



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

**Comprehensive Evaluation Summary of the  
Commonwealth of Kentucky Strategy for Assessing and  
Improving the Quality of Managed Care Services**

FINAL REPORT  
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## Introduction

This comprehensive evaluation summary presents an in-depth review of the accountability strategy, monitoring mechanisms and compliance assessment system described in the Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services. According to federal regulation (42 CFR§438.200 et seq.)<sup>1</sup>, all states that contract with a managed care organization (MCO) or prepaid inpatient health plan (PIHP) are required to have a written strategy for assessing and improving the quality of managed care services provided to Medicaid enrollees.

Authorizing legislation and regulation for state Medicaid managed care (MMC) programs include the Social Security Act (Part 1915<sup>2</sup> and Part 1932(a))<sup>3</sup>, the Balanced Budget Act of 1997 and Title 42<sup>4</sup>, Part 438 of the Code of Federal Regulations (CFR)<sup>5</sup>. Approved by the Centers for Medicare and Medicaid Services (CMS) in September 2012, Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services (also referred to as Kentucky's Quality Strategy) includes the following:

- Program goals and objectives;
- MCO contract provisions that incorporate the standards of 42 CFR Part 438, subpart D;
- Procedures used to regularly monitor and evaluate the MCO's compliance with 42 CFR Part 438, subpart D, including standards for access to care, structure and operations and appropriate use of intermediate sanctions;
- Procedures that assess the quality and appropriateness of care and services provided to all Medicaid enrollees in an MCO;
- Arrangements for annual, external independent reviews of quality outcomes and timeliness of and access to services;
- Procedures for review and update of the strategy;
- Procedures to identify race, ethnicity and primary language spoken; and
- An information system that supports ongoing operation and review of the Kentucky's Quality Strategy.

The intent of this third version of the Comprehensive Evaluation Summary is to continue the evaluation of Kentucky's Quality Strategy using updated information, reports and interviews conducted during 2014 through mid-2015. As part of the introduction, recent developments in Kentucky's MMC Program are discussed including a description of program monitoring responsibilities and evaluation methodology.

## Medicaid Managed Care in Kentucky – Recent Progress

In December 1995, Kentucky received approval from CMS under Section 1115 waiver authority to establish a statewide MMC program that would be phased into different regions of the state over time. The waiver initially established two health care partnerships of medical providers in both public and private sectors that would provide comprehensive medical services to Medicaid beneficiaries living in two designated regions (Region 3 (Jefferson County and 15 surrounding counties) and Region 5 (Fayette County and 20 surrounding counties)). In 1999, the Region 5 partnership withdrew from

the managed care program and by the fall of 2000, Kentucky stopped plans to implement a statewide risk-based managed care program. While the partnership with University Health Care (doing business as Passport Health Plan) continued service in Region 3, the rest of Kentucky’s Medicaid members were enrolled in a fee-for-service system.

With increasing Medicaid health care expenditures and a growing eligible population, the state of Kentucky began to explore ways to more effectively manage health care costs while maintaining and improving access and quality. Kentucky once again returned to risk-based managed care as a solution and in 2011, initiated the procurement process to contract with MCOs to provide services statewide. Three additional MCOs were awarded contracts by July 2011: Coventry Health and Life Insurance Company (doing business as CoventryCares of Kentucky), Kentucky Spirit Health Plan, Inc., and WellCare of Kentucky, Inc. On November 1, 2011, risk-based managed care was implemented. This aggressive timeline was challenging to all stakeholders, including the state, the MCOs, the providers and the enrollees.

After a little more than a year, Kentucky Spirit Health Plan notified the Kentucky Department of Medicaid Services (DMS) that they would be withdrawing from the managed care program as of July 2013. The state successfully procured a new contract with Humana-CareSource and the transition of enrollees was underway before the end of 2013. The Patient Protection and Affordable Care Act (ACA) allowed DMS to expand Medicaid eligibility in 2014 and Kentucky contracted with Anthem Blue Cross Blue Shield to serve Medicaid expansion members in all regions of the state excluding Region. 3

Program enrollment in April 2015 was 1,174,716, for an increase of 19% between April 2014 and April 2015. Anthem Blue Cross Blue Shield more than doubled its enrollment over the last year, followed by Humana-CareSource which saw an 87% increase in enrollment over the same period. Enrollment in CoventryCares of Kentucky has been fairly stable over the past year, overall showing a slight drop of 5% (**Table 1**).

Table 1. List of Current Medicaid MCOs by Service Area and Enrollment

MCO	Enrollment 4/2014	Enrollment 4/2015	Percent Change	Service Area
Anthem Blue Cross Blue Shield	31,361	69,031	+120%	Statewide expansion and traditional enrollment excluding Region 3
CoventryCares of Kentucky	319,189	303,686	-5%	Statewide
Humana CareSource	60,314	113,039	+87%	Statewide
Passport Health Plan	190,417	251,855	+32%	Statewide
WellCare of Kentucky	387,916	437,105	+13%	Statewide
Total	<b>989,197</b>	<b>1,174,716</b>	<b>+19%</b>	N/A

N/A: not applicable

## Responsibility for Program Monitoring

DMS oversees the Kentucky MMC Program and is responsible for contracting with Medicaid MCOs, monitoring their provision of services according to federal and state regulations and overseeing the state's Quality Strategy as well as each MCO's quality program. DMS contracts with an external quality review organization (EQRO) to assist the state in conducting external reviews and evaluations of state and MCO quality performance and improvement.

In mid-2013, DMS underwent an internal re-organization to better address its responsibilities for monitoring and oversight of an expanding MMC Program. A new division within DMS, the Division of Program Quality and Outcomes (DPQ&O), was created and consisted of two branches: Disease and Case Management Branch and Managed Care Oversight – Quality Branch. Effective July 1, 2014, the Managed Care Oversight – Contract Management Branch became part of the Division of Program Quality and Outcomes.

Since the last comprehensive evaluation report, the Managed Care Oversight – Quality Branch has become fully staffed with three nurse consultants, a policy analyst III and a branch manager. The nurse consultants/inspectors monitor progress and review findings from all EQRO documents, encounter data summaries, the Healthcare Effectiveness Data and Information Set (HEDIS®) and other quality reports with an eye toward quality improvement.

The policy analyst III updates the Division's web pages with current documents and information; reviews and modifies all MCO reports; creates spreadsheets, reports and dashboards to display and analyze the data; and monitors the EQRO contract for compliance and correct invoicing.

The Managed Care Oversight – Contract Management Branch is fully staffed with a branch manager and seven liaison positions. This branch is responsible for analyzing encounter data submissions and determining withholds and penalties for late submissions, errors, and performance of contract requirements. Regularly scheduled MCO meetings are held to discuss encounter submission problems. Staff liaisons monitor and review MCO marketing and advertising, prompt payment issues, documents MCOs want to send to members and EQRO reports related to contract requirements. This branch conducts behavioral health provider audits and random MCO web directory look-ups and is responsible for completing Office of the Inspector General reports for suspected fraud/abuse and the corrective action plan (CAP) and letters of concern (LOCs) process.

The Disease and Case Management Branch recently added three nurse consultant/inspectors (one specializing in behavioral health) and a policy analyst III to its staff; the branch is now fully staffed. The responsibilities of this branch cover a broad range of monitoring and coordinating functions. In the past year, the Disease and Case Management Branch has worked closely with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), Department for Aging and Independent Living (DAIL) and the Department of Community-Based Services (DCBS) to discuss individual issues and identify members who may need case management. The branch has focused on care coordination and case management referrals for special populations such as medically fragile children, foster care children and adults in guardianship. The branch's coordinating responsibilities include participation on several advisory committees and workgroups such as quarterly Early and

Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator meetings, the Children's Health Technical Advisory Committee (TAC) meetings, an oral health workgroup, the Dental TAC, Kentucky Cancer Consortium and Kentucky Colon Cancer Prevention Program. Staff monitor the Commission for Children with Special Health Care Needs (CSHCN) contract and the EPSDT Outreach contract. They have recently taken over the disenrollment for cause process, EPSDT services and the appeals hearings process.

With several new staff positions created and filled within the branches during the last year, including staff focusing on encounter data systems and case management, the state has vigorously applied new staff resources and expertise to the development of their expanding Medicaid managed care program thus providing needed direction and cohesiveness for the program moving forward.

## Evaluation Methodology

The methodology for this report included a review of documents from external review activities and plan reporting, literature review and MCO staff interviews. Managed care activities under the ACA were reviewed and experience from other states' external quality reviews and quality improvement initiatives were researched to provide valuable examples of promising practices.

This report includes an overview of Kentucky's MMC data reporting systems obtained from MCO and EQRO reports. Quality Strategies, obtained from state websites, provided information regarding EQRO activities, performance improvement projects (PIPs) and quality improvement (QI) initiatives from other states. Core program goals from Kentucky's Quality Strategy were quantified and statewide aggregate baseline data were obtained from HEDIS®/Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 2014 results.

EQRO documents reviewed as part of this year's evaluation included the following:

- Department for Medicaid Services FY 14 Monitoring Tool;
- 2014 MCO Compliance Report findings;
- External Quality Review Technical Report, September 2014;
- A Member's Guide to Choosing a Medicaid Health Plan, 2014;
- Kentucky Monthly Encounter Validation Report, February 2015;
- Encounter Data Rate Benchmarking Study: MCO HEDIS® 2014 Rates vs. Plan Encounter Data Calculated Rates, January 2015;
- EPSDT Screening Encounter Data Validation, Clinical Focused Study 2014;
- Access and Availability Behavioral Health Survey, October 2014;
- Validation of Managed Care Provider Network Submissions: Audit Report, September 2014 and February 2015;
- Web-Based Provider Directory Validation Study Summary Report Final, September 2014 and February 2015;
- Validation of Reporting Year 2014 Kentucky Medicaid Managed Care Performance Measures, February 2015;
- Experience of Care Survey: Children with a Behavioral Health Condition Focused Study, November 2014;

- Kentucky Behavioral Health Study Final Report, July 2014;
- Kentucky Medicaid Managed Care Early Periodic Screening, Diagnostic and Treatment Services (EPSDT) Review of 2013 Final, December 2014;
- Kentucky MCO Performance Improvement Project Progress Tracking Sheet, SFY 2015; and
- Quarterly Desk Audit Reports, 4<sup>th</sup> Quarter 2014.

A valuable component of this evaluation approach is the perspective gained from conference call interviews with key quality staff in each of the Kentucky MCOs. Dialog with MCO staff allowed the reviewer(s) to obtain insights and information not available in written reports and websites and to better understand the relationships between the MCOs, the state and the EQRO. Interviews were held with staff from DMS, Anthem Blue Cross Blue Shield, CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan, WellCare of Kentucky and the EQRO, Island Peer Review Organization (IPRO).

## Core Program Goals and Results

The primary goal of Kentucky's MMC Program is to improve the health status of Medicaid enrollees and to lower morbidity among enrollees with serious mental illness. As part of Kentucky's September 2012 Managed Care Quality Strategy, statewide health care outcomes and quality indicators for the goals and objectives were designated by DMS in collaboration with input from the Department of Public Health (DPH) and BHDID. Four major goal areas were determined as follows:

- Goal 1: Improve preventive care for adults;
- Goal 2: Improve care for chronic illness;
- Goal 3: Improve behavioral health care for adults and children; and
- Goal 4: Improve access to a medical home.

To measure improvement and evaluate program success, benchmarks from the National Committee for Quality Assurance (NCQA) Quality Compass Medicaid<sup>6</sup> were included for each quality objective listed in the strategy. NCQA's Quality Compass Medicaid is derived from HEDIS<sup>®</sup> data submitted to NCQA by Medicaid plans throughout the nation. Using these standardized measures as benchmarks allows states to make meaningful comparisons of their rates to rates for all reporting MMC plans nationwide and thus allows state policy makers to better identify program strengths and weaknesses and target areas most in need of improvement. In the Kentucky strategy, improvement is measured by a comparison of the state's rate to the 50<sup>th</sup> or 75<sup>th</sup> percentile of the 2012 national Medicaid benchmark or as an improvement of a ten percent difference between the state's baseline rate and the re-measurement rate. The use of national HEDIS<sup>®</sup> performance is a reasonable approach to setting benchmarks particularly since the bar was set at a conservative 50<sup>th</sup> percentile rate for the majority of the measures (colorectal cancer screening, breast cancer screening, cervical cancer screening, comprehensive diabetes care, cholesterol management, antidepressant medication management and outpatient visits). The 75<sup>th</sup> percentile benchmark was selected for measures of behavioral health care and access to care for adults and children.

