did not cover the cost of providing their care, while capitation rates for the AFDC/TANF enrollees population were well above actual costs. Thus, Region 3 benefited by having proportionately more "profitable" AFDC/TANF enrollees compared to Region 5 and proportionately fewer "unprofitable" SSI members. Issues of financing and reimbursement are discussed in greater detail in the next chapter.

11 This represents partnership enrollment at a point in time. DMS's region-wide eligibility estimates include all unique individuals who were eligible (Partnership and FFS beneficiaries) at any time during the calendar year. Therefore DMS enrollment numbers will be higher than Passport's.

CHAPTER 3
PARTNERSHIP FINANCING AND PROVIDER REIMBURSEMENT

Plan representatives, providers, and State officials frequently cited plan financing as contributing to differing outcomes in Regions 3 and 5. This chapter examines two aspects of financing. First we examine the way that DMS paid the regional partnerships. We consider the capitation rate setting process and compare the rates paid to Region 3 and Region 5. Region 5 plan officials claimed that they were disadvantaged by historically low utilization rates in their area and their partnership would have succeeded if it had received higher capitation payments from the State. Second, we examine the way the partnerships chose to reimburse their regions' providers. DMS gave each partnership considerable flexibility in designing their systems of provider reimbursement, and Regions 3 and 5 selected considerably different approaches. In this chapter, we look at how their methods of provider payment varied and the impact this had on the partnerships' success.

3.1 Partnership Capitation Rates

3.1.1 The Rate Setting Process

The partnerships received a monthly capitation payment that varied by region. Separate capitation rates were set for five eligibility categories: 1) AFDC/TANF; 2) children in foster care; 3) SOBRA pregnant women and children; 4) SSI beneficiaries with Medicare; and 5) SSI beneficiaries without Medicare.[12] There were no rate adjustments for enrollee risk characteristics within eligibility categories nor were there geographic adjustments within regions.

In addition to the capitation payments, the partnerships could receive annual "incentive payments" for achieving pre-selected outcome goals as measured by plan performance relative to baseline data. Each plan was to select up to four outcomes and was eligible to receive 0.25 percent of their capitation payments for each goal that was reached, or a maximum of 1 percent of their capitation payments. As of the end of the third year of the Partnership program, Region 5 had received a payment for early provision of prenatal care, but Region 3 had not requested any incentive payments.

Capitation rates were set through separate negotiations between DMS and each partnership. Rate negotiations centered on the "data book" developed by DMS' consulting actuary, which provided estimates of service utilization and costs under the Partnership program based on fee-for-service data for State Fiscal Years 95 and 96. Estimates were presented by region and eligibility category broken out by type of service (e.g., inpatient hospital, outpatient hospital, physician, pharmacy, DME, etc.).[13] These estimates were used to set an upper payment limit (UPL) for capitation rates, as required for budget neutrality. Fee-for-service data were projected forward to the first year of the Partnership program, using actuarial adjustments to

[12] A sixth rate category for the State Children's Health Insurance Program (SCHIP) was added during the third year of the Partnership program.

[13] Data were adjusted to remove services and populations for which the partnerships were not responsible (behavioral health, long-term care services, and all services received by residents of long-term care institutions).

account for historical trends in service use and costs, anticipated managed care impacts, Medicaid program changes, and fee-for-service claims lag. The UPL included a 10 percent loading factor, reflecting 6 percent administrative costs, a 2 percent profit margin, and 2 percent to compensate partnerships for the assumption of risk under capitation. Although DMS provided the data book to the partnerships, it did not disclose the estimated UPL.

DMS and the partnerships renegotiated capitation rates annually. Each year the partnership and DMS negotiated a percent increase over the previous year's rates. These increases were constrained by the State's need to stay under the UPL. While the increase could vary by rate category, the projected weighted average increase had to equal the overall negotiated percent increase.

In addition to the annual negotiated increase, plans received some off-cycle rate adjustments from DMS during FY99. These included a one-time add-on to cover the partnerships' development costs, a one-time rate adjustment based on a retrospective review of FY98 medical expenses, and a rate adjustment based on changes in the State's baseline trend assumptions. Only the adjustment for changes in baseline trend assumptions was included in the base for calculating the rates in subsequent years. While the add-on for development costs had always been planned, the other supplemental payments were essentially bail-outs for the newly established plans.

Both the State and the partnerships indicated that the accuracy of the data book was a major point of contention during the first set of rate negotiations. This issue was also raised during the State's audit of the partnership program (Hatchett, 1999). After its first year of rate negotiations, DMS contracted with a new actuarial firm to update the data book. Several errors in the original data book were discovered at this time. Some costs were erroneously attributed to SSI eligibles without Medicare, instead of those with Medicare. In addition, the projected increase in pharmacy costs was underestimated at 14 percent, rather than 18 percent. This underestimate of drug inflation had a substantial impact on initial cost estimates for dually eligible beneficiaries, given that pharmaceuticals comprise a disproportionately large share of their Medicaid utilization.

Both the plan and State officials agreed that because of these errors initial capitation rates for dually eligible beneficiaries were underestimated, making it difficult for plans to serve them. Although the plans were able to address this by negotiating larger rate increases for dually eligible beneficiaries, these had to be offset by lower rate increases for other categories in order to achieve the agreed upon average increase. While there was a great deal of consternation surrounding the databook, one Passport official reported that after the initial errors were corrected, the plan felt that it fairly represented the cost of providing care.

Once state official described the plans as "600 pound gorillas" in the rate negotiation process because of the absence of competition. Although there was an implied threat of competition because the State had the option of contracting with multiple managed care organizations if it could not reach an agreement with a partnership, this was ultimately not viewed as a credible threat in Region 5. While the State's need to stay under the UPL in order to maintain budget neutrality provided some leverage in rate negotiations, it lacked a meaningful competitive alternative that it could bring to the table.

3.1.2 Baseline Utilization and Cost

The partnerships' initial capitation rates were based on historical utilization and costs. ***Table 3-1*** shows the 1995-1996 average utilization and cost experiences of Regions 3 and 5 for selected services and total services.[14] Across all eligibility categories, Region 3 had higher rates of inpatient hospitalization and physician use than Region 5 during the two years preceding Partnership implementation. While inpatient hospital unit costs were also greater in Region 3 than Region 5 across all eligibility categories except for the dual eligibles, physician unit costs were nearly equal in the two regions.

