



Commonwealth of Kentucky
Department for Medicaid Services
Division of Program Quality and Outcomes

**Managed Care Program Progress Report
IPRO/DMS Contract Year 1
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Background and Introduction

According to federal regulation (42 CFR §438.358(b)(2)) states with a Medicaid managed care program are required to conduct or contract with an EQRO to conduct three mandatory review activities – monitor compliance with state and federal standards; validate performance improvement projects and validate performance measures according to protocols developed by the Centers for Medicare and Medicaid Services (CMS).

As specified in the contract between the Commonwealth of Kentucky's Department for Medicaid Services (DMS) and the External Quality Review Organization (EQRO), the EQRO was tasked with preparing an annual Managed Care Program Progress Report for key stakeholders such as the Kentucky State Legislature. The purpose of this report is to summarize information from the three mandatory external quality review activities that describe the status and progress that has occurred in Kentucky's Medicaid managed care program during the IPRO/DMS contract year September 1, 2012 to June 30, 2013. Three key reports were referenced in preparing this Progress Report, namely the Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services¹, the External Quality Review Technical Report for MCO contract year(s) 2011–2012² and the Comprehensive Evaluation Summary, October, 2013³. The Urban Institute/University of Kentucky's Evaluation of Statewide Risk-Based Managed Care in Kentucky, November, 2012 was also reviewed in preparing this report⁴.

Managed Care Organizations

From July 2000 to December 2012, the Commonwealth operated a partnership plan, known as Passport Health Plan only in Region 3 (Louisville/Jefferson County and the 15 surrounding counties). The partnership functioned as a provider-controlled managed care network and contracted with a private health maintenance organization (HMO) to provide the necessary administrative structure (i.e., enrollment, beneficiary education, claims processing, etc.).

However, in 2011, as a result of an increased demand for cost-effective health care, the Kentucky Cabinet for Health and Family Services, and the Department for Medicaid Services initiated an expansion of the Medicaid managed care program in order to offer quality health care statewide. In November 2011, three MCOs, CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky, joined Passport Health Plan in offering Medicaid services including those related to behavioral health. With this expansion, Medicaid managed care services were made available statewide, allowing all eligible Kentuckians to enroll in a managed care plan. A little more than a year after implementation, Kentucky Spirit Health Plan notified DMS that they would stop providing managed care services to Medicaid beneficiaries as of July 5, 2013. The state was successful in procuring a new contract with Humana-CareSource and the transition of health plan enrollees is underway. Humana-CareSource is not included in this Progress Report, but information regarding Kentucky Spirit Health Plan is included.

MCOs participating in Kentucky's Medicaid managed care program are required to become NCQA accredited within two years of contracting with the state. Passport Health Plan currently has NCQA accreditation and the other plans are in the process of applying.

Regions

With the expansion, Medicaid services in Kentucky were made available to all eight regions in the state, allowing all eligible Kentuckians to enroll in a managed care plan. For the reporting year 2012, Kentucky MCOs operated regionally, as follows: CoventryCares of Kentucky operated in all regions; Kentucky Spirit Health Plan operated in all regions, except Region 3; Passport Health Plan operated in Region 3 only; and WellCare of Kentucky operated in all regions. Humana-CareSource currently has enrollment in Region 3.

Enrollment/Populations

Enrollment in Kentucky's Medicaid managed care program has been steadily increasing, from 172,559 enrolled in Passport Health Plan as of December 30, 2011⁵ to current managed care enrollment in all four MCOs of 687,209, an increase of 76%. Currently 85% of the Medicaid eligible population is enrolled in managed care (Table 1).

Table 1.
Medicaid Enrollment as of September 16, 2013

MCO	Current Enrollment	Percent of Total	Service Area
CoventryCares of Kentucky	262,836	32%	Statewide
Humana-CareSource	16,068	2%	Region 3
Passport Health Plan	125,452	16%	Region 3
WellCare of Kentucky	282,831	35%	Statewide
<i>Managed Care Total</i>	<i>687,209</i>	<i>85%</i>	<i>NA</i>
Fee for Service	121,787	15%	Statewide
Unassigned	22	< .01%	NA
<i>Total Medicaid</i>	<i>808,996</i>	<i>100%</i>	<i>NA</i>

NA: Not applicable

Benefits

Kentucky's Medicaid managed care program, called Global Choices, offers a comprehensive benefit plan for enrollees. The plan covers basic medical services including acute inpatient hospital services, outpatient hospital/ambulatory surgical centers, laboratory, diagnostic and radiology services, physician office visits, preventive services, early and periodic screening, diagnosis and treatment (EPSDT), emergency ambulance and hospital emergency room services, occupational, physical and speech therapy, hospice, chiropractic, hearing and vision services, prosthetic devices and durable medical equipment. Also included in the benefit package are behavioral health services, dental services, maternity services, prescription drugs, home health care, substance abuse covered for pregnant women and children, family planning, podiatry and end stage renal disease and transplants. While a number of services require a small co-payment, some people covered by Medicaid are exempt including non-Kentucky CHIP children, children under 19 years who are in foster care, pregnant women, hospice care and home care patients.

Executive Summary

This Managed Care Program Progress Report presents a summary of quality review activities conducted by the state's external quality review organization (IPRO). IPRO is a national organization providing a full spectrum of healthcare assessment and improvement services that foster more efficient use of resources and enhance healthcare quality to achieve better patient outcomes. Founded in 1984, IPRO holds contracts with federal, state and local government agencies, as well as private-sector clients, in more than 33 states and the District of Columbia.

Medicaid managed care plans in Kentucky are responsible for collecting and submitting data to the state's Department for Medicaid Services (DMS) including Medicaid encounters of service, provider network data and quality performance data. This data is the foundation for information used in monitoring and measuring service utilization, access to providers and quality performance. In compliance with Federal regulations, Kentucky's EQRO is responsible for validating the encounter and provider network data and the Healthy Kentuckians performance measure data submitted by all Medicaid managed care plans – Passport Health Plan, CoventryCares of Kentucky, WellCare of Kentucky and Kentucky Spirit Health Plan. The EQRO also conducts an annual Compliance Review of structure and operations and quality assessment and performance improvement (QAPI) which are summarized in the annual External Quality Review Technical Report. The Compliance Review judges how well the MCO complies with state and federal regulations by rating each of the elements reviewed as fully compliant, substantially compliant, minimally compliant or non-compliant. For reporting year 2012, CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky received a full compliance review while Passport Health Plan received a “re-review” based on findings from its previous Compliance Review.

Provider Network/Access

Provider Network Access was assessed as part of the 2011–2012 Compliance Review and through HEDIS® quality performance data and CAHPS® consumer satisfaction data. Key findings include:

- Three plans (CoventryCares of Kentucky, WellCare of Kentucky and Kentucky Spirit Health Plan) received an overall substantial rating of compliance for access (Access was not reviewed for Passport Health Plan in the 2011–2012 Compliance Review);
- HEDIS® access measures in which all four plans performed above the national average include:
 - Adult Access to Preventive/Ambulatory Health Services for all age groups,
 - Children and Adolescents' Access to Primary Care Practitioners for age groups 12–24 Months and 25 Months–6 Years,
 - Annual Dental Visit,
 - Prenatal and Postpartum Care: Timeliness of Prenatal Care, and
 - Frequency of Ongoing Prenatal Care: 81+ Percent (of visits); and
- All plans reported consumer satisfaction rates for adults and children above the national average for Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate and Customer Service.

- *Opportunities for improvement:*
Although strong performance was demonstrated for several Access/Availability measures, there remains opportunity for improvement:
 - All four plans reported rates below the national average for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life measure;
 - CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky had rates below the national average for Postpartum Care, Adolescent Well-Care Visits and Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment – Engagement of AOD Treatment: Total;
 - CoventryCares of Kentucky, Passport Health Plan and WellCare of Kentucky had rates below the national average for the Call Answer Timeliness measure;
 - CoventryCares of Kentucky and WellCare of Kentucky reported rates below the national average for Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment – Initiation of AOD Treatment: Total;
 - Based on a survey of MCOs conducted by the EQRO, further study of the advantages and disadvantages of conducting a state-sponsored Access and Availability Survey is needed.