In this evaluation summary report, results from Kentucky's HEDIS<sup>®</sup> 2013 serve as baseline rates, and are compared to results from HEDIS<sup>®</sup> 2014 for each measure in order to evaluate improvement from baseline to re-measurement. Kentucky's HEDIS<sup>®</sup> 2013 and HEDIS<sup>®</sup> 2014 state weighted average rates are shown in **Tables 2, 3, 4, and 5** for the objectives listed in the Quality Strategy. The HEDIS<sup>®</sup> 2014 weighted average rate for each objective was compared to the 2012 NCQA<sup>®</sup> Quality Compass national Medicaid percentile rate for that measure. The level of improvement from baseline to re-measurement was calculated as a percent. For example, Kentucky's HEDIS<sup>®</sup> 2014 weighted average statewide rate for Breast Cancer Screening was 59.25% which was above the 2012 national Medicaid 50<sup>th</sup> percentile rate of 50.46%, thus exceeding the objective for this measure. The re-measurement rate for Breast Cancer Screening was 59.25% or an increase of 14.67% over the baseline (51.67%), again exceeding the objective of a 10% improvement over the baseline for this measure. It should be noted that while some measures may reach both benchmark objectives for a measure, it is only necessary to meet or exceed one of the designated benchmarks for the objective to be met. A total of seventeen (17) measures met or exceed the benchmark and another four (4) measures are within five percentage points of the targeted national benchmark (**Tables 2, 3, 4, and 5**).<sup>7</sup> The goal is not achieved if one of the measures did not meet the objective.

Table 2. Goal 1: Improve Preventive Care for Adults

Objectives <sup>1</sup>	2012 Medicaid 50 <sup>th</sup> Percentile	HEDIS <sup>®</sup> 2013 Baseline Rate (%)	HEDIS <sup>®</sup> 2014 Re-Measure Rate (%)	Difference HEDIS <sup>®</sup> 2013–14	% Improved HEDIS <sup>®</sup> 2013–14	Met Objective (Yes/No)
HEDIS <sup>®</sup> Colorectal Cancer Screening <sup>2</sup>	NR	NR	NR	N/A	N/A	N/A
HEDIS <sup>®</sup> Breast Cancer Screening	50.46	51.67	59.25	7.58	14.67%	Yes
HEDIS <sup>®</sup> Cervical Cancer Screening	69.1	49.61	52.96	3.35	6.75%	No

<sup>1</sup>Improvement in preventive care for adults is defined as “all measures meet/exceed 2012 Medicaid 50<sup>th</sup> percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate.”

<sup>2</sup>HEDIS<sup>®</sup> rates for Colorectal Cancer Screening were not reported for Kentucky’s Medicaid population.

<sup>3</sup>NR: not reported; N/A: not applicable.

Table 3. Goal 2: Improve Preventive Care for Chronic Illness

Objectives <sup>1</sup>	2012 Medicaid 50 <sup>th</sup> Percentile	HEDIS <sup>®</sup> 2013 Baseline Rate (%)	HEDIS <sup>®</sup> 2014 Re-Measure Rate (%)	Difference HEDIS <sup>®</sup> 2013–14	% Improved HEDIS <sup>®</sup> 2013–14	Met Objective (Yes/No)
CDC: HbA1c testing	82.38	83.38	86.69	3.31	3.97%	Yes
CDC: HbA1c Poor Control (> 9.0%) <sup>2</sup>	41.68	47.42	40.97	-6.45	13.60%	Yes
CDC: HbA1c Control (< 8.0%)	48.72	44.51	49.69	5.18	11.64%	Yes
CDC: HbA1c Control (< 7.0%)	36.72	35.00	38.65	3.65	10.43%	Yes
CDC: Eye Exam Performed	52.88	41.91	39.07	-2.84	-6.78%	No
CDC: LDL-C Screening	76.16	75.27	81.67	6.40	8.50%	Yes
CDC: LDL-C Control (< 100 mg/dL)	35.86	32.80	34.90	2.10	6.40%	No
CDC: Medical Attention for Nephropathy	78.71	76.67	79.73	3.06	3.99%	Yes
CDC: Blood Pressure Control (< 140/90 mmHg)	63.50	56.67	57.53	0.86	1.52%	No
HEDIS <sup>®</sup> Cholesterol Mgt – LDL-C Screening	82.48	79.91	79.89	-0.02	-0.03%	No
HEDIS <sup>®</sup> Cholesterol Mgt – LDL-C Control (< 100 mg/dL)	42.39	44.59	39.94	-4.65	-10.43%	No

<sup>1</sup>Improvement in preventive care for chronic illness is defined as “all measures meet/exceed 2012 Medicaid 50<sup>th</sup> percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate.”

<sup>2</sup>For this measure, a lower rate is better.

CDC: HEDIS<sup>®</sup> Comprehensive Diabetes Care Measure.

Table 4. Goal 3: Improve Behavioral Health Care for Adults and Children

Objectives	2012 Medicaid 50 <sup>th</sup> Percentile	HEDIS® 2013 Baseline Rate (%)	HEDIS® 2014 Re-Measure Rate (%)	Difference HEDIS® 2013–14	% Improved HEDIS® 2013–14	Met Objective (Yes/No)
HEDIS® Antidepressant Medication Mgt.: Effective Acute Phase <sup>1</sup>	49.42	58.36	55.23	-3.13	-5.36%	Yes
HEDIS® Antidepressant Medication Mgt.: Effective Continuation Phase <sup>1</sup>	32.42	42.98	38.71	-4.27	-9.93%	Yes
Objectives	2012 Medicaid 75 <sup>th</sup> Percentile	HEDIS® 2013 Baseline Rate (%)	HEDIS® 2014 Re-Measure Rate (%)	Difference HEDIS® 2013–14	% Improved HEDIS® 2013–14	Met Objective (Yes/No)
HEDIS® Follow-up After Hospitalization for Mental Illness Within 30 days of Discharge <sup>2</sup>	77.47	62.55	59.43	-3.12	-4.99%	No
HEDIS® Follow-up After Hospitalization for Mental Illness Within 7 days of Discharge <sup>2</sup>	57.68	36.60	35.30	-1.30	-3.55%	No

<sup>1</sup>Improvement in behavioral health care for adults and children for these measures is defined as “measures meet/exceed 2012 Medicaid 50<sup>th</sup> percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate.”

<sup>2</sup>Improvement in behavioral health care for adults and children for these measures is defined as “measures meet/exceed 2012 Medicaid 75<sup>th</sup> percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate.”

Table 5. Goal 4: Improve Access to a Medical Home

Objectives	2012 Medicaid 75 <sup>th</sup> Percentile	HEDIS <sup>®</sup> 2013 Baseline Rate (%)	HEDIS <sup>®</sup> 2014 Re-Measure Rate (%)	Difference HEDIS <sup>®</sup> 2013–14	% Improved HEDIS <sup>®</sup> 2013–14	Met Objective (Yes/No)
<b>HEDIS<sup>®</sup> Adult Access to Preventive/Ambulatory Health Services<sup>1</sup></b>						
Ages 20–44	85.43	86.22	87.86	1.64	1.90%	Yes
Ages 45–64	89.94	91.32	93.56	2.24	2.45%	Yes
Ages 65+	91.11	91.31	93.74	2.43	2.66%	Yes
Total	86.67	88.75	90.69	1.94	2.19%	Yes
<b>HEDIS<sup>®</sup> Children and Adolescents Access to Primary Care<sup>1</sup></b>						
12–24 Months	97.88	97.65	97.20	-0.45	-0.46%	No
25 Months–6 Years	91.40	92.07	92.15	0.08	0.09%	Yes
7–11 Years	92.88	91.95	96.81	4.86	5.29%	Yes
12–19 Years	91.59	91.64	95.80	4.16	4.54%	Yes
Objectives	2012 Medicaid 50 <sup>th</sup> Percentile Visits/1,000 MM	HEDIS <sup>®</sup> 2013 Baseline Visits/1,000 MM	HEDIS <sup>®</sup> 2014 Re-Measure Visits/1,000 MM	Difference HEDIS <sup>®</sup> 2013–14	% Improved HEDIS <sup>®</sup> 2013–14	Met Objective (Yes/No)
Outpatient Visits for all Age Groups <sup>2</sup>	347.76	645.76	573.72	-72.04	-11.16%	Yes
ED Visits for all Age Groups <sup>2</sup>	N/A	84.45	78.11	-6.34	-7.51%	No

<sup>1</sup>Improvement in access to a medical home is defined as “all measures meet/exceed 2012 Medicaid 75<sup>th</sup> percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate.”

<sup>2</sup>Improvement in access to a medical home with regards to state aggregate HEDIS<sup>®</sup> Ambulatory measures are defined as “outpatient visits meet/exceed 2012 Medicaid 50<sup>th</sup> percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate” for the Outpatient Visits for all Age Groups measure, and as “emergency department (ED) visits decrease rate of utilization by 10% between the baseline rate and the re-measurement rate” for the ED Visits for all Age Groups measurement.

MM: member months; N/A: not applicable.

Eleven of Kentucky's HEDIS® 2013 baseline rates met or exceeded the 2012 Medicaid national benchmark rates and seventeen (60.7%) of HEDIS® 2014 re-measurement rates met or exceeded the Medicaid national benchmark. The Breast Cancer Screening rate exceeded the 50<sup>th</sup> percentile national benchmark in both baseline and re-measurement years and showed an increase of 14.67% between HEDIS® 2013 and HEDIS® 2014. Over half of the HEDIS® 2014 Comprehensive Diabetes Care (CDC) measures met or exceeded the 2012 Medicaid national 50<sup>th</sup> percentile. Three of the CDC measures also improved by more than 10% between HEDIS® 2013 and HEDIS® 2014 and these were HbA1c Poor Control (> 9.0%) by 13.60%; HbA1c Control (< 8.0%) by 11.64%; and HbA1c Control (< 7.0%) by 10.43%. While none of the four behavioral health measures designated in the Quality Strategy improved between HEDIS® 2013 and HEDIS® 2014, both of the Antidepressant Medication Management measures (Effective Acute Phase and Effective Continuation Phase) exceeded the 2012 Medicaid 50<sup>th</sup> percentile. Kentucky's MMC Program did exceptionally well in exceeding the 2012 Medicaid 75<sup>th</sup> percentile for Goal 4 measures of Adult Access to Preventive/Ambulatory Health Services and Child and Adolescent Access to Primary Care. One other access measure, Outpatient Visits (all age groups/1,000 member months), not only exceeded the 2012 Medicaid 50<sup>th</sup> percentile, it was also above the 2012 Medicaid 90<sup>th</sup> percentile.

As noted in the Year 2 Comprehensive Evaluation Summary Report (July 2014) the benchmark targets in Kentucky's Quality Strategy were determined at a point in time when Kentucky's experience was with only one MMC plan, in one region of the state. Thus the targets were selected for the Quality Strategy objectives without knowing what the baseline rates would be for the state's current, expanded MMC Program. With HEDIS® 2014 rates added to this year's evaluation, it is evident that Kentucky's MMC Program continues to improve by meeting and exceeding even more of the objective benchmarks. Based on a substantial difference between the Kentucky statewide aggregate HEDIS® 2014 rate and the 2012 national Medicaid benchmark, there are still several measures that present opportunities for improvement and these are:

- Cervical Cancer Screening improved by 6.75% between HEDIS® 2013 and HEDIS® 2014, but is still 16 percentage points below the 2012 Medicaid 50<sup>th</sup> percentile.
- Comprehensive Diabetes Care: Eye Exam Performed rate decreased between HEDIS® 2013 and 2014 and is 14 percentage points below the 2012 national benchmark.
- Cholesterol Management – LDL-C Screening and LDL-C Control (< 100 mg/dL): both rates decreased between HEDIS® 2013 – 2014.
- Follow-up After Hospitalization for Mental Illness Within 30 days and Within 7 days of Discharge: both rates decreased between HEDIS® 2013 – 2014 and the 2012 rate fell short of the 75th percentile by 18 and 22 percentage points, respectively.
- 

The Managed Care Oversight – Quality Branch intends to update the Quality Strategy to reflect the MCO's work toward accomplishing the kyhealthnow 2019 goals.<sup>8</sup> When Kentucky does update their strategy, the benchmark targets should be re-evaluated and either increased to a higher level for those measures that have already met or exceeded the target or lowered in the case of Goal 3, Follow-up After Hospitalization for Mental Illness Within 30 days and Within 7 days of Discharge. Choosing a more recent benchmarking year should also be considered or benchmark targets could be set to reflect a desired percentage increase over the baseline year. As noted in the previous review of the Quality Strategy goals and objectives, the state should consider expanding the goals to address

the large enrollment of women and children in the MMC Program by including goals and objectives for prenatal/postpartum care and preventive measures for children such as childhood obesity, dental care, counseling for nutrition and physical activity and adolescent risk screening. Additional measures related to kyhealthnow 2019 goals would include enrollment growth, smoking cessation, cardiovascular care, overweight and obesity for children and adults, substance abuse, poor mental health and dental care for children and adults.