Across all eligibility categories, with the exception of the SSI population with Medicare coverage, Region 3 had higher per member per month (PMPM) costs than Region 5. The largest eligibility category, AFDC, had total service costs of $125.26 PMPM in Region 3 versus $101.60 in Region 5. The most costly category was the SSI population without Medicare coverage. They had an average cost of $478.83 PMPM in Region 3 and $362.65 in Region 5. The SSI population with Medicare had average costs of $111.22 in Region 3 with slightly higher costs, $121.97, in Region 5.

We are unable to determine whether or the extent to which Region 3's higher baseline PMPM costs reflect historic patterns of higher utilization versus differences between regions in the health status of the Medicaid population or the cost of doing business. If one assumes that the two regions had comparable populations with respect to health status, pre-managed care utilization patterns suggest that Region 3 may have had more opportunities for potential savings than Region 5.

3.1.3 Region 3 and Region 5 Capitation Rates

There were three rounds of rate negotiations during the time period that both Region 3 and Region 5 participated in the Partnership program. In addition, as described previously, the plans received some off-cycle payment increases from DMS. ***Table 3-2*** shows each region's rates by eligibility category for selected time periods during the first three years of the Partnership program.

With the exception of SSI beneficiaries, Region 3 rates were 6-10 percent higher than those in Region 5 in FY98. Region 3 had 32 percent higher rates for SSI beneficiaries with Medicare and 18 percent lower rates for SSI beneficiaries without Medicare. Nonetheless, for all eligibility categories except SSI without Medicare, the rate differentials are less than historic cost differences. These were 11-23 percent higher for non-SSI beneficiaries in Region 3 compared to Region 5 and 9 percent lower for SSI beneficiaries with Medicare (Table 3-1). Thus, DMS at least partially compensated for historic cost differentials by setting Region 5's initial capitation rates higher relative to baseline costs than those in Region 3.

[14] The data in Table 3-1 are derived from the databook used in the first year of rate negotiations and, therefore, reflect the errors in that databook.

Table 3-1
Average Medicaid Utilization and Costs by Region and Eligibility Category, 1995 and 1996

	Region 3			Region 5		
	Annual Use/1000	Unit Cost	PMPM Cost	Annual Use/1000	Unit Cost	PMPM Cost
AFDC						
Home Health Care	399.65	$49.72	$1.66	440.72	$34.09	$1.25
Inpatient Hospital	486.56	999.45	40.52	374.72	841.95	26.29
Outpatient Hospital	4,340.63	75.07	27.15	5,753.33	47.67	22.85
Pharmacy	5,012.90	17.45	7.29	5,723.67	17.74	8.46
Physician	7,026.79	42.43	24.85	6,851.90	41.71	23.82
Primary Care Clinic	3,582.95	37.08	11.07	2,784.47	36.59	8.49
TOTAL			*$125.26*			*$101.60*
Foster Care						
Home Health Care	1,776.00	$55.90	$8.27	1,587.15	$82.02	$10.85
Inpatient Hospital	597.04	986.23	49.07	555.42	769.58	35.62
Outpatient Hospital	3,336.80	67.71	18.83	3,704.44	57.98	17.90
Pharmacy	5,866.24	19.38	9.47	6,110.51	22.77	11.59
Physician	8,419.22	40.07	28.11	7,283.92	41.08	24.94
Primary Care Clinic	2,794.28	30.99	7.22	2,239.52	37.38	6.98
TOTAL			*$159.59*			*$143.77*
SOBRA						
Home Health Care	563.58	$44.02	$2.07	573.87	$32.52	$1.55
Inpatient Hospital	851.23	981.98	69.66	710.73	865.97	51.29
Outpatient Hospital	4,749.32	61.91	24.50	6,626.27	38.39	21.20
Pharmacy	4,681.90	14.09	5.50	4,516.99	13.46	5.07
Physician	10,593.18	46.45	41.00	9,470.89	46.17	36.44
Primary Care Clinic	4,760.14	34.47	13.67	4,870.96	35.22	14.29
TOTAL			*$166.25*			*$138.34*
SSI Without Medicare						
Home Health Care	22,509.66	$26.14	$49.02	21,286.92	$27.39	$48.59
Inpatient Hospital	2,047.55	932.30	159.08	1,580.65	763.74	100.60
Outpatient Hospital	10,648.42	86.12	76.42	12,313.46	54.35	55.76
Pharmacy	32,230.76	26.75	71.85	26,928.81	27.12	60.86
Physician	16,182.56	44.32	59.77	13,875.26	45.81	52.96
Primary Care Clinic	3,268.35	44.39	12.09	2,592.91	30.41	6.57
TOTAL			*$478.83*			*$362.65*
SSI With Medicare						
Home Health Care	7.53	$119.27	$0.07	16.46	$205.95	$0.28
Inpatient Hospital	2,109.26	120.07	21.10	1,786.77	132.40	19.71
Outpatient Hospital	1,658.82	228.53	31.59	2,089.62	141.85	24.70
Pharmacy	13,593.49	19.89	22.53	27,269.81	22.23	50.51
Physician	18,187.36	13.84	20.97	15,559.31	14.68	19.03
Primary Care Clinic	1,392.92	39.99	4.64	563.14	48.41	2.27
TOTAL			*$111.22*			*$121.97*

NOTES:

PMPM is Per Member Per Month. PMPM costs equal total utilization divided by the average number of recipients per month divided by 12.

Average PMPM cost at the service level was derived from the average of 1995 and 1996 utilization and costs for each service.

Average PMPM cost for all services is the average 1995 and 1996 PMPM costs for all services. These include the listed services as well as DME, dental, EPSDT, transportation, family planning, lab and x-ray, and other services. Therefore, total PMPM costs are greater than the sum of the PMPM costs of the listed services.

SOURCE: Databook prepared by William M. Mercer, Incorporated for the Commonwealth of Kentucky.