Quality Measurement and Improvement

Measurement and Improvement is an area of assessment that is reviewed during the annual Compliance Review, but it also includes MCO-conducted Performance Improvement Projects and findings from HEDIS® quality performance measures and Healthy Kentuckians.

The Commonwealth of Kentucky established a strategy for quality assessment and improvement in September, 2012 entitled, Strategy for Assessing and Improving the Quality of Managed Care Services. This document outlines the goals, objectives and expectations of the expanded managed care program in Kentucky. The primary goals of the Kentucky Medicaid managed care program are to improve the health status of Medicaid enrollees and lower morbidity among enrollees with serious mental illness. The strategy was well written, included all CMS-required topics and adequately described the Medicaid managed care program in Kentucky. CMS approved the strategy, which established the following objectives in order to effectively accomplish their goal:

1. Improve access and coordination of care;
2. Provide health care at the local level through the managed care system using public and private providers;
3. Redirect the focus of health care toward primary care and prevention of illness;
4. Monitor and improve the quality of the health care delivery system;
5. Increase health promotion efforts, psychotropic medication management and suicide prevention; and
6. Implement effective and responsive cost management strategies in the health care delivery system designed to stabilize growth in Medicaid costs.

Performance Improvement Projects

A protocol for conducting PIPs was developed by the Centers for Medicare and Medicaid Services (CMS) to assist MCOs in the design and implementation of their PIPs. Kentucky contracts with their EQRO to conduct PIP validation. In addition to validating the PIPs, the EQRO provided valuable technical assistance to MCOs in clarifying project goals, study indicators, sampling and outcome evaluation. In Kentucky, two new PIP topics are proposed each year and are generally completed in two to three years. Topics for study included Antidepressant Medication Management, Reducing Inappropriate ER Utilization, Reducing ER Utilization, Dental Care Rates for Children with Special Health Care Needs, Reducing Inappropriate Antibiotic Use, Smoking Cessation, Utilization of Behavioral Health Management Medication in Children, Improving Cervical Cancer Screening Rates and Improving Prenatal and Postpartum Depression Screening and Management.

Notable common strengths of the MCO PIP topics have included:

- Strong rationale for the topics chosen, often targeting an important public health issue in the state;
- Strong evidence of topic relevance to the plan; and
- Interventions that addressed the barriers and comprehensively addressed the needs of members, providers and MCO system/staff.

As part of the validation process, the EQRO has addressed several opportunities for improvement concerning the PIPs conducted by Kentucky MCOs:

- Clarify study indicator numerators and denominators and timelines for measurement; and
- Better define interventions directed at specific barriers and enhance the scope of interventions proposed to be more likely to achieve results.

Performance Measurement

DMS requires plans to report a total of 32 measures in the *Healthy Kentuckians (HK)* measure set: 11 HEDIS® measures and 21 Healthy Kentuckians (HK) measures developed for the Healthy Kentuckians initiative, including sub-measures.

As required by DMS through the plans' contracts, all non-HEDIS® measures must be validated by the EQRO. For measurement year 2011, the EQRO reviewed all data and documentation used to calculate the performance measures for Passport Health Plan. Only Passport Health Plan reported performance measures for measurement year 2011, since the other MCOs began operation in November of 2011 and were not required to report *HK* or HEDIS® performance measures for 2011.

Notable improvement was made by Passport Health Plan, in regard to *Healthy Kentuckians (HK)*, as demonstrated by two consecutive years of increasing rates for the following measures:

- a. HEDIS® Adult BMI Assessment;
- b. HEDIS® Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile for all 3 age groups;
- c. *HK* Weight Assessment/Counseling for Nutrition and Physical Activity: Healthy Weight for Height age groups 3–11 years and 3–17 years;
- d. Adolescent Screening/Counseling for Mental Health Assessment/Screening; and

- e. Prenatal Education/Counseling for Drug Abuse, Domestic Violence, Smoking Cessation: Smokers and Smoking Cessation: Combined.

Although several measures have shown great improvement, Passport Health Plan continues to report declining rates for measures related to:

- a. HK Weight Assessment/Counseling for Nutrition and Physical Activity: Height and Weight for age group 12–17 years;
- b. HK Prenatal Education/Counseling – Members Screened and Identified as Non-Smokers;
- c. HEDIS® Controlling High Blood Pressure;
- d. HEDIS® Lead Screening for Children;
- e. HEDIS® Well-Child – 15 Months, HEDIS® Well-Child – 3–6 Years; and
- f. HEDIS® Children’s Access to PCPs for age group 25 Months–6 Years.

DMS required all MCOs to report HEDIS® measures for the 2012 measurement year. The measures required for reporting included the following domains: Board Certification, Effectiveness of Care, Access/Availability of Care and Use of Services. This was the first year that the MCO’s reported HEDIS® with the exception of Passport Health Plan. Results of HEDIS® for measurement year (MY) 2012 include:

Strengths:

- Above national average results for all four plans for the Annual Monitoring for Patients on Persistent Medications: Total measure, and Frequency of Ongoing Prenatal Care 81+%.
- Other measures with one or more plans above the national average included Childhood Immunization Status: Combination #3, Antidepressant Medication Management: Effective Acute Phase Treatment and Effective Continuation Phase Treatment, Immunizations for Adolescents: Meningococcal and Childhood Immunization Combination #1, Antibiotic Treatment in Adults with Acute Bronchitis, Well-Child Visits in the First 15 Months of Life: 6+ Visits, Adolescent Well-Care Visits.
- Demonstrated strong performance in measures related to Access and Availability including Adult Access to Preventive and Ambulatory Care, Children and Adolescents’ Access to Primary Care Practitioners for age groups 12–24 Months and 25 Months–6 Years, Annual Dental Visit and Prenatal and Postpartum Care: Timeliness of Prenatal Care.

Opportunities for improvement:

- The overall Board Certification rates were low.
- Performance was below the national average for all plans for the following measures: Cervical Cancer Screening in Women, Appropriate Treatment for Children with URI, Comprehensive Diabetes Care Eye Exam (Retinal) Performed, and Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis and Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life measure.
- All plans’ rates for the Use of Imaging Studies for Low Back Pain measure were below the 10th percentile benchmark.
- Access/Availability measures with poor results included Postpartum Care, the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation of AOD

Treatment: Total and Engagement of AOD Treatment: Total, and the Call Answer Timeliness measure.

Compliance Review 2011–2012 Summary Results

All plans had full or substantial compliance in the following areas:

- Measurement and Improvement,
- Credentialing,
- Delegation,
- Access,
- Utilization Management,
- Care Management, and
- Enrollee Rights.

Findings and recommendations for several elements reviewed reminded MCOs to provide complete documentation for review; that MCO records such as credentialing and case management files should contain all supporting documentation; and that policies and procedures and subcontracts should reflect all state contract rules and regulations.

Compliance Review findings noted that continued communication between DMS and MCOs is needed to resolve issues occurring with coding and other encounter and provider network data submission problems. Also, communication between DMS and other Cabinet of Health and Family Services agencies needs to be continued and enhanced so that managed care enrollees can benefit from improved interagency connections. This is particularly important for coordination between the MCOs and DMS, DCBS and DAIL.

Recommendations

Based on the review of EQRO quality review activities for 2011–2013, and focusing on the opportunities for improvement identified as a result of this progress report review, the following key performance areas are identified for DMS consideration and implementation.

Access and Availability

As an expansion program with several MCOs new to Kentucky Medicaid managed care, a focus on access and availability is critical to assure that all enrollees have adequate access to health care providers.

HEDIS® measures that particularly need monitoring for improvement include:

- Well-Child Visits up to 15 months (6+ visits),
- Well-Child Visits 3–6 years,
- Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment – Initiation of AOD Treatment: Total and Engagement of AOD Treatment: Total,
- Adolescent Well Care,
- Postpartum Visit, and
- Board Certification for Primary Care Providers.