## Quality Monitoring and Assessment

Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services outlines a strategy for quality oversight that is aligned with federal regulations. The Social Security Act (Part 1932(a))<sup>9</sup> requires states that contract with Medicaid MCOs to provide for an external independent review. The Balanced Budget Act of 1997 further described mechanisms states should use in monitoring Medicaid MCO quality. In early 2003, CMS issued a final rule defining the requirements for external quality review and state quality monitoring.<sup>10</sup> This two-part section describes and assesses the activities of Kentucky's EQRO and the review and monitoring activities of DMS.

### EQRO Activities Overview

For states that provide care to Medicaid enrollees through MCOs, there are three mandatory external review activities and five optional activities listed in federal regulation. DMS has a contract with an EQRO to conduct all of the three mandatory review activities as well as many of the optional activities. The Kentucky EQRO work plan includes the following review activities:

- Validate performance improvement projects (PIPs; mandatory),
- Validate plan performance measures (PMs; mandatory),
- Conduct review of MCO compliance with state and federal standards (mandatory),
- Validate encounter data,
- Validate provider network submissions,
- Conduct focused studies,
- Prepare an annual technical report,
- Develop a quality dashboard tool,
- Develop an annual health plan report card,
- Conduct a comprehensive evaluation summary,
- Develop PMs, and
- Conduct access and availability surveys as needed.

In addition to the mandatory and optional activities listed in federal regulations, Kentucky also contracts with their EQRO to validate patient-level claims, conduct individual case reviews, pharmacy reviews, an annual EPSDT review and an annual progress report. Technical assistance and presentations are provided as needed.

**Attachment A** summarizes quality strategy initiatives in five other states. All of the states reviewed for this evaluation use their EQRO to prepare an annual technical report and an annual or every-3-year survey of MCO compliance with contract standards. Four of the five states have their EQRO conduct the three mandatory activities: validate performance measures, validate PIPs and review compliance with state and federal regulations. In Utah, the Office of Healthcare Statistics validates accountable care organization (ACO) PIPs and PMs. It is also common for the EQRO to conduct several optional activities such as validate encounter data and conduct consumer/provider surveys, but conducting focused clinical studies is less common. It is evident from many state Quality Strategies that the state and EQRO not only share monitoring responsibilities, but also provide

technical assistance to MCOs through their validation of PMs, encounter data and PIPs, as well as providing training and technical assistance as needed. This is particularly true in Kentucky.

## Data Reporting Systems Review

Medicaid MCOs in Kentucky are required to maintain a management information system (MIS) to support all aspects of managed care operation including member enrollment, encounter data, provider network data, quality performance data, as well as claims and surveillance utilization reports to identify fraud and/or abuse by providers and members. The MCO verifies, through edits and audits, the accuracy and timeliness of the information contained in their databases. They are expected to screen for data completeness, logic and consistency. The data must be consistent with procedure codes, diagnosis codes and other codes as defined by DMS, and in the case of HEDIS® data, as defined by NCQA.

Of the data submitted to DMS, the EQRO is responsible for validating encounter data, provider network data and Healthy Kentuckians performance data based on validation protocols prepared by CMS.

### Encounter Data

Encounters are defined as professional, face-to-face transactions between an enrollee and a health care provider, and encounter data are submitted to DMS on at least a weekly basis. The encounter data system can be used to monitor service utilization, access, program integrity, and to develop quality performance indicators and calculate risk-based capitation rates.

May 2013 was the first month that CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky submitted encounter data to DMS. For seven years prior to the MCO expansion, only Passport Health Plan submitted encounter data. Passport Health Plan's encounter data submissions were suspended in June 2012 due to the termination of the EQRO contract and was resumed in 2013 after all MCOs successfully submitted files in the 5010 format and the change order for the file layouts was completed by DMS. Humana-CareSource has been submitting encounter data since mid-2013 and Anthem Health Plan, since June 2014.

In early 2013, the EQRO conducted a review of the state's encounter data systems and processes that are used to load MCO encounter files. This review covered state requirements for collection and submission; confirmation of the data submission format; description of the information flow from the MCO to the state; list of edit checks built into the state's system; process for voids and adjustments; error reports; state uses of loaded data; process for quality checks to ensure that all data from the MCO's system and from vendors are loaded completely and accurately into the data warehouse; and key reasons for encounter record rejections. There was also a section on claims processing.

The EQRO receives a final extracted file from DMS each month for further processing and prepares a monthly data validation report which summarizes each MCO's submission. The format of this report has two parts, a file validation report and an intake report. In both reports, data are presented for all

MCOs and for each MCO separately. The validation report presents the number and percent of missing data and the number and percent of invalid data for each encounter variable. A separate validation table is created by encounter type including inpatient, outpatient, professional, home health, long-term care, dental care and pharmacy. The intake report presents the number of encounters submitted to Kentucky Medicaid Management Information System (MMIS) and includes encounter volume reports by place of service.

The most recent validation report reviewed for this evaluation was the Monthly Encounter Data Validation Report, February 28, 2015 for encounters loaded in the system through March 3, 2014. A review of missing data elements by place of service indicated a number of variables consistently have a high percent missing, such as diagnosis codes 4 and above, performing provider key, inpatient procedure codes, procedure modifier codes, referring provider key, inpatient surgical ICD-9 codes 2 and above and all outpatient surgical ICD-9 codes. Most of these codes are not an edit that will fail an encounter and many of these would not be on all encounters such as diagnosis codes 4. Many only have one or two diagnosis.

DMS continues to work with the MCOs, the EQRO and other branches of DMS to correct errors in encounter data submissions and to more closely align the edits used by MCOs with those used by DMS. During 2014, the Contract Management Branch hired new staff to focus on encounter data by monitoring encounter data submissions to make sure they are timely and accurate and in compliance with the MCO's contract. They continually check edits and the resubmission processes. Penalties and withholds are in place when an MCO is out of compliance and withholds are released, penalties are not, once the compliance is met.

Regularly scheduled monthly meetings, held between DMS and the MCOs, have been useful and continue to help the plans solve their encounter data problems. DMS, including both the Contract Management and Quality branches, attend the monthly encounter data meetings along with the MCOs, the Kentucky Office of Administration and Technology Services (OATS) and Hewlett Packard (HP), DMS' encounter data fiduciary. MCOs interviewed commented that their communication with DMS regarding encounter data submissions is positive, and while MCOs continue to be challenged by coding issues, taxonomy and provider matching with the state Medicaid roster, all MCOs are aware of the potential capitation rate withholds if they do not maintain a minimum encounter acceptance rate of 95%. To further assist MCOs in tracking and improving their encounter data completeness, DMS should consider sharing the monthly EQRO encounter data validation reports with the MCOs.

#### *EPSDT Screening Encounter Data Validation Clinical Focused Study*

The EQRO initiated an EPSDT screening encounter data validation study in 2013 to validate encounter data relevant to the receipt of EPSDT services. Using medical record review, this study evaluated codes used to identify well-child visits with regard to comprehensive screenings and behavioral health screening. In addition, hearing and vision screening codes were evaluated relative to medical record documentation.

Developmental Screening in the First Three Years of Life is a measure in the Children's Health Insurance Program Reauthorization Act (CHIPRA)<sup>11</sup> core measure set that examines the percentage of children screened for risk of developmental, behavioral and social delays using a standardized

screening tool in the 12 months preceding their first, second or third birthday. Administrative specifications for the CHIPRA measure numerator for developmental screening with a standardized tool includes the Current Procedural Terminology (CPT) code 96110, but the measure steward recommends assessing the validity of this code relative to medical record documentation of developmental screening with a standardized tool<sup>12</sup>. Code 96110 has been shown to have questionable validity. To assess the validity of the use of code 96110 to represent developmental screening with a standardized tool by providers in the Kentucky MMC Program, two stratified random samples were selected from each of the four MCOs participating in the study (CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky):

- Cohort I: 110 eligible children at least 1 year of age through 20 years by April 30, 2013, for whom an administrative claim for a well-child visit was submitted; and
- Cohort II: 100 eligible children, at least 1 year of age through 3 years by April 30, 2013, for whom an administrative claim for Developmental Screening (CPT code 96110) was submitted. Cohort II was used to assess the validity of claims data as compared to medical record review in order to verify that using CPT code 96110 adequately reflects developmental screening using a standardized tool.

According to the final report, completed in May 2014, the EQRO found that encounter codes evaluated in each cohort do not completely reflect the provision of a comprehensive well-child visit or developmental screening as described in standard clinical guidelines or EPSDT requirements. MCOs were encouraged to collaborate with providers to increase the use of screening tools through interventions for provider education, toolkits and pocket guides that reinforce elements of a well-child visit and EPSDT screening services. MCO auditing of EPSDT visits through periodic medical record reviews was also recommended.

### *Encounter Data Rate Benchmarking Study*

The Encounter Data Rate Benchmarking Study: MCO HEDIS® 2014 Rates vs. Plan Encounter Data Calculated Rates, completed in January 2015, compared MCO-specific HEDIS® rates with rates calculated from the encounter data warehouse. The overall goal was to identify inconsistencies and improve the quality of the data in the data warehouse so that DMS could confidently use the encounter data to reliably calculate measures of quality and cost-for-rate setting. The following four HEDIS® 2014 measures were selected for this study:

- Breast Cancer Screening,
- Annual Dental Visit,
- Children and Adolescents' Access to Primary Care Practitioners, and
- Adults' Access to Preventive/Ambulatory Health Services.

Using the HEDIS® 2014 technical specifications, the EQRO calculated HEDIS® measure rates for these measure areas using encounter data submitted by four Kentucky MCOs: CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky. Anthem Blue Cross Blue Shield was not included, since they had only started submitting encounter data in 2014. The results were then compared to the rates submitted by the MCOs to NCQA for their annual HEDIS® reporting and statistically significant inconsistencies were noted. Each MCO received a file listing discrepancies and

were asked to report on possible reasons for the differences between the results of the MCO HEDIS® rates and the EQRO's calculated rates. Statistically significant differences were found for three CoventryCares of Kentucky rates and six WellCare of Kentucky rates. All reported measures for Humana-CareSource and Passport Health Plan were found to have statistically significant differences. Most inconsistencies were explained when members were found in the HEDIS® denominator, but not in the Kentucky encounter data denominator and vice versa, or when compliant members were identified in the HEDIS® numerator, but not the encounter data numerator and vice versa.

This study method is a cost-effective validation, compared to medical record review studies, and has been successfully used by the EQRO in other states. Another approach that could be considered for validating data completeness would be a medical record review where a sample of encounters are selected and the medical records for those encounters are reviewed to see if the missing data were recorded in the record, but were not recorded in the encounter submission. A similar study was conducted by the EQRO in New York State and resulted in useful information regarding MCO encounter coding practices.

### **Provider Network Data**

Kentucky MCOs maintain a provider network database that is continually updated and submitted to DMS on at least a monthly basis. The MCOs use their provider network data to populate their printed Provider Directory and their online provider query tool for members and potential members. Each MCO runs geo-access reports against their provider network database and submits these reports to the state.

### ***Validation of Managed Care Provider Network Submissions***

The EQRO completed two audits of Kentucky's provider network submissions, one in September 2014 and another in February 2015. Two validations of MCO web-based provider directories were also completed in the same months. The provider network validations used a sample of providers randomly selected from the state's Managed Care Assignment Processing System (MCAPS). Surveys were sent to 100 primary care providers (PCPs) and 100 specialists from each MCO. The overall response rate in September 2014 was 60.9%, and in February 2015, it was slightly higher at 62.5%. In both audits, returned responses validated information that was correct in the MCAPS data system and reported revisions that should be made to incorrect data. A total of 187 out of 375 (49.9%) providers returned the survey noting at least one revision in the September 2014 report, and in February 2015, 213 out of 497 (42.9%) providers submitted responses with changes. Survey items with a substantial percentage of providers with missing data in the MCAPS data included provider license number, secondary specialty, and Spanish and other languages. The EQRO sent plan specific reports including a list of changes and a list of incorrect addresses to the MCOs and requested that the MCOs update their provider directory file with this information.

Based on the findings from the provider network validation studies, the EQRO also recommended that DMS consider expanding the MCAPS data dictionary to include more specificity in the definitions of the data elements and that they consider adding several data elements to the MCAPS to collect information about wheelchair access, hours at site, provider usage of Health Information Technology

(HIT) and providers' Patient-Centered Medical Home certification status and level. Other recommendations called for clarifications or relocations for the field "Spanish," secondary specialty and interpreter/translation services available.