Table 3-2
Capitation Rates by Region and Eligibility Category for Selected Time Periods

Region 3 Capitation Rates

	FY 98 11/1/97- 6/30/1998	FY 99 7/1/98- 12/31/1998	FY 00 1/1/00- 6/30/2000
AFDC	$137.00	$146.20	$144.32
Foster Care	177.38	188.52	144.85
SOBRA	171.02	181.85	202.28
SSI with Medicare	117.00	125.24	204.53
SSI without Medicare	504.65	531.51	496.19

Region 5 Capitation Rates

	FY 98 11/1/97- 6/30/1998	FY 99 7/1/98- 12/31/1998	FY 00 10/1/99- 12/31/1999
AFDC	$124.18	$150.39	$124.10
Foster Care	166.26	194.52	147.48
SOBRA	160.28	188.67	176.80
SSI with Medicare	143.03	170.16	193.29
SSI without Medicare	382.39	421.14	420.10

NOTES:
FY99 rates included:
An increase over FY98, plus one time add-on for development costs,
A 3% increase based on baseline trend factors for FY97, and
A one time adjustment for retrospective review of FY98 medical expenses
FY00:
Negotiated FY00 rate, which included a 2.3% increase over the FY99 base net of development cost.
Rate changes for specific eligibility groups may be more or less than 2.3% based on plan experience.
However, weighted average rate change across all groups is 2.3%.

Rate adjustments in FY99 provided Region 5 with further financial assistance. Indeed, after taking into account the off-cycle rate adjustments, Region 5 had higher capitation rates than Region 3 for all categories except SSI without Medicare during the first 6 months of FY99 (Table 3-2). However, relative rates paid during the second half of FY99 (data not shown), which did not incorporate the off-cycle rate adjustment based on retrospective review of FY98 medical expenses, were similar to those paid in FY98. With the exception of children in foster care, Region 3 capitation rates were again higher for every eligibility category in FY00 with differences ranging from 6 percent (SSI with Medicare) to 18 percent (SSI without Medicare). The third set of rate negotiations ended with KHS' decision to discontinue serving as its region's partnership.

3.2 Rate Setting Concerns

3.2.1 Historic Utilization and Rate Setting

Kentucky's approach to rate setting based on historical utilization was a frequent source of complaints from plans and providers, not only because of questions about the accuracy of the data but also because of the implications for savings under managed care. Some State and plan officials noted that reliance on historical utilization rewarded providers for past excesses. In particular, Region 3 may have been in a more advantageous position than Region 5 because of its higher baseline utilization. Region 5 officials claimed to have a difficult time finding excess utilization within the region that could be reduced under managed care to generate savings. However, as described earlier in Section 3.1.3, DMS paid Region 5 a higher percentage of its upper payment limit as at least partial compensation for past utilization differences.

A second issue raised during our interviews was whether it was realistic to expect the partnerships to achieve savings under managed care if baseline utilization rates were already low. One provider speculated that DMS may have overestimated the savings that could be achieved under the Partnership since the State had operated a PCCM program for many years under KenPAC. This physician noted that patients were already assigned to PCPs under KenPAC and they had worked to limit emergency room utilization, which is an important area for potential savings under managed care. Nonetheless, Passport officials reported that they were able to reduce inpatient days by 20-30% over baseline rates.

3.2.2 The SSI Population and Rate Setting

KHS officials reported that their financial position was particularly hurt by inclusion of the SSI population in the Partnership program. During the third round of rate negotiations they proposed carving out the SSI eligibles as a condition of continuing as the Region 5 partnership. They argued that DMS overpaid for AFDC enrollees in Region 3, allowing Passport to cross-subsidize the cost of their SSI population. KHS officials contended that if they had the same rates as Region 3, their partnership would have still been in operation.

While Region 5 received higher capitation rates for this population in FY98 than Region 3, and both Regions received adjustments in FY99 that factored in a retrospective review of FY98 medical expenses, they continued to voice concern over covering the dually eligible population. In particular, they reported that it was difficult to control the cost of care for this

population because they can access services out of network by virtue of their Medicare eligibility. In addition, dually eligible beneficiaries incur high pharmacy costs, a benefit that both plans reported trouble covering (discussed in the next section).

3.2.3 Prescription Drug Benefits

Representatives from both plans reported problems providing prescription drug coverage because expenditure increases exceeded growth projections. In addition, plans were limited in their ability to control drug utilization under Kentucky's open formulary law, which requires plans to cover pharmaceuticals that are new to the market.

The increasing costs of pharmaceuticals are a common concern among Medicaid programs. Nationally, Medicaid spending on prescription drugs more than tripled between 1990 and 1999, increasing from $4.8 billion in 1990 to $17 billion in 1999 (NIHCM, 2001). Kentucky is no exception; in FY00, its Medicaid drug costs rose 24 percent, followed by a 31 percent increase in FY01 (Moskowitz, 2001). Despite this inflationary trend, the State noted that the plans failed to implement cost controls on drug use, reporting that during their first year of operation the partnerships operated without management systems to control drug utilization. The partnerships similarly reported that during their first year they had almost no utilization control for prescription drugs. For example, they did not have a preferred drug list or a system of prior authorization. However, they reported that this was because they were confused as to what the State would allow. In addition, the plans noted that they did not benefit from the prescription drug rebate that DMS received under FFS Medicaid.

Passport officials reported that after their second month of full membership, they found that costs of prescription drugs were staggering. In addition to dialogue with the State concerning allowable utilization controls, there was considerable discussion between the plans and the State regarding the accuracy of the State's databook. While DMS provided plans with a three percent supplemental rate increase based on a retrospective review of FY98 medical expenses, the partnerships reported that this one-time increase did not solve their ongoing problem of covering the cost of prescription drugs.

After their first year of operation, the partnerships implemented some utilization controls. Passport officials reported that they instituted prior authorization for a limited list of drugs. They communicate with PCPs about preferred prescribing practices, and they developed a fraud and abuse program. Still, the plans reported that they were constrained in their ability to control costs, noting that since 1998 Kentucky's open formulary law has mandated that Medicaid cover new prescription drugs without any restrictions during their first 12 months on the market.[15] In addition, the partnerships reported that they were unable to require copayments for pharmaceuticals.

15 The State of Kentucky used its emergency power to bypass its open formulary law. Beginning in December 2001, physicians will need approval from the Medicaid program to prescribe non-formulary drugs to Medicaid patients.

3.3 Provider Reimbursement

The partnerships chose very different methods of provider reimbursement. While Region 3 capitated PCPs, Region 5 reimbursed PCPs on a FFS basis with a 20 percent withhold. These different approaches had major implications for who bore the financial risk in the newly formed plans and the plans' success at maintaining a provider network to serve the Medicaid population.