In addition to HEDIS® measures, the state should also consider ways of monitoring access and availability of provider appointments. Further study of the advantages and disadvantages of conducting a state-sponsored Access and Availability Survey is needed.

Effectiveness of Care

Since HEDIS®2013 was the first submission for Kentucky Medicaid managed care plans, with the exception of Passport Health Plan, it is not possible to assess improvement based on the measures reported for just one year. However, a number of measures which are below the national average for all four plans should be closely monitored including:

- Cervical Cancer Screening,
- Appropriate Treatment for Children with Upper Respiratory Illness (URI),
- Comprehensive Diabetes Care Eye Exam (Retinal),
- Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis, and
- Use of Imaging Studies for Low Back Pain.

In addition, Childhood Immunization Combo 3 (was below the national average for CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky) and Weight Assessment and Counseling for Nutrition and Physical Activity for Children Adolescents – BMI Percentile (was below the national average for CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky).

Care Coordination

Evidence of poor communication between MCOs and state agencies (namely, DMS, DCBS and DAIL) contributed to the difficulty that all the MCOs experienced in maintaining effective care management and care coordination programs. Closer monitoring of MCO care management activities and the MCOs' communication with DMS, DCBS and DAIL is important. This may require quarterly or semi-annual reviews of a small sample of MCO case management files for evidence of care plans and other DCBS/DAIL baseline information about individuals they oversee to enable timely and appropriate referrals and interventions and to assure access to needed services.

Data Systems

In order to comply with state and federal regulations regarding Medicaid managed care, each MCO has developed a Management Information System (MIS) that supports all aspects of their managed care operation and demonstrates sufficient analysis and interface capabilities for quality management. The following subsystems are part of an MCO's MIS:

- Member Enrollment – enrollment and member demographics;
- Encounter Data System – utilization data including encounters in all settings, emergency room use, outpatient drug therapy, EPSDT and out of network services;
- Provider Network – provider demographics, provider type, specialty code, licensing, credentialing;
- Claims – payment processing, adjustment processing, accounts receivable and all other financial transaction processing;
- Surveillance Utilization Review System (SURS) – capability to identify fraud and/or abuse of providers or members; and
- Healthcare Effectiveness Data and Information Set (HEDIS^{®6}) and Healthy Kentuckians quality performance databases.

This report begins by taking a closer look at the three data collection systems used in submitting data to DMS – encounter data, provider network data and quality performance data.

Encounter Data

All MCOs are required to submit encounter data to DMS on a monthly basis. An encounter is defined as a professional face-to-face contact or transaction between an enrollee and a provider who delivers services. An encounter is comprised of the procedure(s) or service(s) rendered during the contact. Encounter data is required to be in the format specified by DMS and before submitting to the state, MCOs are expected to edit the accuracy and timeliness of the data and screen for completeness. Upon submission, DMS processes the data elements through edits for missing or invalid data elements, duplicate encounters and verifies valid enrollment. MCOs are notified of rejected encounters and if there is more than a 5% rejection rate, those encounters that failed must be corrected and resubmitted. Medicaid encounter data provide a source of comparative information for MCOs and has been used by the EQRO for monitoring service utilization, access and continuity of service. Other potential uses of the data include program integrity, studying special populations and determining capitation rates.

May 2013 was the first month for submitting encounter data for the expansion MCOs. Passport Health Plan had previously submitted encounters for seven years prior to the expansion of managed Medicaid. Passport Health Plan files were suspended in June 2012 due to the EQRO contract ending. Encounter file creation was resumed after all plans successfully submitted files in the 5010 format and the change order for the file layouts was completed by DMS. The EQRO received a final extracted file from DMS for further processing. A monthly data validation report is created by the EQRO to summarize MCO submissions. The format of this report is similar to the

monthly reports previously prepared for encounter submissions through June 2012, which included the following information:

- Number of records received in the most recent month,
- Data issues and follow-up items,
- Intake report of record counts by month by category (encounters, dental, pharmacy, members, encounters Per Member Per Month (PMPM)),
- Intake/Management report with PMPM by category of encounter,
- Encounter volume by place of service, and
- Missing data by encounter record lines.

The monthly data validation reports are used primarily as an internal tool by DMS to monitor encounter data submissions. The state also convened a weekly encounter data workgroup to discuss and resolve current encounter submission problems MCOs are facing, such as coding issues, provider ID code matching, correcting rejected encounter records within the required time frames and revising some of the state's threshold edits to better reflect managed care encounters rather than fee for service claims.

Provider Network Data

Each of the Kentucky MCOs maintains a Provider Network database that is continually updated and submitted to DMS on a monthly basis. The MCOs used their Provider Network data to populate their annually printed Provider Directory and their online provider query tool for members and potential members. The state also used the submitted Provider Network data to populate an online provider query tool. Each MCO prepared geo-access reports against their Provider Network database and submitted these reports to the state on a quarterly basis. The geo-access reports allowed DMS to assess the adequacy of each MCO's geographic distribution of providers and panel availability.

During this contract year, the EQRO conducted a survey of Kentucky MCOs and found that, some, but not all, of the MCOs used their Provider Network database to conduct telephone calls to provider offices in order to assess the availability of appointments. CoventryCares of Kentucky did some secret shopper calls using in-house plan staff but has now contracted with a vendor for the calls. WellCare of Kentucky used a vendor to call provider offices but the callers are not secret shoppers, they identify themselves as representing the plan. Passport Health Plan monitored appointment availability through metrics using calls to member services and also noted that during on-site practice level reviews, the MCO staff reviewed appointment bookings.

The EQRO conducted validation of provider information using two methods: 1) a survey of providers for verification of Provider Network data and 2) a web-based provider directory validation study. As part of the network data verification, a random sample of providers received a summary of selected data elements submitted for their practice and were requested to correct or update any information that was incorrect or incomplete. The response rate for this recent survey was 63.7%. Results from this survey were shared with the MCOs and DMS. MCOs were requested to update their provider network database accordingly.

The second validation study, currently underway, administratively compares information in the MCOs' web directories to information in the state-supported provider dataset, also known as the Managed Care Assignment Processing System (MCAPS). Using a sample of 200 providers (100 primary care and 100 specialists) from each MCO web directory, data matching rates for each MCO are being developed and compared to statewide averages. The final provider network validation report will be shared with DMS and the MCOs including a detailed listing of discrepancies for further follow-up.

Quality Performance Data

HEDIS® quality performance data and Healthy Kentuckians data were successfully submitted by all managed care plans in June, 2013 for services provided in the measurement year 2012. Passport Health Plan had been submitting quality performance data prior to the expansion.

The MCOs verified through edits and audits, that the information contained in their databases was accurate and timely. They screened data for completeness, logic and consistency with procedure codes, diagnoses codes and other codes as defined by DMS and in the case of HEDIS®, as defined by NCQA.

All Kentucky MCOs contracted with vendors to assist in conducting HEDIS® measurement prior to their 2013 submission. The process a plan used to conduct their HEDIS® data collection depended on their preferences for use of in-house staff, temporary staff and/or vendors. MCOs were required to contract with NCQA certified vendors for auditing HEDIS® measures and conducting CAHPS satisfaction surveys. Audit reports were submitted to DMS along with the data.

The EQRO validated the Healthy Kentuckians data submitted by Passport Health Plan in 2012 and are currently validating the data for all four plans using a validation protocol designed by CMS. The audit methodology consisted of the following:

- Information Systems (IS) Capabilities review included an assessment of data capture, transfer and entry methods. Ongoing encounter data validation, as well as the IS assessment included in the plan's annual HEDIS® Compliance Audit were used to provide information for the validation;
- Denominator Validation included an assessment of sampling guidelines and methods;
- Data Collection Validation included an assessment of medical record reviews, sampling and data abstraction; and
- Numerator Validation included a review of member-level data for adherence to established specification.