### ***Web-based Provider Directory Validation***

The web-based provider directory validation was performed to ensure that enrollees are receiving accurate information regarding providers when they access the plan's web-based directory. The objectives of this study were two-fold: 1) to determine if all providers included in the MCAPS submission for each MCO were listed in the web-based provider directory, and 2) to ensure that provider information published in the MCOs' web directories were consistent with the information reported in the MCAPS and/or the provider network audit responses. The September 2014 study used MCAPS submissions from May 2014 for four plans: CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky (Anthem Blue Cross Blue Shield was not included). A random sample of 50% of providers who responded to the provider network validation study was drawn, but no more than 50 providers from each MCO (25 PCPs and 25 specialists) were audited. Overall, 86% of the PCPs and 83% of the specialists were found in the plan web directories. Accuracy of the web directory data was determined by comparing the information published in the MCOs' web directories to both the MCO's MCAPS data and the provider's survey responses. If the web-based data matched either the MCAPS or the provider's survey response, the information was considered accurate. The resulting overall accuracy rate of the provider information published in the web directories was 85% for PCPs and 84% for specialists.

For the February 2015 study, DMS sent the EQRO each MCO's MCAPS submissions as of October 2014. All five MCOs were included in this validation: Anthem Blue Cross Blue Shield, CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky. With a total sample size of 249 providers (124 PCPs and 125 specialists), 90% of the PCPs and 75% of the specialists were found in the MCO web directories. Web directory information that matched either the MCAPS submission data or the provider's survey responses resulted in overall accuracy rates of 85% for the PCPs and 88% for the specialists. It was suggested that DMS follow up with MCOs to ensure that inaccuracies in provider information from this validation study and the provider network survey are corrected and are accurately reflected in both the MCO's MCAPS submissions and their web directories.

It was noted that a limitation of this web-based provider directory validation methodology was that the study sample only included providers who responded to the provider network survey and thus did not take into account the entire population of providers in the MCAPS. Further, the EQRO recommended that the web-based directory validation should also include a measure that indicates whether the web directory information is more consistent with the MCAPS or the provider network survey responses as a way to target data improvement.

### ***Quality Performance Data***

Quality performance data are the basis for quality review and improvement activities. MCOs are responsible for contracting with a certified HEDIS® auditor to conduct an NCQA approved audit prior

to submitting their HEDIS® and CAHPS®<sup>13</sup> data to DMS. The Healthy Kentuckians data, submitted annually to DMS, is validated by the EQRO based on the CMS protocol: *Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities (updated 2012)*<sup>14</sup>. All audit findings are compiled as part of the EQRO's validation of quality performance data, and audit reports including reportable rates are prepared for each MCO. The performance validation methodology includes an information systems capabilities assessment; denominator validation; data collection validation; and numerator validation. For HEDIS® 2014, all effectiveness of care, access and availability, dental access and utilization measures were required to be submitted. DMS elected not to rotate any of the measures that were selected for rotation by NCQA. The state is reviewing the possibility of rotation of HEDIS® measures for future submissions.

During the MCO interviews, one MCO suggested that access to Kentucky immunization and lead screening data could enhance the HEDIS® data collection process and resulting rate calculations. In New York State, MCOs submit enrollee data files to the New York State Department of Health (NYSDOH) and the New York City Department of Health and Mental Hygiene (NYCDOHMH) for matching with the Immunization and Lead Data files. Results of these matched files allow MCOs to obtain information regarding immunizations and lead testing received by their enrollees.<sup>15</sup> Data obtained in this fashion is allowed to be used in HEDIS® numerator counts.

Quality performance data results were presented in the following EQRO documents:<sup>16</sup>

- A Member's Guide to Choosing a Medicaid Health Plan, 2014 (also referred to as the Annual Health Plan Report Card);
- Kentucky MCO Dashboard HEDIS® 2014 (for internal DMS use only); and
- The 2014 External Quality Review Technical Report.

### ***Annual Health Plan Report Card***

An annual health plan report card is developed by the EQRO in collaboration with DMS to provide quality performance information as a guide for individuals when choosing a MMC health plan. Entitled "A Member's Guide to Choosing a Medicaid Health Plan," the first edition was published in 2013 and was distributed in written format to Kentucky enrollees during the open enrollment period. The 2014 edition was available in a printed version as well as electronically on the DMS website.<sup>17</sup>

The format for 2014 was a tri-fold brochure with an MCO comparison of performance in the center and questions members should ask their MCO on the back. This tool is a consumer-friendly document that describes managed care, shows MCO service areas and provides MCO contact information. An enrollee can compare each MCO's performance in the areas of preventive care, access and satisfaction by the number of stars shown, i.e., 3 stars representing above average, 2 stars for average and 1 star for below average performance. By posting this report on the DMS website, the state has made this information available not only to Kentucky Medicaid enrollees, but to the public in general. In future versions of the annual health plan report card, DMS may want to research various options for content and format to determine what their members would prefer. Conducting member focus groups is one way to obtain their input and perspectives.

All of the MCOs interviewed are familiar with the 2014 Member's Guide and were pleased to be given an opportunity to comment on the guide's format and content for the 2015 publication. MCOs

interviewed were in agreement that using five stars instead of three may offer more differentiation between plans for each measure.

### *Quality Performance Dashboards*

Two types of MCO dashboards are used for monitoring. A monthly MCO dashboard is prepared by DMS using data obtained from MCO monthly reports submitted to DMS and includes information regarding claims, encounter data submissions, prior authorizations, as well as information about member, provider and behavioral calls. Financial metrics, provider credentialing, terminations from MCO, program lock-ins and the number of new members in the foster care and adult guardianship programs are also included. Data cells that are in compliance are highlighted in green while cells shaded red indicate they are out of compliance. MCOs commented that the monthly MCO Dashboard has been useful to their leadership teams by identifying potential operational inefficiencies. They also noted, however, that the data in the MCO Dashboard are derived from the monthly submitted reports and questioned whether every MCO is interpreting the reporting specifications in the same way.

Using HEDIS® 2014 data, the EQRO designed a quality performance dashboard to pictorially describe national, statewide and MCO-specific performance on selected quality and satisfaction measures using graphs and charts. This version of the dashboard is posted on the EQRO website for DMS internal monitoring purposes. The dashboard content was comprehensive and clearly displayed, making it easy to navigate the site and quickly obtain information.

While the original intent of the EQRO quality dashboard concept was to be an internal DMS monitoring tool, the comprehensiveness of the data presented and the ease of navigating the site would make this a useful tool not only for DMS staff, but for the Kentucky MCOs, as well as MMC enrollees, other states and the general public.

### *Technical Report*

The Balanced Budget Act of 1997 requires state agencies that contract with Medicaid MCOs to prepare an annual external, independent review of quality outcomes, timeliness and access to health care services. The report, entitled “External Quality Review Technical Report,” was completed by the EQRO in September 2014 for Kentucky’s four Medicaid MCOs: CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky. The report included quality performance data, CAHPS® satisfaction data, results of compliance reviews, validation results of PMs and validation of PIPs. MCO strengths and opportunities for improvement were outlined for each MCO. Also included was a summary of each MCO’s strengths and areas for improvement. The MCOs were required to submit a response for each opportunity for improvement, which were then published in the next annual Technical Report. While the federal regulations require an annual review of access, timeliness and quality of care, a full review is only necessary every three years.

The report, completed in September 2014, provided a concise summary of each MCO’s measures of access and quality performance from HEDIS® 2013 compared to a weighted statewide average and also included findings from the 2014 Compliance Reviews for elements of each review category where the plan was not fully compliant. While the report covers the required areas of quality

outcomes, timeliness and access to health care services, the timing of the data reviewed is not consistent. For example, the report completed in September 2014 includes findings from the 2014 Compliance Reviews, whereas the HEDIS® and CAHPS® data presented is for measurement year (MY) 2012. The HEDIS® and CAHPS® data that were submitted in June 2014 (for MY 2013) were not available by the time the technical report was completed. In order to present findings that are more consistent by year, the completion date for the report would need to be delayed until the more recently submitted HEDIS® and CAHPS® data are available.

## Annual Compliance Reviews

Federal regulations require that every state with a MMC program conduct a full review of MCO compliance with state and federal regulations at least once every three years. The reviews can be done by the state or the EQRO. In Kentucky, the EQRO conducts the annual reviews for compliance with contract requirements and state and federal regulatory standards. In reporting year 2014, two MCOs (CoventryCares of Kentucky and WellCare of Kentucky) received a re-review, based on findings of the previous review. Passport Health Plan received a full review, since this was the plan's first year under new contract requirements, and Humana-CareSource also received a full review, as this was the plan's first year participating in the Kentucky Medicaid program.

According to 42 CFR§ 438.360, states can use information obtained from a national accrediting organization's review for the mandatory external quality review activities conducted by either the state or its EQRO. With this authority, states can deem NCQA standards equivalent to state requirements and thus use the information obtained through accreditation surveys to streamline their oversight process.<sup>18</sup> Currently, three Kentucky MCOs are accredited: CoventryCares of Kentucky, Passport Health Plan and WellCare of Kentucky. Anthem Blue Cross Blue Shield and Humana-CareSource anticipate submitting applications in 2015. Since Kentucky has specific measures that are not included in the accreditation reviews, the state prefers to use a policy for deeming based on previous plan performance rather than deeming based on accreditation.

DMS remains committed to conducting compliance reviews on an annual basis. But, in an effort to streamline the compliance review requirements, in 2014 DMS began a review of the MCO reports used in the annual review. Instead of reviewing MCO quarterly reports while conducting the annual compliance review, the EQRO received the reports as they were submitted and created Desk Audit Tables by plan and by quarter for the following review areas:

- Availability and Access,
- Continuity and Coordination,
- Coverage and Authorization of Services,
- Enrollee Rights, and
- Grievance System.

DMS commented that reviewing the quarterly reports as they were submitted made it easier when it came time to conduct the annual review as some of the documents had already been reviewed. The quarterly audit tables are sent to the MCOs during the year, which gives them an opportunity to

remedy elements that were found non-compliant prior to the annual review. At the annual review, the EQRO only has to recheck elements found non-compliant in the quarterly reviews. DMS continues to encourage MCOs to use the response column on the audits when they reply to DMS and the EQRO. DMS is working with the EQRO to further revise the MCO report forms to clarify definitions so that the information submitted by the plans is more comparable.

In addition to the annual compliance reviews, DMS is monitoring the CAPs issued for the compliance reviews and are now issuing LOCs for substantial scores in three consecutive years due to failure to implement the EQRO's suggestions. The following year will result in a CAP, even if the findings result in a Substantial rating is still due to failure to implement the previous recommendations. Plans view these CAPs seriously and do attempt to implement suggestions made in the review. However, suggestions that are not reflected in the MCO Model Contract and that may also have a financial impact on the plan should not be penalized for failure to implement. If a plan is substantial two years in a row for the same item, they will be at a minimal and a CAP required. If a plan receives 3 years substantial determination in a row for same area, it is non-compliant and CAP is required.

## State Review Activities Overview

As described earlier, the Kentucky MMC quality review and oversight activities are the responsibility of the Division of Program Quality and Outcomes:

- *Managed Care Oversight – Contract Management Branch* has oversight responsibilities for the Kentucky MMC Program. Staff members, serving as plan managers, function as liaisons between the MCO and state regarding contract compliance and management. They participate in compliance review activities and review and analyze monthly encounter data reports from the EQRO and quarterly reports submitted directly to DMS from the MCOs.
- *Disease and Case Management Branch* has oversight responsibility for Medicaid enrollee care coordination including MCO case management programs and MCO coordination with other state agencies such as DCBS and DAIL. This branch oversees the disenrollment for cause process, EPSDT services and the appeals hearing process. The branch plays a key role in facilitating communication and coordination through numerous workgroups and TACs.
- *Managed Care Oversight – Quality Branch* oversees the EQRO contract, reviews the compliance review findings, and works with the EQRO to develop quality measures and activities to improve Kentucky's health care quality and outcomes.

In 2014, in response to the previous Comprehensive Evaluation Summary Report recommendations, DMS posted many quality-related materials on its website. The website now includes descriptions of the state review activities, DMS branch responsibilities, HEDIS® and CAHPS® results and all EQRO reports. The website also has links to the Kentucky Quality Strategy, the annual MCO report cards and a definitions and acronyms page. Each branch has a webpage with links to all reports relevant to the branch. For example, the Disease and Case Management Branch provides links to EPSDT reports, the State Fair Hearing report, EPSDT data reported on form CMS 416 and Disenrollment for Cause reports.