3.3.1 Passport Health Plan Provider Reimbursement

Passport Health Plan pays PCPs on a capitated basis adjusted for age, sex, and eligibility category. PCPs are only at risk for primary care services. In addition, they are not capitated for dually eligible SSI beneficiaries. Passport reimburses PCPs on a FFS basis for lab and radiology services at 95 percent of the Medicaid fee schedule. In addition, PCPs receive FFS reimbursement for certain direct access services including prenatal care, EPSDT services, and immunizations.

PCPs are also eligible for performance-based bonus payments. The plan pays PCPs a comprehensive services bonus of $1 PMPM. Between 25 and 30 percent of practices regularly qualify for this bonus, which is designed to encourage doctors to offer extended office hours, maintain appointment reminder systems, and accept new patients. Passport also pays physicians an encounter claims bonus of $1 for every non-FFS claim submitted. Passport pays out roughly a quarter million dollars for PCP encounter data annually.

Performance utilization incentives are available to Passport PCPs in groups with a minimum panel size of 150 patients. The plan's initial system of physician rewards was based on three indicators: emergency room visits, inpatient days, and specialty referral costs. Utilization by the members of a PCP panel, adjusted for eligibility category, was compared to historical experience based on the State's original databook. Passport later adopted a profiling system based on PCP panel members' total costs adjusted for actuarial risk. PCPs are divided into urban and rural peer groups. PCPs with costs below the actuarially-adjusted mean for their peer group are eligible for incentive payments. The plan allocates $1.30 PMPM for the performance incentives and payments are calculated on a quarterly basis. Passport guarantees to pay out at least 20 percent and up to 100 percent of the total pool. Passport determines the portion of the incentive pool that is paid out based on the percent of withholds returned to specialists and hospitals. For example, at the time of our site visit, the average withhold returned to specialists and hospitals over the four previous quarters was 91.9 percent, so the same proportion of the PCP incentive pool was dispersed to PCPs. In addition, PCPs received a one-time $3.00 PMPM payment for the first six months of 2000 "in recognition of their commitment to the plan and improved plan performance."

Passport reimburses specialists on a FFS basis at 105 percent of the current Medicaid fee schedule with a 10 percent withhold. All specialty visits require authorization from a PCP. The plan reimburses hospitals on a per diem basis at Medicaid rates with a 10 percent withhold. During the partnership's first year of operation, none of the hospital or specialist withhold was returned, but in 1999 85 percent of the withhold was returned. The partnership planned to return 100 percent of withhold for FY2000.

Passport also maintains a safety net fund to help sustain community providers that serve a disproportionately large segment of the medically indigent population. To be eligible for support from this fund the provider organization must be a primary care center operating on a sliding fee-scale and at least 25 percent of its patients must be uninsured and below the poverty level. The amount in the safety net fund is based on a percentage of the revenue that Passport receives from the State, and it is distributed to eligible providers on a monthly basis with payments determined by historical costs.

3.3.2 Kentucky Health Select (KHS) Provider Reimbursement

KHS reimbursed physicians and hospitals using the current Medicaid fee schedule with a 20 percent withhold. FQHCs were paid a discounted percentage of their 1996 cost-based rate trended forward for inflation. Although FQHCs were to supposed to migrate to FFS billing, this had not occurred by the time KHS withdrew from the Partnership program.

Primary care physicians were organized into "pools of doctors" or PODs, which served as the basic contracting unit and the primary means for monitoring and controlling utilization. Primary care centers and FQHCs that served as PCPs were also included in PODs. The PCPs in a POD were located in the same geographic area and were usually part of a pre-existing group. However, in order to assure that PODs had an adequate enrollee base, KHS sometimes grouped together PCPs with no natural relationship to each other. In designing their payment system, KHS estimated that each POD would have to serve a minimum of 1,500 enrollees to protect the providers from excess risk. Once implemented, however, a typical POD had about 1,000 assigned members. On average, there were approximately 20 PCPs in each POD, but PODs in rural areas included as few as 4-5 physicians.

Each POD operated within a budget cap that included primary and specialty care, pharmacy and ancillary services, hospitalizations, and transportation. KHS set the budget caps based on the projected costs of the mix of rate categories served by the POD. At the end of each accounting period, actual health care experience was compared to the budget for each POD to evaluate its performance relative to the budget cap. If expenditures exceeded the projected budget, the amount of the 20 percent withhold returned to providers would be reduced. If the POD's actual experience fell at or below budget targets, all of the provider withholds would be returned and any surplus was shared based on the following percentages:

- PCPs: 25%
- Specialists: 25%
- Hospitals: 50%.

After its first year of operation, KHS did not return any provider withholds. However, the off-cycle payment increases during Year Two allowed KHS to eventually return approximately 50 percent of the Year One withhold. At the time of our interview, although the partnership had ceased operations, KHS officials indicated that they were planning to return some of the Year Two withholds, although the exact amount had not been determined.

3.4 Provider Reimbursement Concerns

3.4.1 PCP Risk

For a State with limited managed care experience, KHS's decision to use FFS reimbursement with a withhold was initially viewed as far more acceptable to providers than the PCP capitation arrangement adopted by Passport. Indeed, Region 3 had considered adopting a similar reimbursement structure, but given the compressed time frame for implementation, AmeriHealth Mercy required that Passport adopt the PCP capitation payment system used in other plans it administered.

Despite the FFS reimbursement, in practice Region 5 providers bore more risk than those in Region 3. According to KHS staff, CHA was not willing to bear any of the risk for operating KHS and the substantial 20 percent withhold was required to shift this risk to providers. Furthermore, KHS had guaranteed that it would repay CHA's initial capital investment in the partnership relatively quickly. Because of this, KHS staff reported they had never expected to return provider withholds in the early years of operation, regardless of the PODs' utilization experience. However, providers did not fully comprehend this or the extent to which they were shouldering the plan's financial risk. One DMA official noted that the 20 percent withhold created a false hope among providers.

The Region 5 partnership received a fair amount of praise from DMS and providers during its early implementation. Prior to managed care, UK was the primary Medicaid provider in the region. KHS officials reported that they built up interest among physicians who never participated in Medicaid before. They noted that initial physician participation under KHS was higher than it had been under KenPAC. However, providers became disillusioned with the partnership when the Year One withholds were not returned. Although KHS was able to return a portion of the withhold in the second year, provider support for the partnership had been severely undermined and there were concerns that the provider network could not be maintained in the long run. Although there had been some erosion of participation by the time it withdrew from the Partnership program, KHS staff contended that physician participation remained higher than it was under KenPAC.