The EQRO summarized quality performance data for DMS using a Dashboard presentation format. A consumer-friendly summary of key measures was also prepared by the EQRO in an Annual Plan Report Card entitled *A Member's Guide to Choosing a Medicaid Health Plan*. Copies of the guide were included in mailings during open enrollment in 2013.

Provider Network Access

According to their contract, Kentucky Medicaid MCOs are required to maintain and monitor a network of appropriate providers and to provide necessary services that are not available in the network. The MCO is responsible for conducting ongoing review of provider credentials and assures that timely access is provided to services within designated time and travel parameters. Assurances of adequate provider capacity and that the network of providers is sufficient in number, mix and geographic distribution are required.

The short time frame in implementing the program was particularly challenging for the MCOs that were new to the state of Kentucky and did not have established statewide networks or provider familiarity with their plans. The MCOs' experience in enlisting their provider networks is evidenced by results of the 2011–2012 Compliance Review and rates of access and availability and use of services from the Healthcare Effectiveness Data and Information Set (HEDIS®) submitted by the MCOs for the 2012 measurement year. Access and availability are also measured using results of the adult and child surveys of the CAHPS®⁷ consumer satisfaction survey which was conducted by each MCO in 2012 and submitted with the HEDIS® data for the 2012 measurement year.

As part of the 2011–2012 Compliance Review, the EQRO's assessment of access included, but was not limited to a review of policies and procedures for direct access services, provider access requirements, program capacity reporting, evidence of monitoring program capacity and provider compliance with hours of operation and availability. Findings from the 2011–2012 Compliance Review related to provider network access indicated the following:

- Three plans (CoventryCares of Kentucky, WellCare of Kentucky and Kentucky Spirit Health Plan) received an overall substantial rating of compliance for access (Access was not reviewed for Passport Health Plan in the 2011–2012 Compliance Review).
- Of the 233 total elements reviewed, 16% required a corrective action plan. All MCOs submitted responses addressing each required corrective action plan.
- *Opportunity for improvement*
 - Further study of the advantages and disadvantages of conducting a state-sponsored Access and Availability Survey is needed. MCOs are handling their assessment of access and availability using different methodologies which could render results non-comparable and thus not provide a valid, overall program assessment of access and availability.

HEDIS® Access/Availability of Care measures examine the percentages of children and adults who access their primary care provider (PCP) for preventive services, dental services, alcohol and other drug (AOD) dependence treatment as well as the prenatal and postpartum services for Medicaid managed care enrollees. HEDIS® Use of Services includes four measures related to access.

Statewide, performance measures related to Access/Availability and Use of Services had mixed results for the Kentucky MCOs:

- Measures in which all four plans performed above the national average include:

- Adult Access to Preventive/Ambulatory Health Services for all age groups,
- Children and Adolescents' Access to Primary Care Practitioners for age groups 12–24 Months and 25 Months–6 Years,
- Annual Dental Visit,
- Prenatal and Postpartum Care: Timeliness of Prenatal Care, and
- Frequency of Ongoing Prenatal Care: 81+ Percent (of visits).
- Although strong performance was demonstrated for several Access/Availability measures, there remains opportunity for improvement:
 - All four plans reported rates below the national average for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life measure;
 - Three plans (CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky) had rates below the national average for Postpartum Care; Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment – Engagement of AOD Treatment: Total; and Adolescent Well-Care Visits; and
 - Three plans (CoventryCares of Kentucky, Passport Health Plan, and WellCare of Kentucky) reported rates below the national average for the Call Answer Timeliness measure.

Both the CAHPS 5.0 adult survey and the child survey showed strong consumer satisfaction with access/availability measures:

Adult:

- All plans reported rates above the national average for Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate and Customer Service.
- All plans scored below the national average for the Shared Decision Making measure.

Child:

- All plans reported rates above the national average for Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate and Customer Service.
- Passport Health Plan exceeded the 90th percentile for all measures except Shared Decision Making, Rating of Personal Doctor and Rating of Specialist Seen Most Often.
- All plans failed to exceed the 10th percentile for the Shared Decision Making measure.

QAPI – Measurement and Improvement

Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement is an area of assessment for the annual Compliance Review and included, but was not limited to quality improvement (QI) program description, annual QI evaluation, QI work plan, QI Committee structure, Performance Improvement Projects (PIPs), performance measure reporting and clinical practice guidelines. The 2011–2012 Compliance Review findings for Measurement and Improvement included the following:

- All four MCOs achieved substantial compliance on the QAPI – Measurement and Improvement review items; and
- Of the 307 total elements reviewed for the four plans, only 4% required a corrective action plan. All plans submitted corrective action plans where required. Passport Health Plan did not have any corrective action plans requested.

Quality Programs

In keeping with federal regulation and in an effort to show its dedication to the national initiative, *Healthy People 2010*, DMS issued a measure set which Medicaid plans would be required to report. This initiative, *Healthy Kentuckians*, includes ten leading health indicators along with related goals and objectives. Other performance measures, including ones derived from HEDIS[®], are included in the requirement for plan reporting to allow for comparison to national benchmarks.

In September 2012, DMS issued the Kentucky Managed Care Quality Strategy (MCQS) which outlined the goals, objectives and expectations of the expanded managed care program. The primary goals of the Kentucky Medicaid managed care program are to improve health status of Medicaid enrollees and lower morbidity among enrollees with serious mental illness. The strategy was well written, included all CMS-required topics and adequately described the Medicaid managed care program in Kentucky. CMS approved the strategy which established the following objectives in order to effectively accomplish this goal:

1. Improve access and coordination of care;
2. Provide health care at the local level through the managed care system using public and private providers;
3. Redirect the focus of health care toward primary care and prevention of illness;
4. Monitor and improve the quality of the health care delivery system;
5. Increase health promotion efforts, psychotropic medication management and suicide prevention; and
6. Implement effective and responsive cost management strategies in the health care delivery system designed to stabilize growth in Medicaid costs.

DMS identified six health care conditions and utilization trends which presented statewide issues and, as such, have been selected as targets for improvement during the current measurement year:

- Diabetes,
- Coronary Artery Disease Screenings,
- Colon Cancer Screenings,
- Cervical/Breast Cancer Screenings,
- Mental Illness, and
- Reduction in ED Usage/Management of ED Services.

In an effort to improve overall health care, especially as it related to the conditions listed above, DMS set the following goals and objectives:

1. Improve preventive care for adults by increasing the performance of the state aggregate HEDIS® Colorectal Cancer Screening, HEDIS® Breast Cancer Screening and HEDIS® Cervical Cancer Screening measures to meet/exceed the 2012 Medicaid 50th percentile or to exceed the baseline performance rate by at least 10 percent;
2. Improve care for chronic illness by increasing the performance of the state aggregate HEDIS® Comprehensive Diabetes Care and HEDIS® Cholesterol Management for Patients with Cardiovascular Conditions measures to meet/exceed the 2012 Medicaid 50th percentile or to exceed the baseline performance rate by at least 10 percent;
3. Improve behavioral health care for adults and children by increasing the performance of the state aggregate HEDIS® Antidepressant Medication Management and HEDIS® Follow-up After Hospitalization for Mental Illness measures to meet/exceed the 2012 Medicaid 50th percentile and 75th percentile, respectively, or to exceed each baseline performance rate by at least 10 percent;
4. Improve access to medical homes by increasing the performance of the state aggregate HEDIS® Adults Access to Preventive/Ambulatory Health Services and HEDIS® Children and Adolescents Access to Primary Care Practitioners measures to meet/exceed the 2012 Medicaid 50th percentile or to exceed the baseline performance rate by at least 10 percent. In addition, DMS aims to increase the HEDIS® Ambulatory Care – Outpatient Visit rate to the Medicaid 50th percentile or by 10 percent and decrease HEDIS® Ambulatory Care – ED Utilization rate by 10 percent.