MCOs use the DMS website to access DMS information, the monthly MCO Dashboard and EQRO quality reports, but commented that the reports are embedded in each of the branch web pages, so before you can access a report, you need to know what branch is responsible for that report. A left navigational box to link to a list of all Medicaid managed care reports would be helpful and give MCOs and the public easier access to the reports. However, the number of links listed in the left navigational boxes is already long and requires the searcher to scroll down to see all entries. So, instead of adding one more link, DMS (or the Cabinet for Health and Family Services) website designers should consider revising and simplifying the overall navigation for this page. Another consideration for revision is the Kentucky MMC webpage.<sup>19</sup> It appears that this webpage has not been updated in well over a year. Anthem Blue Cross Blue Shield is not included in the list of plans and the latest “News” posting was for October 4, 2012 (accessed on...).

### **MCO Reporting Requirements**

The state’s current Medicaid MCO Model Contract incorporates established standards for access to care, structure and operations and quality measurement and improvement. To monitor MCOs’ compliance with these standards, DMS requires MCOs to regularly submit a multitude of different monitoring reports on a monthly, quarterly, or annual basis. All three branches have staff reviewing specific reports to assure that they are all adequately reviewed and information is tracked and evaluated. As noted earlier, the Quality Branch prepares a monthly MCO Dashboard summary of data from several key monthly reports.

Over the past year, the Managed Care Oversight – Quality Branch initiated a workgroup that includes members from DMS, DBHDID and the MCOs to review all required MCO reports. DMS requested MCO input and meetings were held to discuss ways to modify, combine, reduce or eliminate some of the required reports in order to reduce the burden and increase the quality of information. As a result, report requirements will be changed for the new contract year. Some reports have been changed from monthly to quarterly; some have been eliminated; and some reports are being revised to provide better and more accurate data. DMS further reviewed and clarified definitions and data specifications so that all MCOs are interpreting the report specifications in the same way. DMS reports that all members of this workgroup were extremely satisfied with the outcome and many have commented that it was the best and most productive workgroup they have been involved in since contracting with DMS.

Another way to achieve a reduced reporting load for the MCOs could be through deeming. Federal regulation allows states to deem selected items reviewed by accrediting organizations as compliant with state standards. In Kentucky, MCOs are required to obtain NCQA accreditation, and to date, three of the five MCOs have been accredited. When all Medicaid MCOs have accreditation, this deeming capability could be a desirable alternative to a number of current report requirements.

As a result of new MCO contracts that are effective July 1, 2015, there will be a new Model Contract for Medicaid MCOs in which the specific reporting requirements will be outlined. This is a perfect time to evaluate the reporting requirements and make changes to clarify definitions and specifications, delete unnecessary reports, eliminate redundancy, combine reports and reduce MCO reporting burden.

## Monitoring Access to Care

Geo-access reports are a key part of the state's monitoring requirement to assure access to providers. The average distance (in miles) to a choice of providers for all members is presented, and the average distance to one provider for key geographic areas is also provided. Providers include PCPs, primary care centers, dental care providers, specialty care providers, non-physician providers, hospitals, urgent care centers, local health departments, federally qualified health centers, pharmacies, significant traditional providers, maternity care providers, vision care providers and family planning clinics. MCOs also monitor access to high volume specialists, such as those specializing in cardiology, obstetrics/gynecology and surgery. Analyses are provided for enrollees in urban and rural areas. The EQRO's quarterly Desk Audit of Availability and Access of Services for the compliance reviews identified gaps in access that could be addressed by the MCO prior to the annual review. The EQRO commented that the MCO geo-access reports were inconsistent in content; for example, some reports did not cover access to all required provider types and some provider types were not submitted by region (urban/rural).

In addition to geographic access and validation of provider network submissions, each MCO conducts surveys to determine appointment availability for urgent or non-urgent care in accordance with contract availability standards. In 2013, the EQRO conducted a survey requesting each MCO to describe the method they used for surveying provider access and availability of appointments. The responses indicated that each MCO conducts this survey differently, with some, but not all, using a "secret shopper" methodology and some conducting phone calls or on-site visits to determine the next available appointment. Because these surveys use various methods for data gathering, it is difficult to summarize and aggregate results on a state-program level. Corrective actions for providers who fail to comply with the appointment standards are also not standardized and vary by MCO. DMS reports that the Managed Care Oversight – Contract Compliance Branch conducts secret shopper calls monthly to random providers in the MCOs' network, to assess compliance with the contract standards. During the MCO interviews, the advantages and disadvantages of using secret shopper calls to assess appointment availability was discussed. Concerns were raised by some MCOs that this type of survey places an undue burden on busy provider office staff and is limited by practices that require patient information, such as member name, date of birth or MCO identification number prior to scheduling an appointment.

### *Access and Availability Behavioral Health Survey*

During 2014, DMS and the EQRO collaborated on a design to conduct an access and availability survey for behavioral health providers using the "secret shopper" methodology. The objective of the survey was to measure compliance with the contract standard requiring MCOs to maintain a compliance rate of at least 80% for appointment availability within 60 days. The study design intended to draw a random sample of 250 behavioral health providers from each MCO, but after receiving the MCAPS file from DMS and excluding providers who did not meet the study criteria, the final file contained fewer than 250 providers for each plan. Random sampling was not conducted and the entire universe of 904 providers was selected. There were three provider types included: psychiatrists, psychologists

and social workers/counselors/therapists. The four participating MCOs were: CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky.

The survey was fielded between August and October 2014, allowing time for initial phone calls and recalls for providers after obtaining updated phone numbers. The methodology used several different scenarios for requesting an appointment with the behavioral health provider depending on the type of provider being called and whether the member was an adult or child/adolescent. Surveyors made up to four attempts to contact a live person at each provider office to complete the survey. If contact was not made with a live staff member, the surveyor did not leave a phone number for the provider to call back.

Among the 904 providers, surveyors were able to make contact with 651 providers (72%), with contact rates by plan ranging from 69.4% to 77.0%. Across provider types, contact rates ranged from 68.5% for psychologists to a high of 73.2% for psychiatrists. Of the 253 providers who were not able to be contacted, 51% used an answering machine or voice mail system. Compliance with the access standard was measured by the proportion of appointments that were made within 60 days. Overall, only 10.3% of appointments were made within 60 days, far below the compliance standard of 80%. By plan, compliance rates ranged from 5.7% to 14.1%, and by provider type, the compliance rate was lowest for psychiatrists (5.8%) and highest for social workers/counselors/therapists (21.3%). Approximately 30% of study providers were not able to be contacted.

MCOs received a plan-specific summary of providers who could not be contacted and those who could not give an appointment within the standard time frame. MCOs were asked to review the files and submit explanations regarding the providers who could not be contacted and appointments that were not made.

DMS noted that one limitation of this study was the fact that on the MCAPS file, there is no indicator for whether the behavioral health provider's panel is open or closed, while this indicator is present for PCPs. They also feel that not leaving a call-back phone number when the surveyor encountered an answering machine or voice mail system had an adverse impact on the number of providers counted as contacted. That being said, DMS expressed concern that the study results do indicate a problem with access for behavioral health providers that needs to be addressed. DMS suggested that MCOs could develop a system of claims sweeps that would alert them if a provider has not submitted a claim within a certain time period. The MCO can then follow-up to see if the provider is still active or needs to be removed from the network.

MCOs interviewed agreed that there is an access/availability issue for behavioral health providers in Kentucky MMC, but felt that the results of this survey did not accurately reflect the true rate of access. Some of the issues raised by the MCOs regarding the survey included:

- The methodology for not leaving a call-back number when the surveyor encountered an answering machine biased the results toward larger practices and clinics that are likely to have staff to answer phones. Individual practices depend on answering machines and voice mail to allow the provider to call back.

- The MCAPS file does not have an indicator for closed or open panels, so providers with closed panels were included in the survey, but they would not be taking new patients.
- Provider specialty type on the MCAPS file is not always accurate. The provider may be specializing and does not provide the service required for the survey scenario.
- The survey was conducted at a time when there was a lot of change and growth in the behavioral health benefit and the number of new providers.
- Several MCOs commented that they called each provider who did not answer the survey calls or who could not schedule an appointment and did not experience the same outcomes.
- MCOs should have had an opportunity to review and comment on the methodology prior to the survey.

When deciding to conduct a survey of health care providers using a secret shopper methodology, it is important to first consider the applicability of this method to the specific provider type being surveyed. In the case of behavioral health providers, prior consideration of the operational limitations expressed by the MCOs may preclude the use of a secret shopper methodology for this provider type.

### Care Coordination

Provisions of the ACA strongly support the role of care coordination in providing care to individuals with special health care needs. MCOs have traditionally embraced this concept and many have developed sophisticated systems to identify enrollees at risk, provide disease and case management services and monitor and track outcomes. Identifying new enrollees with care coordination needs can start with the completion of a health risk assessment (HRA). MCOs are required to request that all members complete an initial HRA. MCOs also identify enrollees in need of care coordination by using encounter data algorithms or predictive modeling to track high-risk diagnosis codes, high utilization, repeat use of emergency rooms, frequent inpatient stays and hospital readmissions as markers. This use of encounter data highlights another reason why it is important for MCOs to have accurate and complete encounter data. DMS's Disease and Case Management Branch plays an active role in working with MCOs to enhance care coordination and case management referrals for special populations, such as medically fragile children, foster children and adults in guardianship. The disenrollment for cause process has allowed DMS to identify member problems with MCOs, report on trends and refer members directly to case management.

Compliance reviews conducted in 2014 continued to note coordination challenges between the MCOs and Kentucky's DCBS and DAIL individuals. It is critical that the MCOs have access to baseline information about individuals identified by DCBS and DAIL to enable timely and appropriate referrals and for MCO case managers to assure access to needed services.

DMS, through the Disease and Case Management Branch, has established a system of communication between the state agencies and the MCOs that has resulted in a more collaborative environment according to several Kentucky MCOs.

## Program Integrity

DMS actively monitors MCO program integrity through quarterly reporting requirements that include utilization management, utilization by subpopulations, member satisfaction, provider satisfaction, credentialing and re-credentialing activities, member and provider grievances, appeals, grievances and appeals trends/problems and fraud, waste and abuse reports. MCO administrative changes and other organizational changes are also monitored. The Managed Care Oversight – Contract Management Branch monitors MCO member services activities through review of quarterly MCO reports and call center reports. Results of the CAHPS® member satisfaction surveys are also monitored for questions related to customer service. As part of the EQRO compliance review, assessments of plan operational policies and procedures and interviews with MCO staff are conducted regarding member grievances, prior authorization, cultural and linguistic services, marketing and program integrity. The 2014 Compliance Review findings for program integrity indicated that one Kentucky MCO was in full compliance, two had substantial compliance and one MCO was found to be minimally compliant.

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. Kentucky MCOs that use a centralized call center require vendor oversight and extensive reporting to monitor activity and track trends.

## EPSDT Compliance

Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally required Medicaid program for children that has two major components: EPSDT Screenings and EPSDT Special Services. The Screening Program provides well-child check-ups and screening tests for Medicaid eligible children in specified age groups. EPSDT Special Services are only provided when medically necessary, if they are not covered in another Medicaid program, or are medically indicated and needed in excess of a program limit. DMS contracts with Kentucky's EQRO to validate that the MCOs' administration of EPSDT benefits is consistent with federal and state requirements.

### *Kentucky Medicaid Managed Care EPSDT Review of 2013, Final December 2014*

The EQRO conducted a review of adherence to the EPSDT protocol using MCO EPSDT data reports and a review of a sample of files related to complaints, grievances, denials and care management. Other reports and data referenced included 2013 HEDIS® (MY 2012 data) and Healthy Kentuckians performance measures (MY 2012), MCO statutory reports, and an EPSDT encounter data validation study. EPSDT programs for each of the four Kentucky Medicaid MCOs participating in 2013 were evaluated and included CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky. Anthem Blue Cross Blue Shield did not begin enrolling child and adolescent members until July 2014 and thus was not included in this evaluation.

Statutory reports relevant to EPSDT services submitted by Kentucky MCOs included the following:

- Quarterly Report #24 – Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death,

- Annual Report #93 – EPSDT Annual Participation Report (as reported on CMS-416),
- Quarterly Report #17 – Quality Assessment and Performance Improvement Work Plan,
- Quarterly Report #85 – Quality Improvement Program Evaluation,
- Annual Report #94 – CAHPS® Medicaid Child Survey, and
- Annual Report #86 – Annual Outreach Plan.

As described earlier, the EQRO also conducted a validation study of encounter data relevant to the receipt of EPSDT services using medical record review. The study evaluated codes used to identify well-child visits with regard to comprehensive screenings including behavioral health screening. In addition, hearing and vision screening codes were evaluated relative to medical record documentation. Developmental Screening in the First Three Years of Life is a measure in the CHIPRA core measure set that examines the percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding their first, second or third birthday.<sup>20</sup> This screening can be represented in encounter data by CPT code 96110, but the CHIPRA developmental screening measure steward recommend that states conduct an assessment of the validity of CPT code 96110 to represent developmental screening with a standardized tool. . The EQRO study conducted a validity assessment of claims data as compared to medical chart review in order to verify that using CPT code 96110 adequately reflects developmental screening using a standardized tool.