In contrast, after some initial problems, Region 3 providers were generally satisfied with their reimbursement under Passport. Given the high return on withholds after the first year of operation, specialists reimbursement rates were higher than the FFS rates paid under KenPAC. PCPs are able to augment their capitation payments through FFS reimbursement for selected services and performance-based bonus payments.

3.4.2 Utilization Controls

Region 5's method of organizing providers into PODs proved ineffective at managing physician behavior and was a source of complaint among PCPs from the region. First, in many cases PODs were not naturally occurring but were created by KHS and may have included a disparate group of PCPs who had not previously worked together. The lack of PCP cohesion within some PODs was problematic since the POD required a high degree of collaboration among its members to effectively manage care. Second, PCPs lacked timely information on

utilization, which is required under the POD system for the group to control costs. Since the POD concept requires group judgement and influence, for this approach to work, the POD needs timely and accurate information on member doctors' practice patterns. However, most of the PODs did not have the capacity to generate this information and KHS was slow to provide these data. As a result, there was little the PODs could do to identify any overutilization and control costs. Finally, while a POD might be able to influence specialist practice behavior in rural areas where specialists received referrals from only a few PODs, in urban areas the incentives for specialists were too diffuse to have an impact.

CHAPTER 4
PLAN ADMINISTRATION AND MANAGEMENT

While both partnerships confronted administrative challenges during start-up and underwent changes in plan staffing after their first year in operation, Region 3 was more effective at responding to on-going administrative programs and hiring local management with Medicaid and managed care experience. In addition, Region 3 was more successful than Region 5 at developing positive relations with providers (particularly safety net providers), local businesses, and political leaders.

4.1 Administrative Differences

Region 3's decision to contract with an administrative service organization (ASO) to perform claims processing, member and provider services, medical management information system, case management, and health education was an important factor contributing to Passport's success, although this was not apparent at the plan's outset. State officials and providers from Region 3 reported early dissatisfaction with Passport's ASO, AmeriHealth Mercy. State Medicaid officials and providers indicated that they were initially concerned that the ASO did not have adequate familiarity with the service population. Providers, in particular, reported they were dissatisfied that managed care functions were being performed outside of Kentucky. Not only were they concerned about the geographic distance between the Philadelphia-based AmeriHealth administrators and the Region 3 Medicaid population and providers, but they also expressed some early resentment that limited Medicaid dollars were flowing out of State.

However, despite initial dissatisfaction with certain AmeriHealth Mercy staff and the exporting of Medicaid administrative functions, partnership representatives reported that the ASO brought much needed managed care experience to their initiative. AmeriHealth Mercy had established provider payment utilization management and management information systems that it could put in operation rapidly. The ASO promised the Region a quick start-up, but in exchange, the partnership had to agree to implement AmeriHealth's preferred system of reimbursement, a model it had previously implemented in other states. While this lack of flexibility on the part of the ASO meant the partnership would have to forego alternative payment schemes, the resulting system proved to be more viable than the reimbursement approach that Region 5 developed (discussed in Chapter 3).

Once concerns over the ASO emerged, Region 3 was quick to respond to its early management problems and underwent a major change in administration near the end of its first year of implementation, hiring new local management staff. Reflecting on their Year One experience, partnership representatives reported that the plan's initial local management and staffing were substandard, and the plan lacked legislative support. They reported that AmeriHealth needed to modify its initial approach drawing instead from management that was based in Kentucky. In response, the partnership fired its first executive director and hired a locally-based administrator with managed care and clinical experience, who subsequently hired additional staff from the Louisville area. While these administrators were employees of AmeriHealth Mercy and the partnership could continue to take advantage of the ASO's administrative infrastructure, the new staff were based in Passport's Louisville office and had

strong ties to Louisville health services and business circles. Several interviewees representing the State, providers and Passport noted that this was a critical turning point for Passport since it provided local credibility.

Rather than contract with an outside administrative entity, Region 5 relied on CHA HMO, Inc., a commercial plan created in 1995 by the providers in the region with UK Hospital playing a leadership role. By joining the Region 5 partnership, the relatively inexperienced CHA hoped to expand its membership base. As of July 1, 1998, the plan had been in operation for just over 3 years, and its total HMO enrollment (public and private payers) was only 141,192[16] (Interstudy, 1999). Almost half of these members were Medicaid beneficiaries that were enrolled beginning in November of the previous year.

Several respondents indicated that reliance on CHA was highly problematic due to the organization's limited experience administering managed care systems and its primary ownership by a single hospital in the region. State officials and providers noted that the plan lacked sufficient experience to implement the partnership program, particularly given its relatively fast start-up. One State official reported that CHA was not sufficiently sensitive to the needs of physicians in the region and that it was distracted by its on-going struggle to maintain a presence within the commercial managed care sector. CHA's financial strength actually improved once it dropped the Medicaid population from its rolls. Following the Region 5 partnership's discontinuation, Standard and Poor's raised its rating for CHA's financial strength from a 'CCCpi', indicating very weak financial security characteristics, to a single 'Bpi', indicating weak financial security characteristics (Standard and Poor, 2001).

Region 5 also went through organizational changes during its first year and a half of implementation. However, State officials argued that Region 5 still lacked the caliber of top-line management needed for the partnership to succeed. They claimed that, as a result, there was an absence of pressure in Region 5 to decrease utilization and that KHS's response to financial shortages was to rely on political pressure to leverage more funding from the State rather than seek ways to generate savings out of the system. KHS officials, on the other hand, reported that the system was underfunded and that they had substantially less over utilization prior to managed care relative to Region 3. Providers from both regions, however, agreed that Region 3 contracted with a more experienced administrative entity, while in Region 5, CHA lacked the administrative experience and skills to succeed.

4.2 Management Differences

In addition to being able to overcome administrative challenges more easily than Region 5, the Region 3 partnership had better relations with providers, the business community and key political players from their region. While Passport benefited from its region's history of provider collaboration, particularly around issues of indigent care, it also spent considerable effort responding to provider concerns as they arose. In addition, Region 3's plan had staff who were highly skilled in public relations and were able to generate a network of support for the plan among providers, local businesses, and political leaders.

16 CHA HMO, Inc. also had 26,500 members in a preferred provider organization (PPO) and 13,706 self-insured traditional members.

4.2.1 Provider Relations

Providers and State officials reported that the Region 3 partnership was more attentive to the providers in their region throughout the partnership development and implementation process than the Region 5 partnership. In particular, they noted that the Region 3 partnership was more sensitive to the viability of safety net providers under the partnership program.