Annual reviews of the effectiveness of the previous year’s quality plan will be used to update the MCQS to ensure that appropriate strategies are being utilized in order to achieve desired improvement. Updates to the MCQS will be influenced by the findings of the following annual activities:

1. The EQR Technical Report, which summarized the results of performance measurement, PIPs and other EQR activities;
2. The EQRO’s Comprehensive Evaluation Summary, which evaluated the state’s MCQS and made recommendations for updating;
3. Participant input, which included results of annual surveys of members’ and providers’ satisfaction with quality and accessibility of services, enrollee grievances and public forum; and

4. Public input, which is facilitated by the following groups:
 - a. MCO-maintained Quality and Member Access Committee (QMAC), comprised of members who represent the interests of the member population;
 - b. Medicaid Advisory Council; and
 - c. Medicaid Technical Advisory Committee(s).

Performance Improvement Projects (PIPs)

Conducting PIPs is an opportunity for MCOs to follow a problem solving approach to achieve improvement. A protocol for conducting PIPs was developed by the Centers for Medicare and Medicaid Services (CMS) to assist MCOs in the design and implementation of their PIPs. Federal regulations require that all PIPs be validated according to guidelines specified in another CMS-designed protocol. Kentucky contracts with their EQRO to conduct PIP validation. In addition to validating the PIPs, the EQRO provided valuable technical assistance to MCOs in clarifying project goals, study indicators, sampling and outcome evaluation.

In Kentucky, two new PIP topics are proposed each year and are generally completed in two to three years. Initially, the MCO selected its PIP topics based on HEDIS® results. Currently, DMS has designated two topic categories – physical health and behavioral health – and each MCO is able to determine a specific PIP project within each category. PIPs conducted during the 2011–2012 contract year included the following topics:

- Antidepressant Medication Management (CoventryCares of Kentucky),
- Reducing Inappropriate ER Utilization (CoventryCares of Kentucky, WellCare of Kentucky),
- Reducing ER Utilization (Passport Health Plan),
- Dental Care Rates for Children with Special Health Care Needs (Passport Health Plan),
- Reducing Inappropriate Antibiotic Use (Passport Health Plan),
- Smoking Cessation, Yes You Can! (Passport Health Plan),
- Utilization of Behavioral Health Management Medication in Children (WellCare of Kentucky),
- Improving Cervical Cancer Screening Rates (Kentucky Spirit Health Plan), and
- Improving Prenatal and Postpartum Depression Screening and Management (Kentucky Spirit Health Plan).

In their validation, the EQRO recognized several overall strengths and opportunities for improvement of the PIPs conducted by Kentucky MCOS:

Strengths:

- There was strong rationale presented for the topics chosen including literature citations and state and plan-specific data indicating the need for improvement.
- The project often targeted an important public health issue in the state.
- There was strong evidence of topic relevance to the plan.
- The interventions addressed the barriers and comprehensively addressed the needs of members, providers and MCO system/staff.

Opportunities for Improvement:

- Study indicator numerators and denominators need to be more clearly defined.
- Interventions were not always clearly directed at specific barriers.
- Interventions proposed were sometimes passive and not likely to achieve results, such as newsletter articles, mailed educational letters, information and guidelines posted on a website and on-hold messages.
- Timelines were unclear for baseline and re-measurement.

Performance Measurement

DMS requires plans to report a total of 32 measures in the *Healthy Kentuckians (HK)* measure set: 11 HEDIS® measures and 21 Healthy Kentuckians (HK) measures developed for the Healthy Kentuckians initiative.

As required by DMS through the plans' contracts, all non-HEDIS® measures must be validated by the EQRO. For measurement year 2011, the EQRO reviewed all data and documentation used to calculate the performance measures for Passport Health Plan to ensure the validity and reliability of the reported measures. Only Passport Health Plan reported performance measures for measurement year 2011, since the other MCOs began operation in November of 2011 and were not required to report *HK* or HEDIS® performance measures for 2011. The EQRO validated the 2010–2012 *Healthy Kentuckians* rates for Passport Health Plan which was presented in the 2011–2012 Technical Report. The 2011–2012 Technical Report also included the HEDIS® 2013 rates (for measurement year 2012) for all four Medicaid managed care organizations in Kentucky and compared rates to the NCQA HEDIS® 2012 National Medicaid Benchmarks.

Healthy Kentuckians Performance 2010–2012 (Passport Health Plan)

Notable improvement was made by Passport Health Plan, in regard to *Healthy Kentuckians (HK)*, as demonstrated by two consecutive years of increasing rates for the following measures:

- HEDIS® Adult BMI Assessment;
- HEDIS® Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile for all 3 age groups;
- *HK* Weight Assessment/Counseling for Nutrition and Physical Activity: Healthy Weight for Height age groups 3–11 years and 3–17 years;
- Adolescent Screening/Counseling for Mental Health Assessment/Screening; and
- Prenatal Education/Counseling for Drug Abuse, Domestic Violence, Screening and/or Counseling for Tobacco and Smokers Who Received Counseling for Smoking Cessation.

Although several measures have shown great improvement, Passport Health Plan continues to report declining rates for the following measures:

- *HK* Weight Assessment and Counseling for Nutrition and Physical Activity: Weight and Height for age group 12–17 years;
- *HK* Prenatal Education/Counseling: Members Screened and Identified as Non-Smokers;

- HEDIS® Controlling High Blood Pressure;
- HEDIS® Lead Screening for Children;
- HEDIS® Well-Child – 15 Months; and HEDIS® Well-Child – 3–6 Years; and
- HEDIS® Children’s Access to PCPs for age groups 25 Months–6 Years.

HEDIS® 2013 Quality Performance

The objectives established for the Commonwealth of Kentucky’s Quality Strategy⁸ are all measured using NCQA’s Healthcare Effectiveness Data and Information Set, referred to simply as HEDIS®. National benchmarks used were derived from the NCQA’s Quality Compass which is an aggregate report of Medicaid managed care plans’ HEDIS® submissions. While MCOs that are NCQA accredited must submit audited HEDIS® data to NCQA annually, submission is optional for non-accredited MCOs.⁹ Quality Performance data includes effectiveness of care measures, access to services, use of services and member satisfaction measures in the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

HEDIS® reporting is a contract requirement for Kentucky’s Medicaid plans. DMS required all MCOs to report HEDIS® measures for the 2012 measurement year. The measures required for reporting included the following domains: Board Certification, Effectiveness of Care, Access/Availability of Care and Use of Services. Since this was the first year that the MCO’s reported HEDIS® with the exception of Passport Health Plan, analysis of trends over time was not possible and comparing MCO results to HEDIS® 2012 national rates as a benchmark may be somewhat unreliable. Each MCO also submitted CAHPS® consumer satisfaction survey results with HEDIS® rates in 2013.

Summary data results from this most recent HEDIS® submission were prepared by the EQRO in a one-page document entitled *A Member’s Guide to Choosing a Medicaid Health Plan*. Copies of the guide were included in open enrollment mailings by DMS to eligible enrollees for their recent open enrollment period. A Quality Performance Dashboard format was also developed by the EQRO using selected measures for DMS monitoring.

Results of the HEDIS® 2013 quality performance measures are summarized as follows:

Board Certification

HEDIS® Board Certification rates measure the percentage of physicians in the MCO’s provider network who were board certified as of the last day of the measurement year (December 31, 2012). While Passport Health Plan exceeded the national average for family medicine providers (78.39%) and Geriatricians (100%), Board Certification rates were low overall when compared to national averages, and represent an opportunity for improvement. WellCare of Kentucky and CoventryCares of Kentucky did not exceed the national average for any provider type, and Kentucky Spirit Health Plan did not report Board Certification rates.

Effectiveness of Care

HEDIS® 2013 Effectiveness of Care measures evaluate how well a health plan provided preventive screenings and care for members with acute and chronic illnesses, including: respiratory illnesses, cardiovascular illnesses, diabetes, behavioral health conditions and musculoskeletal conditions. In

addition, medication management measures were included. For several measures, the plans that began operation in 2011 did not report rates due to small sample sizes.