Findings from the 2014 Compliance Reviews revealed that all four MCOs were either substantially or fully compliant with review elements related to EPSDT services. All four plans reported participation rates for EPSDT services below 80% and had implemented a variety of initiatives to educate and outreach to members, educate providers and facilitate EPSDT services including several innovative member outreach efforts, such as promoting EPSDT services at schools, meetings with grandparents raising grandchildren and homeless advocacy groups. All MCOs encourage providers to outreach to members in need of services and all MCOs actively track receipt of services by member and provider. Case management outreach and service coordination for members needing services is also well documented by each MCO. All four MCOs showed evidence of providing a sufficient network of EPSDT providers, but efforts to monitor providers’ delivery of services varied across plans. Results of the EPSDT validation study and HEDIS® and Healthy Kentuckians measures indicated opportunities for improvement in mental health, vision, hearing and developmental screening; depression and behavioral risk screening for adolescents; BMI screening and nutrition/physical activity counseling; immunizations; and lead screening.

## Strategies and Interventions to Promote Quality Improvement

Kentucky's Quality Strategy includes several activities focused on quality improvement including Performance Improvement Projects (PIPs), focused clinical studies, public reporting and state-MCO-EQRO communications. This section discusses the current projects completed or ongoing by the MCOs, DMS and the EQRO. Experience from other states and innovative improvement initiatives are also presented for consideration.

### Performance Improvement Projects (PIPs)

A protocol for conducting PIPs was developed by CMS to assist MCOs in the design and implementation of a PIP. Federal regulations require that all PIPs be validated according to guidelines specified by CMS. In Kentucky, the EQRO is responsible for validating all PIPs.

Conducting a PIP is an ideal way for an MCO to try out an improvement initiative and create performance indicators to measure progress and effectiveness. The PIP protocol is based on a problem solving approach to achieve improvement known as a Plan-Do-Study-Act (PDSA) cycle.<sup>21</sup> Each state's MMC program determines the number of PIPs required to be conducted each year. A review of other state Quality Strategies indicated that most require one or two PIPs annually, but this year's review of other states highlighted several states requiring as many as 9 annual PIPs in Georgia and 5 annual PIPs in Tennessee. In Kentucky, two new PIP topics are proposed each year and are generally completed in two to three years, thus, an MCO is likely to have two to six PIPs at various stages of activity: initiation, baseline measurement, implementation, and up to two years of re-measurement (**Table 6**).

The EQRO's process for validating MCO PIPs starts with DMS approval of the PIP topic. Then, using a team of two to three reviewers, the EQRO reviews the PIP proposal, topic selection rationale, methodology, planned interventions and study indicators. The EQRO follows each PIP through completion with conference calls with each MCO to discuss progress and problems. In addition, the EQRO also conducts training for MCOs on PIP development and implementation. PIP results are scored based on the first and second re-measurement results. While a PIP's result may or may not indicate that an MCO achieved success in meeting their goals, every PIP can provide a valuable learning experience in the QI process which can be applied to other improvement efforts.

The EQRO validation team approach is a key tool used in validating the PIP results, but more importantly, it helps the MCO refine the measurement indicators and study methodology prior to implementation. The MCO benefits from a shared perspective of more than one reviewer. Periodic calls with each MCO to discuss ongoing activities helps the MCO identify problems early and allows for possible revisions.

Initially, Kentucky MCOs selected their own PIP topics, usually based on HEDIS® results that needed improvement. More recently, 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. In 2014, Kentucky initiated a statewide collaborative PIP, entitled "Safe and Judicious Antipsychotic Medication Use in Children and Adolescents," to satisfy the behavioral health category requirement. All MCOs are currently identifying barriers to care and developing interventions. DMS reports that the

EQRO has been instrumental in all of the PIP processes by conducting conference calls and working with all groups involved to better define the interventions and address barriers.

The EQRO is also coordinating efforts with another collaborating partner, the University of Louisville (Uof L) Physicians Data Team, to determine data collection methods for the MCOs. Six indicators have been chosen for measurement. It should be noted that three of these measures are new, first-year measures for HEDIS® 2015 and as such, results of these measures will not be published, but will be analyzed by NCQA for variation and compared to results of the field test. The Committee on Performance Measurement (CPM) reviews the results and votes on moving a measure to public reporting. The other three measures have not yet been adopted by NCQA, which means that there is no HEDIS® software and no technical specifications available for these measures, hence MCOs must develop their own, thus increasing the risk that plans may be interpreting the measures differently.

Table 6. PIP Project Status 2012–2015

Plan	PIP Topic	Proposal Submitted	PIP Period
Anthem Blue Cross Blue Shield	Reducing Avoidable Emergency Department Utilization	2014	2014–2016
	Statewide PIP – Safe and Judicious Antipsychotic Medication Use in Children and Adolescents	2014	2014–2016
CoventryCares Of Kentucky	Major Depression: Anti-Depressant Medication Management and Compliance	2012	2012–2014
	Decreasing Non-Emergent Inappropriate Emergency Department Use	2012	2012–2014
	Secondary Prevention by Supporting Families of Children with Attention Deficit Hyperactivity Disorder (ADHD)	2013	2013–2015
	Decreasing Avoidable Hospital Re-admissions	2013	2013–2015
	Increasing Comprehensive Diabetes Testing and Screening	2014	2014–2016
	Statewide PIP – Safe and Judicious Antipsychotic Medication Use in Children and Adolescents	2014	2014–2016
Humana- CareSource	Untreated Depression	2013	2013–2015
	Emergency Department Use Management	2013	2013–2015
	Increasing Postpartum Visits	2014	2014–2016
	Statewide PIP – Safe and Judicious Antipsychotic Medication Use in Children and Adolescents	2014	2014–2016
Passport Health Plan	Reduction of Emergency Room Care Rates	2012	2011–2013 <sup>1</sup>
	Reduction of Inappropriately Prescribed Antibiotics for Pharyngitis and Upper Respiratory Infections (URI)	2012	2011–2013 <sup>1</sup>
	You Can Control Your Asthma! Development and Implementation of an Asthma Action Plan	2013	2013–2015
	Psychotropic Drug Intervention Program	2013	2013–2015
	Reducing Readmission Rates of Postpartum Members	2014	2014–2016
	Statewide PIP – Safe and Judicious Antipsychotic Medication Use in Children and Adolescents	2014	2014–2016
WellCare of Kentucky	Utilization of Behavioral Health Medication in Children	2012	2012–2014
	Decreasing Inappropriate Emergency Department	2012	2012–2014

Plan	PIP Topic	Proposal Submitted	PIP Period
	Utilization		
	Follow-up After Hospitalization for Mental Illness	2013	2013–2015
	Management of Chronic Obstructive Pulmonary Disease (COPD)	2013	2013–2015
	Postpartum Care	2014	2014–2016
	Statewide PIP – Safe and Judicious Antipsychotic Medication Use in Children and Adolescents	2014	2014–2016

<sup>1</sup>Final EQRO review of second re-measurement was sent to MCO 2/24/2015.

MCOs interviewed commented on the value of the periodic conference calls with the EQRO to discuss PIP progress and felt that the one-on-one calls between the EQRO and each MCO were preferable to conference calls with all MCOs. It was also noted that the turnaround time for proposal review and feedback to the MCOs was not always timely and caused some delay for the MCO in getting their PIP interventions started. Three of the MCOs expressed concern about the quantity of PIPs that are ongoing at any one time (as many as four to six), which places a burden on MCO resources and may result in fewer or less aggressive interventions.

The number of PIPs performed and the period of time for a PIP is determined by the state and not mandated by CMS. In New York State, because the PIPs often use HEDIS® rates to measure improvement, the PIP period is 18 months which allows for one calendar year to implement interventions and then another six months in order to include re-measurement with HEDIS® rates submitted in June. Collaborative PIPs in New York are always two or more years in duration since they typically require more comprehensive interventions. In New York State, MCOs are only required to conduct one PIP at a time.

The statewide PIP collaborative study topic was agreed upon when the Kentucky DMS Medical Director convened meetings with the Advisory Council for Medical Assistance (MAC) and the MCO medical directors to discuss the collaborative topic, PIP processes and measurement indicators. Uof L Physicians Data Team was engaged to provide guidance to the project regarding the measurement process, data collection and analysis. As this PIP develops, it is critical that all participating stakeholders (DMS, the EQRO and the Uof L) be included or at least aware of activities that may be occurring with sub-group meetings or conference calls. For instance, it may be necessary for the EQRO and/or Uof L, to work individually with each MCO regarding their specific barriers and interventions or their data collection processes, but a brief summary of what was discussed and changes made to the PIP projects should be communicated to the EQRO, as the collaborative PIP coordinator.

Continual feedback from the MCOs regarding the statewide collaborative PIP progress can be very informative and contribute to the PDSA cycle that is continually evolving. The state should use this PIP process as a way to foster sharing between the MCOs and to this end, have a regular schedule of all-plan conference calls or in-person meetings. Another advantage that a statewide collaborative offers is the opportunity for shared learning. Other state collaborative PIPs offer presentations and training by PIP topic-related experts to assist MCOs in barrier analysis and intervention development. In New York State’s Pediatric Obesity Collaborative, for example, printed and electronic materials

such as BMI wheels and BMI percentile charts were made available to MCOs from the New York State Department of Chronic Disease and Prevention. A full-day training for MCOs on provider academic detailing techniques was provided by the NYCDOHMH. Throughout the project, several all-plan conference calls were scheduled for selected plans to present their project progress and answer questions.

## **Focused Clinical Studies**

Described in federal regulation as an optional quality review activity, the Commonwealth of Kentucky has chosen to include focused clinical studies in their Quality Strategy. A focused clinical study examines a particular aspect of clinical or non-clinical service at a point in time. The EQRO initiates new topic selection by annually developing several proposals that are reviewed and discussed with DMS. DMS makes the final choice of topics. During 2014, the two study topics were both related to behavioral health: an administrative data analysis of Kentucky behavioral health and an experience of care survey of children with a behavioral health condition.

### ***Kentucky Behavioral Health Study***

This study provided a profile of behavioral health disorder prevalence and service utilization in Kentucky MMC population during 2013 using electronic encounter data files to identify the eligible population and create the study dataset. Chronic physical condition prevalence and service utilization patterns were quantified in order to identify susceptible subpopulations for targeted case management, care coordination and other quality improvement interventions. A third aim of the study was to identify demographic and clinical risk factors for outcomes of all-cause hospitalization, behavioral health hospitalization and all-cause and psychiatric emergency department (ED) re-visits within 30 days of a behavioral health hospital discharge.

The behavioral health eligible population comprised 34% (245,011/713,888) of the total Kentucky MMC population. Prominent behavioral health diagnoses for the adult subset included anxiety (43%), depression (39%), and drug abuse (17%). Adolescents (ages 13–17 years) were most frequently diagnosed with attention deficit hyperactivity disorder (43%), depression (25%), anxiety (17%), psychoses (17%), and conduct disorder (15%), while children (ages 0–12 years) had prominent behavioral health diagnoses of attention deficit hyperactivity disorder (48%), conduct disorder (21%), speech delay (11%), and anxiety (10%). The all-cause hospitalization rate for this behavioral health population was 13.67%. Encounter data analysis also indicated that 83% of adults with a behavioral health hospitalization lacked a follow-up mental health visit within 30 days of their behavioral health hospital discharge. Another important finding indicated that 86% of adults with a behavioral health disorder also had at least one chronic physical condition. Increased odds for hospitalization were found to be associated with increased age, male gender, black or other race/ethnicity, urban residence and enrollment in foster care.

Recommendations proposed for Kentucky MMC plans included targeting care management to susceptible subpopulations based on risk; identifying and sharing best practices among providers; evaluating access to follow-up visits; offering continuing education to providers on clinical guidelines; collaborating with providers to screen for substance abuse and depression; considering new quality performance measures for 2015, and implementing evidence-based interventions in PIPs that target

identified behavioral health problem areas. Based on findings from the Kentucky Behavioral Health Study, DMS was encouraged to provide guidance to the MCOs and collaborate with DCBS in addressing the issues identified in the report. Findings from this study have also been very useful to the MCOs as they considered barriers and interventions for their collaborative PIP topic of Safe and Judicious Antipsychotic Medication Use in Children and Adolescents.