Providers from both regions noted that the medical schools in the two regions operate differently, with the University of Louisville (U of L) functioning in a more decentralized manner than UK's Medical Center. This is partly due to fact that UK has a stronger research focus, while much of U of L's faculty is in private practice rather than research. This difference worked to UK's benefit during its early stages of implementation since it was able to make decisions quickly at the highest levels of the organization. However, the decentralized structure of U of L's medical school forced it to work collaboratively with a variety of providers across the region. Providers from Region 3 reported that this ultimately worked to Passport's benefit since it fostered a sense of ownership among the region's providers and encouraged their participation in solving problems.

Region 3 had a history of provider collaboration around issues of indigent care going back to the CitiCare program, a prototype Medicaid managed care program that it implemented in the early 1980s. As discussed in Chapter 3, the Region 3 partnership attempted to ensure that safety net providers remained financially secure under their plan by maintaining a safety net fund. In addition, Passport representatives reported that they involved their region's health departments in the partnership's outreach activities for EPSDT screening and KCHIP enrollment.

Region 5, on the other hand, had fewer provisions to maintain the existing network of safety net providers, which had previously been dependent on Medicaid funds to subsidize core public health functions. Safety net providers in Region 5 reported problems with the implementation of KHS. One Lexington-based FQHC, which received most of its revenue from the Medicaid program, reported that its number of Medicaid enrollees dropped due to an administrative problem that assigned their historical clients to other PCPs. In addition, this FQHC reported that it had difficulty financially sustaining itself given low reimbursement rates. One physician operating out of an FQHC noted that KHS did give FQHCs special reimbursement rates but contended that this was only after substantial lobbying from the region's safety net providers and that the rates still fell below the traditional FFS level, particularly after the 20 percent withhold. This particular center suffered a loss of approximately $100,000 in the second year of KHS implementation, which was absorbed by the county government. Another FQHC reported similar problems, but since the county government did not cover its losses, it was forced to lay off staff.

One Lexington-based FQHC reported that while it had financial difficulties under KHS and experienced an initial drop in enrollment due to administrative errors, it eventually saw its number of Medicaid patients grow during the course of the demonstration. They reported that this was due to active outreach on the part of the clinic and the fact that many physicians in the region had refused to take new Medicaid patients. This FQHC continued to accept Medicaid

patients from within Fayette County, many of them from the UK pediatrics department, which had stopped taking new Medicaid patients.[17]

4.2.2 Political Support

By the time the partnerships in Regions 3 and 5 were being implemented, voters in Kentucky had elected a new Governor, Paul E. Patton, a Democrat who entered office in December 1995 and went on to be reelected to a second term in 1999. One State official reported that during Patton's first administration, the Democrat-controlled legislature distanced themselves from the partnerships, "constantly pointing their fingers at them." To staff at DMS, it seemed like a deliberate attempt to dismantle the initiative. There were few Partnership supporters in the legislature, and since Medicaid and HMOs are often the subject of criticism in Kentucky, those legislators supporting the Partnership initiative tended to remain silent but refrained from actively opposing the Partnership program. Medicaid agency officials reported that the legislature's lack of support for the program slowed the development of partnerships across the State. It was difficult to bring up new partnerships in the regions that had not yet entered into agreements with the State since they foresaw the potential demise of the program given an unsupportive legislature. Representatives from the plans in Regions 3 and 5 reported that their implementation was challenging because of the close legislative oversight to which they were subjected. They indicated that this distracted them from attending to the start-up problems that both plans encountered during their first year of operation.

While both partnerships faced political obstacles, the Region 3 partnership was eventually able to generate support for its plan. Partnership representatives and Passport management spent considerable effort developing positive public relations, not only with the region's providers, but also with the local business community and political representatives. Having an ASO and management team with experience marketing managed care plans and responding to complaints proved to be highly important.

In addition, Passport benefited politically from having a large portion of its beneficiaries and providers concentrated in the greater Louisville areas (see Chapter 2). Several provider, State, and partnership representatives reported that the State legislature often treats Louisville as an entity that is different than the rest of the State and was willing to accept the continuation of Passport if Louisville's political leaders were in agreement. As one provider reported, "If you have Louisville on board, you're all set." This provider indicated that as long as providers in Louisville were satisfied, the Region 3 partnership would be able to gain support from politicians representing Louisville, and the region's plan would remain viable despite any possible discontent from outlying counties.

17 The University of Kentucky's pediatrics department was the largest Medicaid provider in Region 5 that refused to take new Medicaid patients. UK physicians reported that this step was reluctantly taken because the department suffered financially under the partnership program.

CHAPTER 5
CONCLUSION

5.1 Summary of Kentucky's Partnership Experience

The Kentucky Health Care Partnership Program was an ambitious attempt to introduce capitated managed care in an environment with limited managed care experience and a high level of resistance from providers. Encouraging providers and consumers to become integrally involved in the development of a managed care entity circumvented any tough political battles that would have accompanied a direct solicitation of commercial plans and helped diffuse distrust of managed care. In addition, contracting with a single entity in each region eliminated concerns about marketing practices and selection bias in plan enrollment. Plans also have a greater incentive to invest in prevention because they do not have to be concerned that beneficiaries will switch plans. However, this innovative approach came with its own set of challenges.

First, the Partnership created a monopoly plan in each region, which reduced the State's leverage in subsequent rate negotiations. In addition, several plan, State, and provider representatives noted that it was probably not feasible for partnerships to operate in all eight regions that DMS had established. Given their sparse populations, many of the regions had difficulty generating the capital necessary to initiate a partnership agreement with the State. Once established, it is questionable whether the plans would have had an adequate number of members to remain financially viable. Some State officials and plan representatives speculated that the partnership concept might have worked in Kentucky if the State were divided into fewer regions encompassing larger populations.

This analysis focused on the two regions that successfully formed partnerships and initiated managed care contracts with the State. While Region 3 continues to serve its Medicaid membership, Region 5 decided to terminate its partnership after its third year of operation. A comparison of their experiences highlighted important considerations in implementing such a program. Following is a summary of some of the important differences between the regions and lessons learned from their experiences that may be helpful to other states considering instituting systems of managed care for their Medicaid populations.