While results of the HEDIS® Effectiveness of Care measures for measurement year (MY) 2012 tended to be below the national averages, there were also several measures with notable performance:

- All plans performed above the national average for the Annual Monitoring for Patients on Persistent Medications: Total measure;
- Passport Health Plan exceeded the 90th percentile for Childhood Immunization Status: Combination #3;
- CoventryCares of Kentucky exceeded the 90th percentile for Antidepressant Medication Management: Effective Acute Phase Treatment and Effective Continuation Phase Treatment, while Passport Health Plan and WellCare of Kentucky both exceeded the 75th percentile for these measures;
- CoventryCares of Kentucky, Passport Health Plan and WellCare of Kentucky exceeded the 75th percentile for Immunizations for Adolescents: Meningococcal and Childhood Immunization Combination #1;
- Kentucky Spirit Health Plan, Passport Health Plan and WellCare of Kentucky each exceeded the 75th percentile for Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis; and
- Performance was below the national average for all plans for the following measures: Cervical Cancer Screening in Women, Appropriate Treatment for Children with URI, Comprehensive Diabetes Care Eye Exam (Retinal) Performed, and Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis. Further, all plans' rates for the Use of Imaging Studies for Low Back Pain measure were below the 10th percentile benchmark.

Access and Availability

HEDIS® Access/Availability of Care rates measured the percentages of children and adults who accessed their PCPs for preventive services, as well as the prenatal and postpartum services for the Medicaid product line. Statewide, Kentucky MCOs demonstrated strong performance in measures related to Access and Availability, but there are still opportunities for improvement:

- Measures in which all four plans performed above the national average included: Adult Access to Preventive/Ambulatory Health Services for all age groups, Children and Adolescents' Access to Primary Care Practitioners for age groups 12–24 Months and 25 Months–6 Years, Annual Dental Visit and Prenatal and Postpartum Care: Timeliness of Prenatal Care;
- CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky had rates below the national average for the Postpartum Care measure, Adolescent Well-Care Visits and the Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment – Engagement of AOD Treatment: Total;
- CoventryCares of Kentucky and WellCare of Kentucky had rates below the national average for Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment – Initiation of AOD Treatment: Total; and

- CoventryCares of Kentucky, Passport Health Plan and WellCare of Kentucky reported rates below the national average for the Call Answer Timeliness measure.

Use of Services

This domain contained four measures that have the same structure as the Effectiveness of Care domain measures, including: *Frequency of Ongoing Prenatal Care; Well-Child Visits In the First 15-Months of Life; Well-Child Visits In the Third, Fourth, Fifth and Sixth Years of Life; and Adolescent Well-Care Visits:*

- All four plans exceeded the national average for Frequency of Ongoing Prenatal Care 81+%;
- CoventryCares of Kentucky and Passport Health Plan exceeded the national average for Well-Child Visits in the First 15 Months of Life: 6+ Visits;
- Passport Health Plan exceeded the national average for Adolescent Well-Care Visits;
- None of the plans reported rates above the national average for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life measure; and
- Kentucky Spirit Health Plan failed to exceed the 10th percentile benchmark for Well-Child Visits in the First 15 Months of Life: 6+ Visits, Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life and Adolescent Well-Care Visits.

Consumer Satisfaction

DMS required that all plans conduct an annual assessment of member satisfaction with the quality of and access to services using the CAHPS[®] survey. MCOs contracted with an NCQA certified survey vendor to conduct this member satisfaction survey for both the adult and child member populations. Through Quality Compass, NCQA releases benchmarks for both the adult satisfaction survey and the child/adolescent satisfaction survey.

The adult member satisfaction survey was sent to a random sample of members aged 18 years and older as of December 31, 2012, while the child and adolescent member satisfaction survey was sent to the parent/guardian of randomly sampled members aged 17 years and younger as of December 31, 2012.

Adult

- Performance on the CAHPS 5.0 adult survey demonstrated strengths for each of the plans. For the following measures, all plans reported rates above the national average: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service and Rating of Personal Doctor.
- All plans scored poorly on the Shared Decision Making measure.

Child

- Performance on the CAHPS 5.0 child survey demonstrated strengths for most of the plans. For the following measures, all plans reported rates above the national average: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate and Customer Service.
- For both the adult and child surveys, all plans scored below the national average for the Shared Decision Making measure.

QAPI – Structure and Operations

The evaluation of structure and operations includes a review of MCO credentialing practices and delegation of services.

Credentialing

DMS requires that all MCOs be responsible for the ongoing review of provider performance and credentialing. The 2011–2012 Compliance Review assessed the MCO's written policies and procedures regarding the selection and retention of providers in the network. Providers, including individuals and facilities, must be validly licensed and/or certified to provide services in the state and may also be accountable to a governing body for review of credentials including physicians, dentists, advanced registered nurse practitioners and vision care.

The 2011–2012 Compliance Review of credentialing indicated the following findings and opportunities for improvement:

- CoventryCares of Kentucky, WellCare of Kentucky and Kentucky Spirit Health Plan were all in substantial compliance with credentialing standards. This category was not required to be evaluated for Passport Health Plan;
- Ten PCP records and 10 specialist records were reviewed for WellCare of Kentucky and CoventryCares of Kentucky and a total of 12 records were reviewed for Kentucky Spirit Health Plan; and
- For all three MCOs together, only 10 (or 4%) of the 238 total items reviewed required corrective action. MCO responses were received and entered into findings.
- *Opportunities for improvement:*
 - The EQRO recommended that MCO credentialing files include a physician profile form to summarize information required for credentialing.

Delegation

MCOs, with the approval of DMS, are able to enter into subcontracts for the performance of administrative functions or the provision of services to members. Kentucky MCOs used subcontractors for a variety of purposes such as HEDIS® data collection and record review, claims processing, call centers, behavioral, dental and vision providers, to name a few. The MCOs are required to notify DMS in writing, of all subcontracts on a quarterly basis and of the termination of a subcontract within ten days of termination. The 2011–2012 Compliance Review of delegation of services indicated the following findings:

- All four MCOs were rated substantially compliant for delegation of services;
- A sample of 7–12 subcontracts was reviewed for each MCO;
- For all four MCOs together, 10 (or 7%) of the 136 total items reviewed required corrective action. MCO responses were received for all correction action plans required; and
- Passport Health Plan did not have any minimal or non-compliant findings.
- *Opportunities for improvement:*
 - The EQRO recommends that subcontract language should be consistent and reflect all contract requirements.

Utilization Management

A comprehensive Utilization Management (UM) program reviews services for medical necessity and monitors and evaluates the appropriateness of care and services on a regular basis. Each MCO is required to have in place mechanisms to check the consistency of the application of clinical review criteria and protocols. Decisions requiring clinical judgment and denials based on lack of medical necessity should be made by qualified medical professionals.

The 2011–2012 Compliance Review of the MCOs' utilization management programs included, but was not limited to, review of UM policies and procedures, UM committee minutes and review of a sample of UM files. Findings from the 2011–2012 Compliance Review of utilization management indicated the following:

- Passport Health Plan and WellCare of Kentucky were fully compliant and CoventryCares of Kentucky and Kentucky Spirit Health Plan were substantially compliant;
- There were no corrective action plans required for CoventryCares of Kentucky, Passport Health Plan or WellCare of Kentucky; and
- Kentucky Spirit Health Plan had four non-compliant findings and was required to develop action plans addressing 17 of the 49 elements reviewed (or 35%). All corrective action plans were submitted by the MCO.