### *Experience of Care for Children with a Behavioral Health Condition*

The EQRO collaborated with DMS to implement this experience of care focused study in 2014. The study aim was to identify pediatric experience of care problems and opportunities for improvement in physical health care, behavioral health care and coordination of care. The EQRO, in collaboration with DMS, developed the experience of care survey questions to address access, satisfaction, inclusion of family in treatment, education, cultural competency, perceived improvement and ease of getting information from the health plan. The sample was made up of members aged 0–17 years who were randomly selected from the total administrative claims-based file of Kentucky MMC enrollees with a behavioral health diagnosis or a prescription for psychotropic medication during 2013. This study was conducted via a mail-in survey to parents of a random sample of 4,800 children, 1,200 from each of the four participating MCOs: CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky.

Of the 4,800 surveys mailed, 779 (16.2%) were undeliverable, yielding an adjusted population of 4,021 (the number of surveys mailed minus the undeliverable surveys). A total of 912 surveys were completed yielding an overall response rate of 22.7%.

Children’s physical health status was reported as excellent or good by 85.7% of respondents while the corresponding rate for behavioral health status was only reported as excellent or good by 51.5% of the respondents. Among survey respondents who reported that their child needed treatment or counseling for behavioral health problems, only 22.9% reported that they saw improvement in their child’s condition. In terms of satisfaction with care received, 70.6% of respondents were “very satisfied” with care for physical health problems, while 53% were “very satisfied” with their behavioral health care.

Findings suggested that there were problems with provider-parent communication regarding medication use. Also, while timely access to a general provider for treatment of a physical health problem was reported as “always” for 64.9% of respondents, timely access to specialists for a physical problem was reported as “always” by only 50.6% of respondents. Corresponding rates for timely access to general and specialty behavioral health providers were 59.9% and 54.6%, respectively. An analysis of risk factors provided valuable information regarding drivers of dissatisfaction with physical health care, behavioral health care and care coordination and included: lack of health plan explanation of both health care benefits and choices of doctors; and lack of timely access to general physical and behavioral health providers and specialists.

In order to improve member satisfaction among the pediatric behavioral health population, it was recommended that interventions in the statewide collaborative PIP should take advantage of the insights shared in this study to address the following:

- Member education about their behavioral health benefits and choice of providers;
- Provider education consistent with guideline recommendations for medication management, counseling interventions and communication with the family to encourage family involvement in treatment decisions; and
- Health plan interventions to improve care coordination.

Two new topics selected for focused clinical studies in FY 2015 are: 1) Medically Fragile Children in Foster Care, and 2) Child Obesity.

*Medically Fragile Children in Foster Care – Relational Care Coordination and Health Care Utilization*

This study has two aims: 1) profile health care utilization among children in foster care for whom approval for a medically fragile designation has been obtained from DCBS Medical Support Section, and 2) identify gaps in care coordination and opportunities to improve the performance of the care coordination team (MCO care/case managers, DCBS social workers and nurse consultants with the Kentucky Commission for Children with Special Health Care Needs (CCSHCN). The health care utilization profile will link children in foster care who were identified by DCBS as medically fragile with their administrative claims/encounter data records for the study period of 7/1/2013–6/30/2014. Utilization overall and by MCO will be profiled for hospitalizations, ED visits, outpatient visits by PCP and specialties and dental visits for medically fragile children compared to all other children. A validated survey instrument, entitled “Relational Coordination Survey for Patient Care,”<sup>22</sup> will be modified and used to survey MCO care/case managers, DCBS social workers and CCSHCN nurse consultants.

*Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity Among the Kentucky Medicaid Managed Care Population*

This focused study will assess the implementation of recommendations for assessment, prevention and treatment of overweight and obesity among children in accordance with the expert committee guidelines<sup>23</sup> in order to identify gaps in care and highlight opportunities for improvement. Findings for this study will be derived from a medical record review of all outpatient visits to the member’s PCP during MY 2014 for a random sample of Kentucky MMC enrollees 2–18 years of age.

Overall, while the results of the clinical focused studies have been useful to the MCOs, they continue to urge DMS and the EQRO to consider the timing for making data requests from the plans and providers. The HEDIS® data collection period of late Spring to early Summer should be avoided when designing a medical record review study. During this period, providers are receiving many requests for HEDIS® related records and to add the additional burden of a focused study record request is problematic for many providers.

**State-MCO-EQRO Communication**

Communication and collaboration are important in fostering effective quality monitoring and improvement. On a regular basis and sometimes ad hoc, communication between the state, MCOs and the EQRO occurs in a variety of ways. Over the past year, DMS has made considerable effort to improve communications, as evidenced by:

- Data sharing between the state, EQRO and the MCOs which is made possible through the EQRO's FTP portal;
- Additions to the DMS website which now includes reports and data generated by all three branches of the Division of Program Quality and Outcomes and the EQRO;
- Workgroup to discuss MCO reporting requirements;
- Monthly MCO medical directors meetings led by DMS's medical director;
- Monthly encounter data meetings with MCOs, DMS, OATS and HP;
- Quarterly meetings with MCO Quality Services; Operations; EPSDT coordinators; Behavioral Health; and Information Technology (IT);
- Coordination and facilitation of numerous meetings and workgroups by the Disease and Case Management Branch, including:
  - Meetings with DBHDID) and DCBS to discuss issues and identify members in need of case management,
  - Meetings between DAIL and the MCOs to discuss the adult guardianship population,
  - Children's Health TAC for providers, DMS and MCOs to discuss policy and recommendations for policy change,
  - Oral Health Workgroup and the Dental TAC,
  - Kentucky Cancer Consortium and the Kentucky Colon Cancer Prevention Program, and
  - State Innovation Models (SIMs) project;
- EQRO-initiated periodic conference calls with each MCO to discuss PIP progress and problems. The EQRO provides technical assistance to MCOs both by phone and in scheduled training sessions.

QI calls were scheduled quarterly and included staff from DMS, the EQRO and the MCOs. The purpose of these calls was to share information related to quality. The MCOs were encouraged to contribute topics for the agenda and to actively participate on the calls, but the MCOs were reluctant to contribute to the discussion and/or share quality strategy with other MCOs. DMS and the EQRO discussed ways of improving MCO participation and decided to change from the quarterly QI calls to individual MCO quarterly quality meetings that include the MCO, EQRO and DMS. The first of these was held in July 2014. MCOs interviewed for this evaluation expressed a preference for the individual MCO meetings rather than the all-plan QI calls. It was commonly believed that more is accomplished during the individual MCO calls as the MCO feels more comfortable asking questions and sharing what could be considered trade secrets.

MCOs agreed that having an agenda prior to any meeting was necessary and encouraged the EQRO and DMS to solicit agenda topics from the MCOs prior to the meeting. Also, by knowing the agenda beforehand, DMS can make sure that the right people from the state are in attendance. For example, if provider enrollment is to be discussed, a representative from provider enrollment should be there to answer questions or if a policy issue is on the agenda, DMS leadership staff should be represented. There may also be some redundancy or crossover in topics for these meetings.

MCOs reported that there is a good working relationship between the state, MCOs and the EQRO. Input and feedback from the MCOs is often sought and both DMS and the EQRO are responsive to phone calls. The workgroup to discuss MCO reporting requirements was mentioned by each of the MCOs and was described as one of the more effective initiatives they've been involved in. During

interviews with the MCOs, a number of suggestions to improve communication and collaboration were discussed:

- The operational meeting and the IT meeting could be combined as one, since they are often discussing the same topics.
- More timely feedback from DMS regarding questions raised during the meetings/workgroups would be helpful.
- Telecommunications equipment used by DMS sometimes resulted in poor sound quality, making it difficult for an MCO to hear all the speakers from the state.

## Enhancing State Quality Improvement Initiatives

While Medicaid has long played an important role in the evolution of our nation's health care system, the years 2014 and 2015 demonstrate remarkable examples of significant change and transformation. With an improving economy over the past year, Medicaid programs across the country have focused on the many changes made possible by the ACA. Innovative delivery and payment system reforms are being implemented to improve access, quality and cost effectiveness. To achieve a reduction in the number of uninsured, states are expanding Medicaid eligibility and implementing new targeted enrollment strategies. As of November 6, 2014, 17 states have established state-based marketplace (SBM) health insurance models, including the state of Kentucky. Twenty-seven states are using the federally-facilitated marketplace (FFM) and another 7 states are working in partnership with the FFM<sup>24</sup>. Federal financial support made available through the ACA and new tools and technical assistance support through CMS have given states the ability to implement innovations and improvements in their Medicaid programs. In this section we will explore several of these key promising initiatives.

A review of other states' Quality Strategies further provides an opportunity to examine a range of different approaches to monitoring MMC quality and conducting quality improvement. This year's evaluation included a review of Quality Strategies from Georgia,<sup>25</sup> New Hampshire,<sup>26</sup> Pennsylvania,<sup>27</sup> Tennessee,<sup>28</sup> and Utah<sup>29</sup> (**Attachment A**).

## Enhanced Role for CMS<sup>30</sup>

The years 2013 and 2014 were exceedingly busy for both state governments and CMS as they focused on implementing new provisions of the ACA. Delivery system and payment reform initiatives have been taking form with support from CMS through guidance and technical assistance and funding opportunities. Final rules have been issued for implementing provisions of the ACA related to eligibility, enrollment, benefits and cost-sharing in Medicaid, Children's Health Insurance Program CHIP and the health insurance marketplace (HIM). The administration of the program has been modernized by moving from a paper-driven, process-intensive approach to more streamlined ways of doing business with states including streamlined state plan amendment submissions and a model, single streamlined Medicaid application. CMS has been collaborating with states as they determine how to best coordinate eligibility and enrollment with the HIM and has demonstrated a willingness to assist states in an effort to find coverage options that work for them.

CMS's Learning Collaborative (LC) initiative continues to engage states to work together to promote experimentation, to share implementation challenges and to learn from experts in the field. Collaborative focus areas included expanded coverage, FFM, data analytics, exchange innovators, value-based purchasing and the basic health program. The Medicaid and CHIP (MAC) LC State Toolbox was created to provide technical assistance and background materials and is available on the CMS website.<sup>31</sup> In 2014, CMS also launched a Quality Improvement Learning Series (QI201), which offered a ten-month learning program for 10 state teams focusing on maternal and/or infant health projects.

Many states have also participated in initiatives led by the CMS Innovation Center, either through grant funding and/or the State Innovation Models (SIM) Initiative. There have been two rounds of funding for SIMs. In the first round, 16 states participated in model design, 6 states received model test awards and 3 states received pre-test awards. Some of the many topics addressed in the approved models included bundled episode payments; coordinated care initiatives for enrollees with Medicare and Medicaid; enhanced health data collection and analytic capacity; care coordination; value-based purchasing; patient-centered medical homes; health homes; enhanced communication across the health care continuum; partnerships with hospitals, PCPs and local health and social services agencies; integration of long-term care and behavioral health services; appropriate services to "super-utilizers;" telemedicine services in rural areas; ACOs; enhanced HIT; adequate health care workforce; and promotion of wellness and healthy lifestyles. While Kentucky was not included in the SIM first round activity, the state did receive SIM funding for model design in the second round along with 20 other states. Stakeholder representatives from state agencies, providers, insurance companies, community mental health centers, residential health care facilities, federally qualified health centers, hospitals, public advocacy groups and members of the public participate in workgroups for payment reform, integrated and coordinated care, increased access, quality strategy and metrics, and HIT infrastructure.

With feedback received from states across the country, in July 2014, CMS started a new collaborative initiative, called the Medicaid Innovation Accelerator Program (IAP). The IAP is intended to help states accelerate their development and testing of new payment and service delivery models and provide infrastructure and resources to address common challenges such as data analytics, quality and performance measurement. The first topic area to be addressed through the IAP is "Reducing Substance Use Disorders."

One final note regarding the enhanced role of CMS is evident in their updated website<sup>32</sup>: the Medicaid.gov website launched a new section to focus on state Medicaid programs and how they are moving forward in 2014. A comprehensive profile of each state's Medicaid and CHIP managed care programs is provided including implementation activities, statutory authorities, enrollment and populations served, quality measurement, accreditation requirements and public release of reports. The site provides a great reference resource for state administrators with information regarding CMS activities under the ACA as described in this report as well as updated specific state activities and would be a good site to bookmark and refer to often.

## Expanded Eligibility

Following a Supreme Court ruling on the ACA's constitutionality, states have an option to expand eligibility to nearly all low-income adults with incomes at or below 138% of the federal poverty level (FPL), which is approximately \$16,242 per year for an individual in 2015. As of February 2015, 29 states (including the District of Columbia) are implementing expansion. Twenty-four states, including Kentucky, have adopted the Medicaid expansion as set forth by law, while five states (Arkansas, Iowa, Michigan, Pennsylvania and Indiana) have received approval of a Section 1115 waiver to implement expansion in ways that do not meet the federal rules, but will still allow them to receive enhanced federal matching funds for newly eligible adults. Tennessee and Utah have waiver proposals pending or in development as of early 2015.