5.2 Capitation Rates

Capitation rates were set higher in Region 3 relative to Region 5 based on historical utilization and cost patterns. While we do not have data to document this, representatives from DMS and both partnerships agreed that Region 3 had greater baseline excess utilization than Region 5, particularly for inpatient care, which made it easier for Passport to achieve savings. However, the State at least partially compensated Region 5 for these baseline differences by paying it a higher percent of the UPL. Region 5 also had a larger proportion of SSI enrollees among its members than Region 3. Both regions found capitation rates for the SSI population were inadequate to cover the actual costs of serving this population. In addition, the partnerships were limited in their ability to manage the care of dually eligible beneficiaries.

States should realize the importance of accurate historical utilization data when moving to a system of managed care. Underestimates of service use may lead to an under-funded managed care system, particularly if there was little excess utilization during the pre-managed care period. This can have serious implications on the sustainability of the system of managed care or beneficiaries' access to care.

5.3 Provider Reimbursement Methodology

Region 5 chose to reimburse providers on a FFS basis using a 20 percent withhold, whereas Region 3 capitated primary care physicians and used FFS reimbursement with a 10 percent withhold for other providers. Although Region 5's FFS payment method was initially more acceptable to providers than Region 3's use of capitation, in practice, Region 5 providers ended up bearing more risk than those in Region 3. Region 5 was not able to provide the PODs with timely information on utilization that was needed to manage care, and the PODs themselves did not have the capacity to generate these data. Region 5 was not able to return any withholds during its first year of operation, although they retroactively paid 50 percent of the withhold for the first 14 months during their second year of operation (as a result of a special bail-out from the State). However, by this time there was considerable ill-will among providers that undermined KHS's ability to sustain its provider network. While Region 3 PCPs were capitated, they generally fared well financially and were satisfied with Passport. In addition, the plan was able to return a high percentage of its withhold to hospitals and specialists.

States implementing systems of managed care should realize that while providers may have a strong preference for FFS reimbursement, they do not always fare better financially under these systems, particularly if they are subject to large withholds. Furthermore, States should ensure that managed care incentives dependent on feedback to regulate provider behavior are supported by data systems that can generate a timely and accurate account the service utilization at the individual provider level.

5.4 Plan Administration

Both plans experienced significant administrative problems during their first year of implementation, but Region 3 was more effective at restaffing and reorganizing its plan in order to respond to problems. In addition to drawing on the managed care experience of its ASO, they brought in local managers with extensive Medicaid and commercial managed care experience. The plan administration in Region 3 also placed greater emphasis on public relations and building goodwill with legislators. As a result, they were less vulnerable than Region 5 when providers complained about the Partnership program to legislators.

Region 5's HMO, CHA, decided to retain administrative services rather than contract with an ASO. However, given CHA's limited managed care experience, Region 5 was less successful than Region 3 at overcoming early administrative problems. KHS was also less active than its Region 3 counterpart at developing positive public relations with providers, beneficiaries, and politicians. The more dominant hospital role in the leadership of the Region 5 partnership also made it difficult to effect needed changes, whereas primary care and safety net providers played a more central role in the governance of the Region 3 partnership.

States should realize that moving from a traditional FFS system to managed care comes with enormous organization, financial, and administrative challenges. Experienced managed care plans or ASOs may offer needed expertise and workable models that are particularly helpful during early implementation. However, states should be cautious that systems remain sensitive to local needs and interests in order to remain viable in the long-term.

5.5 Cohesiveness of Provider Community

Providers in Region 3's Jefferson County have a history of working together on indigent care, dating back to the Citicare program in the early 1980s. In addition, the University of Louisville is integrated with providers in the community, whereas there is a more traditional town/gown split in Lexington. The Region 3 partnership appeared to have more success in integrating a broad spectrum of providers in decision making, whereas UK Hospital seems to have driven the Region 5 partnership.

The Region 3 Medicaid population is heavily concentrated in Louisville, whereas Region 5's population is more rural. Thus, Region 3 could focus more exclusively on making the partnership work in Louisville, whereas Region 5 had to worry more about rural areas where there was little experience with managed care and considerable hostility.

The partnership concept relied on the ability of diverse providers and interests to coalesce around a common goal of serving the Medicaid population using capitated managed care. Such an approach may be appealing States with limited private sector managed care experience or with stakeholders who want to pre-empt commercial plans from serving the Medicaid population. However, Kentucky's unique experiment showed that the bonds that providers form for such an endeavor can be tenuous, particularly if their financial well-being is at stake. While such partnerships may be an attractive way for states to introduce managed care for the Medicaid population, once implemented, provider dissatisfaction can threaten the initiative. A plan's success at sustaining a provider network may be hampered if providers have limited history working together or are geographically dispersed.

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APPENDIX A
PARTNERSHIP CRITERIA

Kentucky administrative regulations (907 KAR 1:705) specified that each Health Care Partnership should meet the following criteria.

- Be a coalition of consumers and health care providers in both the public and private sectors.

- Be licensed, or contain an entity that shall be licensed and meet minimum requirements of the Kentucky Department of Insurance as a provider sponsored integrated health delivery network.

- Meet fiscal solvency requirements and accessibility requirements including maintenance of an adequate number of health care providers.

- Establish a governance body, or board of directors, that:

  – Assumes responsibility for establishing and implementing policies and procedures regarding health services delivery to members of the partnership;

  – Broadly represents the partnership region's health service providers and incorporates currently enrolled Medicaid providers and other providers, including hospitals, primary care providers, specialty providers, non-physician health professionals, dentists, primary care centers, public health departments, and the University of Louisville and University of Kentucky medical centers for the regions in which they are located;

  – Includes at least four consumer representatives who are members of the partnership and represent each of the following categories of recipients: children and family related beneficiaries, children with special health care needs, the aged, and disabled; and

  – Is approved by DMS to ensure that its composition is in compliance with State regulations.

- Demonstrate adequate protection against insolvency by establishing and maintaining an insolvency reserve in accordance with State specification.

- Submit monthly financial statements to DMS within 45 days of the end of each month during the first year of operation and on a quarterly basis, or as designated by the department, thereafter.

- Cooperate with the State's Medicaid agency, Office of Inspector General, and Office of Attorney General to control fraud and abuse related to the State's Medicaid program.

- Include specified provider representatives in the partnership network or submit documentation for DMS's approval that establishes that services and service sites adequately meet the needs of members if the specified representatives are not included in the network.

- Use public health departments in the partnership's region to provide direct access services, collaborate in assessment of health and health care needs of the member population and partnership region, collaborate in the development and implementation of members and partnership region health promotion programs, and serve on the partnership governance body.