Program Integrity

The responsibility for maintaining Program Integrity includes guarding against fraud, abuse and deliberate misuse of Medicaid program benefits; ensuring that Medicaid enrollees receive necessary quality medical services; and ensuring that providers and recipients are in compliance with federal and state Medicaid regulations. In determining MCO compliance with federal and state regulations for program integrity, the EQRO's evaluation for the 2011–2012 Compliance Review, included, but was not limited to, a review of MCO policies and procedures, training programs, reporting and analysis, Compliance with Annual Disclosure of Ownership (ADO) and financial interest provisions and file review of program integrity cases. The 2011–2012 Compliance Review indicated the following findings:

- CoventryCares of Kentucky and WellCare of Kentucky were rated substantially compliant and Kentucky Spirit Health Plan received a minimal rating. Program Integrity was deemed for the 2011–2012 Compliance Review and therefore not reviewed;
- Each MCO had between 10 – 15 program integrity files reviewed;
- Of the 352 total elements reviewed among the three plans (CoventryCares of Kentucky, WellCare of Kentucky and Kentucky Spirit Health Plan), 68 (or 19%) required a corrective action plan. All required corrective action plans were submitted by CoventryCares of Kentucky and WellCare of Kentucky; and
- Kentucky Spirit Health Plan did not submit responses for any of the required corrective action plans.
- *Opportunities for improvement:*
 - EQRO recommends that case files should contain all supporting documentation and that all cases should proceed to closure in a timely manner.

Care Management/Coordination

Care coordination is a cornerstone of managed care and is based on the assurance that all enrollees have an ongoing source of primary care 24 hours a day, 7 days a week. The MCO also plays a unique role in being able to identify persons with special health care needs (including chronic physical, developmental, behavioral, neurological or emotional conditions) and offer care coordination through case management. The MCO can identify enrollees in need of care coordination from health risk assessments (HRAs) when completed for new enrollee and by using encounter data algorithms to track diagnosis codes, high utilization, repeated use of emergency rooms, frequent in-patient stays and hospital readmissions as markers. As Medicaid managed care programs expand enrollment to include populations historically exempted, the need for care coordination and case management will become even more important.

Coordination between MCOs and the Kentucky Departments of Community Based Services (DCBS) and Department for Aging and Independent Living (DAIL) is important. The MCOs are responsible for ongoing care coordination for these members and thus it is critical that the MCOs have access to baseline information about these individuals to enable timely and appropriate referrals and interventions to assure access to needed services. DCBS/DAIL service plans are the key source of this baseline information and ongoing communication with DCBS/DAIL staff is essential to coordinate the most appropriate services needed by individual members. DCBS/DAIL staff members are key members of the care coordination team, working with the MCOs to identify changing needs, assess the effectiveness of interventions taken, and modify care plans accordingly.

The 2011–2012 Compliance Review evaluation of case management/care coordination included, but was not limited to, review of policies, procedures and processes for case management and care coordination of DCBS and DAIL clients; dissemination of information to members and providers; and monitoring, analysis, reporting and interventions. Compliance Review findings of case management/care coordination included the following:

- All four MCOs received a substantial rating of compliance;
- Twenty case files were reviewed for each MCO;
- Passport Health Plan did not have any non-compliant elements; and
- Corrective action plans were required for 23% of the 101 total reviewed elements. All plans submitted responses for required corrective action plans.
- *Recommendation:* All relevant entities (DCBS, DAIL, DMS, and MCOs) establish mutually-agreeable communication and information-sharing protocols to remedy any issues of coordination in order to comply with federal and state requirements, and most importantly, permit active, effective care coordination for these members.
- *Opportunities for improvement:*
 - Improve the linkage of care coordination with other MCO and DMS systems; and
 - DMS agreed with the EQRO's findings and agreed to facilitate improved communications between the MCOs and DMS, DCBS and DAIL as follows:
 - § review DCBS contract,

- § review MCO contract,
- § discuss findings with DMS,
- § meet with DCBS to discuss their contract scope of work and responsibilities,
- § meet with each MCO to discuss their scope of work and contract responsibilities,
- § meet with DCBS, and each MCO to review service plan process and determine what barriers exist to prevent completion of the service plans,
- § review process for completing the service plans,
- § make changes as warranted, and
- § monitor the progress and if warranted, have additional meetings and amend process.

Enrollee Rights and Responsibilities

MCO Member Services is responsible for providing information, education and resolving problems and complaints from enrollees or referring them to appropriate MCO staff for resolution. They educate the enrollee on the process of selecting or changing one's primary care provider and assist in the new enrollee's selection of a PCP. MCO Member Services is also responsible for sending written information such as a member handbook explaining services covered and how to access services. State and federal regulations call for cultural awareness and sensitivity in handling member grievances, cultural issues and program integrity. Kentucky MCOs conduct ongoing monitoring of their Member Services activities by tracking the content and efficiency of calls including returned calls, call resolution, repeat callers and abandonment rates. MCOs using a call center service require vendor oversight and extensive reporting to track trends.

Evaluation of enrollee rights and responsibilities were evaluated in the 2011–2012 Compliance Review through an assessment of policies and procedures for member rights and responsibilities, PCP changes and Member Services functions. Findings included the following:

- All four MCOs received a rating of substantial compliance;
- Of the 287 total elements reviewed, 16% required a corrective action plan;
- Passport Health Plan had zero elements requiring a corrective action plan; and
- CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky all submitted corrective action plans where required.
- *Opportunities for improvement:*
 - MCOs should routinely review Member Handbook and Member Services policies and procedures for consistency with MCO contract requirements.

Strengths and Opportunities for Improvement

Strengths and opportunities for improvement regarding the Commonwealth of Kentucky's Medicaid managed care program based on findings from external quality review activities is presented in this section as a summary of findings from related EQRO documents. The state's strengths in assessing and improving the quality of care for Medicaid managed care enrollees, opportunities for improvement and recommendations are summarized below.

Strengths

Overall

- Contracts with four managed care organizations are in place with capacity to serve Medicaid enrollment statewide.
- Passport Health Plan has received NCOA accreditation. The other three plans are in the process of obtaining accreditation.
- The state's Quality Strategy, published in September, 2012 was well written, included all required topics and adequately described the Medicaid managed care program in Kentucky. The strategy was approved by CMS and all MCO contract provisions incorporated the standards of Part 438, subpart D.
- Core program goals were selected to reflect Healthy Kentuckians goals and reflect the particular needs of the Medicaid population. Standardized benchmarks are used to measure improvement. MCOs are aware of the Quality Strategy goals and are setting their own performance goals to align with the state's goals.
- A contract with an external quality review organization is in place. The EQRO is conducting all of the mandatory and several of the optional quality monitoring and improvement activities as part of their contract. There is a good working relationship between the state, the MCOs and the EQRO.
- MCO data collection systems were in place and included encounter data, provider network data and HEDIS® and Healthy Kentuckians quality performance data. All MCOs submitted data to DMS according to established timeframes.
- The EQRO conducted validation of encounter data, provider network data and Healthy Kentuckians quality performance data.

Quality Review Programs

- PIPs undertaken by Kentucky MCOs have covered numerous topics of relevance and need in the state, and often targeted an important public health issue.
- Access/Availability measures in which all four plans performed above the national average included: Adult Access to Preventative/Ambulatory Health Services for all age groups, Children and Adolescents' Access to Primary Care Practitioners for age groups 12–24 Months and 25 Months–6 Years, Annual Dental Visit and Prenatal and Postpartum Care: Timeliness of Prenatal Care and Frequency of Ongoing Prenatal Care 81+%.
- Adult and Child consumer satisfaction surveys demonstrated strengths for each of the plans. For the following measures, all plans reported rates above the national average: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate and Customer Service.