- Establish a program integrity unit to identify and refer to the State any suspected fraud activity concerning health care service of members.

- Submit public requests for financial information concerning partnership operations to DMS.

APPENDIX B
STANDARD BENEFIT PACKAGE FOR KENTUCKY'S MEDICAID MANAGED CARE PARTNERSHIPS

Appendix B
Standard Benefit Package for Kentucky's Medicaid Managed Care Partnerships

Capitated Services	Excluded Services
Inpatient Hospital Services	Mental Hospitals
Outpatient Hospital Services	Psychiatrists
Urgent and Emergency Services	Psychiatric Beds (Inpatient Hospital)
Outpatient Surgical Services	Non-Emergency Transportation (Mental Health)
Medical services provided by:	AIS/MR Services
Physicians	ICF/MR
Advanced Practice RNs	Targeted Case Management (Behavioral Health)
Physician Assistants	Home and Community-Based Waiver Services
FQHCs	Certain Medicare-Only Services
Primary Care Centers	CORF Services
Rural Health Clinics	Chiropractors
Laboratory	Physicians Assistant
X-rays	Physical and Occupational Therapy
Home Health Services	Psychologist
Pharmacy and Limited OTC Drugs	Clinical Social Worker
Dental Services	Nursing Facility Services
Medical Transportation	EPSDT Special Services (Behavioral Health)
Appropriate Escort Meals and Lodging	School-Based Services for Disabled Students
Therapeutic Evaluation and Treatment	Early Intervention Services for Infants and
Physical Therapy	Toddlers with Disabilities
Speech Therapy	
Occupational Therapy	
EPSDT Services	
Vision Care	
Preventive Health Services provided by:	
Public Health Departments	
FQHCs	
Rural Health Centers	
Hearing Services (under age 21)	
Durable Medical Equipment	
Alternative Birthing Services	
Podiatry Services	
Family Planning Clinic Services	
Renal Dialysis	
Hospice Services	
Organ Transplant Services	
Specialized Case Management for Children and Adults with Complex Conditions	
Behavioral Health (Limited to PCP)	
Medical Detoxification	

NOTES:
Partnerships were required to cover capitated services. Excluded services were to be covered on a FFS basis or capitated through a separate waiver. (DMS initially planned to capitate behavioral health services under a separate waiver program but abandoned these plans.)

SOURCE: Kentucky Department of Medicaid Services. *Kentucky Medicaid Managed Care Partnership, Program Summary. April 1999.*

APPENDIX C
KENTUCKY MEDICAID MANAGED CARE PARTNERSHIP IMPLEMENTATION TIMELINE

APPENDIX C
KENTUCKY MEDICAID MANAGED CARE PARTNERSHIP IMPLEMENTATION TIMELINE

July 5, 1985	CMS approves the Kentucky Patient Access and Care program (KenPAC) a primary care case management (PCCM) program for AFDC and AFDC-related beneficiaries.
May 26, 1993	CMS approves Kentucky's original Section 1115 waiver, the Medicaid Access and Cost Containment Project to CMS. This demonstration was designed to initially rely on the KenPAC's PCCM program with the potential to expand to other types of managed care entities.
June 22, 1995	Kentucky submits an amendment to its 1115 waiver, Kentucky Health Care Partnership Program.
October 6, 1995	CMS approves the Kentucky Health Care Partnership Program
September 1996	The Region 3 Medicaid Managed Care Partnership and University Health Care, Inc., (UHC) is created.
December 1996	UHC selects AmeriHealth Mercy Health Plan (AMHP) to administer the Region 3 partnership.
January 1997	UHC obtains an HMO license.
March 7, 1997	CMS approves Kentucky 1915b waiver, Kentucky Access, allowing the state to contract with managed behavioral health care organization on a regional basis.
April 1, 1997	Region 5 planning group is formally constituted as the Central Kentucky Regional Provider Entity.
September 1997	A three-party contract (Commonwealth of Kentucky, UHC, Inc., and Region 3 Medicaid Partnership Council) is executed with the state in Region 3.
September 1, 1997	A Region 5 partnership contract with the state is signed.
November 1, 1997	Passport enrolls Jefferson County AFDC recipients KHS enrolls AFDC recipients from six small counties
January 1, 1998	Passport enrolls Jefferson County's SSI population. KHS enrolls the remaining AFDC recipients in Region 5
March 1, 1998	3.
April 1, 1998	KHS enrolls all elderly and disabled SSI recipients eligible for the partnership program.
November 1, 1998	Partnerships began transmitting encounter data to DMS
July 1, 1999	KCHIP Phase II enrollment begins.
July 1, 1999	Rates based on DMS's revised databook go into effect.
October 1, 1999	The state establishes an Ombudsman's office.

APPENDIX C
KENTUCKY MEDICAID MANAGED CARE PARTNERSHIP IMPLEMENTATION TIMELINE (continued)

November 1999	KHS informs the state that they would no longer serve as the Region 5 partnership.
December 1999	Passport announces that it is returning 70% of its provider withhold for the last six months of 1999.
January 1, 2000	KHS phase-out begins
June 30, 2000	Region 5 serves its last recipients. KHS participants are transitioned in KenPAC.
July 2000	DMS fails to receive offers that it deems responsive to its solicitation for commercial managed care plans. It begins to implement an Enhanced KenPAC program.
July 1, 2000	Phase I of Enhanced KenPAC begins with a monthly management fee increase and increased DMS staffing of the program.
July 11, 2000	Kentucky submits an amendment to its 1115 demonstration requesting continuation of the partnership program in Region 3 only.
July 17, 2000	CMS approves Kentucky's 1932(a) plan, which transitioned KenPAC from 1915b waiver authority to 1932(a) SPA authority.
August 1, 2000	Passport decides to return 100% of its provider withhold for the first six months of 2000 and the last six months of 1999. The plan also pays a one-time $3 PMPM administrative fee to PCPs in recognition of their improved financial performance and commitment to the plan.
October 1, 2000	Phase II of Enhanced KenPAC begins. Adult SSI outside of Region 3 are phased in.
March 2001	Passport and DMS agree to an average 8 percent rate increase for SFY2001.
May 1, 2001	CMS approves Kentucky's 2nd amendment to its 1115 waiver allowing the state to continue the partnership in Region 3.
October 31, 2002	CMS approves an extnesion of Kentucky's 1115 waiver.