- Passport Health Plan exceeded the national average for board certification of family medicine providers (78.39%) and Geriatricians (100%), but WellCare of Kentucky and CoventryCares of Kentucky did not exceed the national average for any provider type.
- Passport Health Plan showed two consecutive years of increasing rates for the following *Healthy Kentuckians (HK)* measures:
 - HEDIS® Adult BMI Assessment;
 - HEDIS® Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile for all 3 age groups;
 - *HK* Weight Assessment/Counseling for Nutrition and Physical Activity: Healthy Weight for Height age groups 3–11 years and 3–17 years;
 - Adolescent Screening/Counseling for Mental Health Assessment/Screening; and
 - Prenatal Education/Counseling for Drug Abuse, Domestic Violence, Screening and/or Counseling for Tobacco and Smokers Who Received Counseling for Smoking Cessation.
- All plans performed above the national average for Annual Monitoring for Patients on Persistent Medications: Total and Frequency of Ongoing Prenatal Care 81+%.
- Other measures where one or more plans exceeded the national average included:
 - Antidepressant Medication Management: Effective Acute Phase Treatment and Effective Continuation Phase Treatment (CoventryCares of Kentucky, Passport Health Plan, WellCare of Kentucky),
 - Immunizations for Adolescents: Meningococcal and Childhood Immunization Combination #1 (CoventryCares of Kentucky, Passport Health Plan, WellCare of Kentucky),
 - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (Kentucky Spirit Health Plan, Passport Health Plan, WellCare of Kentucky),
 - Well-Child Visits in the First 15 Months of Life: 6+ Visits (CoventryCares of Kentucky, Passport Health Plan),
 - Childhood Immunization Status: Combination #3 (Passport Health Plan), and
 - Adolescent Well-Care Visits (Passport Health Plan).
- Summary data results from the HEDIS®2013 submission were prepared by the EQRO in a one-page document entitled *A Member's Guide to Choosing a Medicaid Health Plan*. Copies of the guide were included in open enrollment mailings by DMS to eligible enrollees for their recent open enrollment period.
- The EQRO prepared a quality performance Dashboard presenting key HEDIS®2013 measures for DMS internal monitoring.

Compliance Review

- All plans had full or substantial compliance in the following areas:
 - Measurement and Improvement,
 - Credentialing,
 - Access,
 - Utilization Management,
 - Delegation,
 - Care Management, and

- Enrollee Rights.

Opportunities for Improvement

Overall

- The state's Quality Strategy's core program goals address preventive care for adults, chronic illness, behavioral health care for adults and children and access to a medical home. DMS may want to expand the number and/or focus of their goals to include prenatal and child health measures and to remove measures that have small sample sizes.
- MCOs are handling their assessment of access and availability using different methodologies which could render results non-comparable and thus not provide an overall program assessment of access and availability. Further study of the advantages and disadvantages of conducting a state-sponsored Access and Availability Survey is needed.
- Validating the completeness and accuracy of encounter data will allow DMS to broaden its use of the encounter database to better monitor service utilization, access and continuity of service and to develop quality and performance indicators on a real-time basis.
- Kentucky has not taken advantage of the many avenues for public reporting that are available not only for HEDIS® performance data, but for enrollment reports, EQRO technical reports, focused study findings and PIP summaries. Kentucky should review their policies regarding public reporting and data transparency.

Quality Review Programs

- The EQRO identified several areas for PIP improvement including study indicator numerators and denominators that need to be more clearly defined, interventions that were not always clearly directed at specific barriers or were sometimes passive and not likely to achieve results, such as newsletter articles, mailed educational letters, information and guidelines posted on a website and on-hold messages.
- PIP timelines for baseline and re-measurement need to be more specific.
- All four plans reported HEDIS® rates below the national average for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life measure.
- CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky had rates below the national average for Postpartum Care, Adolescent Well-Care Visits and the Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment – Engagement of AOD Treatment: Total;
- CoventryCares of Kentucky and WellCare of Kentucky had rates below the national average for Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment – Initiation of AOD Treatment: Total;
- CoventryCares of Kentucky, Passport Health Plan and WellCare of Kentucky had rates below the national average for the Call Answer Timeliness measure;
- Adult and Child consumer satisfaction with shared decision making was below the national average for all plans.
- Board certification rates for WellCare of Kentucky and CoventryCares of Kentucky were below the national average for all provider types.

- Effectiveness of care performance was below the national average for all plans for the following measures: Cervical Cancer Screening in Women, Appropriate Treatment for Children with URI, Comprehensive Diabetes Care Eye Exam (Retinal) Performed, and Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis. Further, all plans' rates for the Use of Imaging Studies for Low Back Pain measure were below the 10th percentile benchmark.

Compliance Review

- Findings and recommendations for several elements reviewed reminded MCOs to provide complete documentation for review, that MCO records such as credentialing and case management files should contain all supporting documentation and that policies and procedures and subcontracts should reflect all state contract rules and regulations.
- Review of case management files should contain a subset of complex cases enrolled in case management.
- Kentucky Spirit Health Plan did not submit responses to corrective action plans requested for delegation of services and program integrity.

Coordination

- DMS, MCOs, providers and enrollees are still adjusting to a quick transition to statewide managed care. MCOs are building enrollment statewide, enlisting participating providers and educating providers and enrollees in managed care processes. DMS and the MCOs need to provide continued information for both providers and enrollees through public media and MCO staff functions such as member services, provider relations and compliance.
- Continued communication between DMS and MCOs is needed to resolve issues occurring with coding and other encounter and provider network data submission problems.
- Communication between DMS and other Cabinet of Health and Family Services agencies needs to be continued and enhanced so that managed care enrollees can benefit from improved interagency connections. This is particularly important for coordination between the MCOs and DMS, DCBS and DAIL.

Recommendations

Based on the review of EQRO quality review activities for 2011–2013, and focusing on the opportunities for improvement identified as a result of this progress report review, the following key performance areas are identified for DMS consideration and implementation.

Access and Availability

As an expansion program with several MCOs new to Kentucky Medicaid managed care, a focus on access and availability is critical to assure that all enrollees have adequate access to health care providers.

HEDIS® measures that particularly need monitoring for improvement include:

- Well-Child Visits up to 15 months (6+ visits),
- Well-Child Visits 3–6 years,
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment,
- Adolescent Well Care,
- Postpartum visit, and
- Board certification for primary care providers.

In addition to HEDIS® measures, the state should also consider ways of monitoring access and availability of provider appointments. Further study of the advantages and disadvantages of conducting a state-sponsored Access and Availability Survey is needed.

Effectiveness of Care

Since HEDIS®2013 was the first submission for Kentucky Medicaid managed care plans, with the exception of Passport Health Plan, it is not possible to assess improvement based on the measures reported for just one year. However, a number of measures which are below the national average for all or several plans should be closely monitored including:

- Cervical Cancer Screening,
- Appropriate Treatment for Children with Upper Respiratory Illness (URI),
- Comprehensive Diabetes Care Eye Exam (Retinal),
- Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis,
- Use of Imaging Studies for Low Back Pain,
- Childhood Immunization Combo 3, and
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children Adolescents – BMI Percentile.

Care Coordination

Evidence of poor communication between MCOs and state agencies (namely, DMS, DCBS and DAIL) contributed to difficulty in maintaining effective care management and care coordination programs for all MCOs. A closer monitoring of MCO care management activities and the MCOs' communication with DMS, DCBS and DAIL is important. This may require quarterly or semi-annual reviews of a small sample of MCO case management files for evidence of care plans and other

DCBS/DAIL baseline information about individuals they oversee to enable timely and appropriate referrals and interventions and to assure access to needed services.

References

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² IPRO, "External Quality Review Technical Report, MCO Contract Years 2011-2012," Final, August, 2013.

³ IPRO, Comprehensive Evaluation Summary of the Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services, October, 2013.

⁴ Urban Institute and University of Kentucky, Evaluation of Statewide Risk-Based Managed Care in Kentucky, A First Year Implementation Report. November 2, 2012.

⁵ Passport Health Plan Quality Improvement 2012 Program Description. On-line at:

www.passporthealthplan.com/pdf/member/eng/qi-program/2012-description.pdf

⁶ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

⁷ Consumer Assessment of Healthcare Providers and Systems (CAHPS) provided by the Agency for Healthcare Research and Quality; <http://cahps.ahrq.gov/about.htm>.

⁸ Cabinet for Health and Family Services, Department of Medicaid Services, "Commonwealth of Kentucky Strategy for Assessing and Improving the Quality of Managed Care Services, September, 2012.

⁹ Toppe, Kristine Thurston, National Committee for Quality Assurance. NCQA Medicaid Managed Care Toolkit 2012 Health Plan Accreditation Standards Effective July 1, 2012-June 30, 2013; Assistance for State Agencies in Using NCQA Accreditation for Medicaid Managed Care Oversight, March, 2012.