Regardless of a state's decision to expand Medicaid enrollment, all states are required to streamline Medicaid enrollment and renewal processes, transition to a uniform income eligibility standard (referred to as modified adjusted gross income [MAGI]), and coordinate with FFM. Many states have adopted one or more of the five targeted enrollment strategies identified:

1. Early adoption of MAGI-based rules (15 states);
2. Delayed renewals and date of completion (36 states);
3. "Fast Track" enrollment through administrative data transfers from other programs (7 states all using Supplemental Nutrition Assistance Program SNAP transfers);
4. Enrollment of parents based on children's eligibility (4 states); and
5. Adoption of 12 months of continuous eligibility for parents and other adults (0 states).

The state of Kentucky was approved in June 2014 to implement strategy #2 so that renewals that would otherwise occur during the first quarter of the calendar year would occur later. While this was the most common strategy chosen by states, there were several states that implemented more than one strategy. New Jersey, Oregon, and West Virginia were approved for the first 4 strategies; Illinois was approved for the first 3 strategies and California was approved for strategies 2, 3 and 4.

## Payment and System Delivery Reform

As evidenced by the models being designed and tested by states in the SIMs Initiative, many states are growing increasingly interested in new approaches for payment and delivery system reform. Integration and collaboration play a major role in many of the new approaches. As described by a Kaiser Family Foundation report, these emerging models seek to align payment and delivery systems to reward quality and promote more integrated care and include initiatives to coordinate physical and behavioral health care, coordinate acute and long-term care or enhance care management by targeting persons with multiple chronic conditions.<sup>33</sup> Another key factor in all the SIM initiatives is the modeling of several approaches to work together to achieve the desired results. This section highlights several components for payment and delivery reform that are being implemented by states and supported by CMS.

## *Payment Models*

Value-based purchasing (VBP) is defined as a broad set of performance-related payment strategies that link financial incentives to provider performance on a set of defined metrics. Several of these strategies, such as pay-for-performance (P4P), shared savings, bundled payments and ACOs have been used in different provider settings.<sup>34</sup> These reimbursement methodologies are being adopted to incentivize improved quality and outcomes and to reduce costs. Components of a value-based program design includes clear program goals, defined measures of performance and a financial incentive structure that defines criteria providers must meet to receive incentives and includes a methodology for calculating incentive payments. According to the Kaiser Family Foundation's 50-state survey of Medicaid programs, 34 states were adding or enhancing P4P programs in fiscal year (FY) 2014 or 2015.<sup>35</sup> Of the quality strategies reviewed for this report, some form of performance-related payment strategy was being implemented in New Hampshire, Pennsylvania, Tennessee and Utah. In New Hampshire, MCOs are required to implement a payment reform strategy. One percent of the capitation payment is withheld and can be recouped when payment reform strategy milestones are implemented.

Many state Medicaid programs across the country have implemented, or are considering implementing, some form of P4P incentives as part of their state quality strategies; however, as noted in the RAND Corporation report "Measuring Success in Health Care Value-Based Purchasing Programs," there is a substantial gap in the knowledge base about what has been learned regarding design and implementation in large P4P programs. The RAND study technical advisory panel identified five features that can influence the success of VBP programs and thus should be considered when designing an incentive plan:<sup>36</sup>

1. The incentive payment should be large enough to compensate providers for the effort.
2. Measure selection should give all providers a clear statement of what is important.
3. Providers should be involved in the design and implementation planning.
4. Performance targets and methodology used to calculate rewards should be based on both achievement and improvement.
5. Data and other quality improvement support should be made available, such as use of HIT and data registries.

Another emerging payment reform initiative is referred to as "episode-of-care" or "bundled payments." Unlike fee-for-service (FFS) reimbursement, where providers are paid separately for each service, or capitation where payment is on a per-member-per-month basis, an episode-of-care payment encompasses the care that the member receives through a course of treatment for a specific illness or medical event such as total hip replacement, pregnancy and delivery or heart attack. In a 50-state survey of state Medicaid programs in 2014, the Kaiser Family Foundation reported that Arkansas and Tennessee had an episode-of-care initiative in place in FY 2013 and FY 2014 with plans to expand in FY 2015. Five other states (Arizona, New Mexico, Ohio, Pennsylvania and South Carolina) planned to implement an episode-of-care program in FY 2015<sup>37</sup> and a number of other states have included episode-of-care programs in their SIMs.

The state of Kentucky is currently developing a quality incentive program for MCOs to be incorporated in the new MCO Model Contract. While still under development, it is likely to involve a

capitation withhold with incentives based on HEDIS® performance. The MCOs expressed mixed opinions regarding the implementation of a performance-based incentive in Kentucky. They were all aware of its development and supported an incentive in concept, but reserved any in-depth comment until a final version was presented.

### *System Delivery Reform*

Most state Medicaid programs are using MCOs to provide access, improve quality and achieve cost efficiency. By July 2014, all states, except three (Alaska, Connecticut and Wyoming), had some form of managed care in place, but 30 states reported other delivery system reform efforts underway in FY 2014 and as many as 40 states had delivery system activities planned for FY 2015. Other reform initiatives planned for implementation or expansion for FY 2015 included:<sup>38</sup>

- Medicaid Health Homes (26 states);
- Patient Centered Medical Homes (20 states);
- Coordination of Care for Dual Eligibles (19 states);
- Accountable Care Organizations (10 states); and
- Hospital Delivery System Reform Incentive Payment (DSRIP) Program (9 states).

Kentucky did not report plans to implement any of the above-listed reform initiatives.

## Strengths and Opportunities for Improvement

The strengths and opportunities for improvement for Kentucky's MMC Program are presented in this section as a culmination of this comprehensive evaluation summary. The Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services (September 2012) was the basis for this evaluation of program accountability, monitoring mechanisms and compliance assessment systems.

### Strengths

#### *Program Administration*

- The Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services was approved by CMS in September, 2012 and included all required elements, adequately described.
- Kentucky has a contract in place for external quality review, including work plan activities for the annual technical report, the three mandatory quality review activities and several optional activities, such as conducting focused clinical studies, validation of encounter data and provider network data.
- With several new staff positions created and filled within the Division of Program Quality and Outcomes, including staff focusing on encounter data systems and case management, the state has vigorously applied new staff resources and expertise to the development of their expanding MMC Program thus providing needed direction and cohesiveness for the program moving forward.
- All required data collection systems are in place and data submissions are occurring according to schedule.
- DMS has enhanced their internet website to include MCO data reports and external quality review reports.

#### *Goals and Benchmarks*

- The core program goals, as described in the state's Quality Strategy, cover aspects of managed care quality and access compared to standardized national benchmarks.
- HEDIS® 2014 measure results compare favorably with national benchmarks with as many as seventeen (17) measures meeting or exceeding the benchmark and another four (4) measures within five percentage points of the targeted national benchmark.

#### *Quality Monitoring and Assessment*

- Kentucky's MMC Program is composed of five MCOs. The total enrolled population served has increased by 19% from 989,197 (April 2014) to 1,174,716 (April 2015). The state of Kentucky was approved in June 2014 to implement an expanded eligibility to allow renewals that would otherwise occur during the first quarter of the calendar year to occur later.
- In an effort to streamline reporting requirements, DMS convened a workgroup to review and make changes to the reports MCOs are required to submit monthly, quarterly and annually.
- An annual health plan report card entitled "A Member's Guide to Choosing a Medicaid Health Plan" was prepared for 2014 open enrollment. It was also posted on the DMS website.

- Using HEDIS® 2014 data, the EQRO prepared a Quality Performance Dashboard as an internal monitoring tool for DMS.
- DMS prepares a monthly MCO Dashboard using data submitted in MCO monthly reports.
- EQRO monitoring is evident in timely, well written MCO compliance reviews, monthly encounter data validation reports, provider network validations, MCO web-based provider directory validations and quality performance validations.
- All four MCOs showed evidence of providing a sufficient network of EPSDT providers. MCOs continue to implement a variety of initiatives to improve EPSDT screening, including educating and outreaching to members, educating providers and facilitating EPSDT service through several innovative member outreach efforts, such as promoting EPSDT services at schools, meetings with grandparents raising grandchildren and homeless advocacy groups.
- The annual technical report meets federal regulations and provides a useful summary of external quality review findings related to access, timeliness and quality of care.
- There are excellent lines of communication between the state, EQRO and the MCOs. Using quarterly in-person meetings and conference calls, DMS has facilitated numerous workgroups and regularly scheduled meetings to discuss program progress and resolve issues.

### *Quality Improvement*

- The EQRO effectively validates MCO PIPs using an established process that includes proposal review, ongoing progress, re-measurement and final report. Close communication between the MCOs and the EQRO is a critical component of the process.
- A collaborative statewide PIP was initiated in 2014, entitled “Safe and Judicious Antipsychotic Medication Use in Children and Adolescents.” MCOs are preparing barrier analyses and developing interventions with the assistance of collaborating partners including the EQRO and Uof L.
- Two recently completed focused clinical studies provide valuable insight for the state and MCOs regarding behavioral health in Kentucky.
- Kentucky requires all MCOs to become NCQA accredited, which encourages MCOs to aspire to a higher national standard and offers the opportunity to streamline compliance review requirements based on federal deeming guidelines. Currently three of the five MCOs have obtained accreditation.

## **Opportunities for Improvement**

### *Program Administration*

- Kentucky’s Quality Strategy is due to be updated. DMS plans to update the Quality Strategy to reflect the kyhealthnow 2019 goals. A date for completing the update has not been set.
- Coordination opportunities still exist between DMS, the MCOs and other state agencies, including DCBS, DAIL and DBHDID to address and improve care coordination for foster children, aged members and individual with behavioral health, developmental and intellectual disabilities.
- MCO efforts to improve encounter data completeness and accuracy could be enhanced by receiving the EQRO’s monthly encounter data validation reports.

- The overall framework of the DMS website is cumbersome and difficult to navigate. A web page redesign could be considered to improve navigation. The Kentucky MMC page (<http://medicaidmc.ky.gov/Pages/index.aspx>) requires updating.

#### *Goals and Benchmarks*

- Kentucky's Quality Strategy could be strengthened by adding goals for prenatal/postpartum care and childhood preventive health. Additional measures related to kyhealthnow 2019 goals would include enrollment growth, smoking cessation, cardiovascular care, overweight and obesity for children and adults, substance abuse, poor mental health and dental care for children and adults.
- After two years of HEDIS® data (with the 2014 submission), a review of benchmarks may be warranted to adjust for measures with baseline rates already above the national benchmark. A more recent benchmarking year could be selected.
- Opportunities for improvement are identified, based on a substantial difference between the Kentucky statewide aggregate HEDIS® 2014 rate and the 2012 national Medicaid benchmark for the following measures:
  - Cervical Cancer Screening,
  - Comprehensive Diabetes Care: Eye Exam Performed,
  - Cholesterol Management – LDL-C Screening and LDL-C Control (< 100 mg/dL), and
  - Follow-up After Hospitalization for Mental Illness within 30 days and within 7 days of Discharge.

#### *Quality Monitoring and Assessment*

- The data presented in the annual technical report is not for consistent time periods. The state could consider changing the timing for the completion of the annual technical report so that data presented is closer to the same time period.
- Quality monitoring and assessment efforts by the MCOs could benefit by having access to the EQRO-developed Quality Performance Dashboard.
- Results of the statewide access and availability survey for behavioral health providers indicated that appointments could be made within 60 days for only 10.3% of the providers contacted, which is far lower than the contract standard of 80%. Limitations in the application of this methodology need to be reconsidered when surveying access to behavioral health providers.
- Reported participation rates for EPSDT services were below 80%. Results of the EPSDT validation study and HEDIS® and Healthy Kentuckians measures indicated opportunities for improvement in mental health, vision, hearing and developmental screening; depression and behavioral risk screening for adolescents; BMI screening and nutrition/physical activity counseling; immunizations; and lead screening.
- Opportunities to improve communication at meetings and workgroups include soliciting meeting participants for questions and suggested agenda items; preparing an agenda; having appropriate state staff in attendance to discuss and answer questions regarding agenda items; and timely responses from DMS for questions raised.

#### *Quality Improvement*

- MCOs expressed concern about the quantity of PIPs that are ongoing at any one time (as many as four to six), which places a burden on MCO resources and may result in fewer or less aggressive interventions.
- The state has an opportunity to use the statewide collaborative PIP to foster sharing between the MCOs through all-plan conference calls or in-person meetings and learning sessions with experts in the field of behavioral health and antipsychotic medication use by children and adolescents.
- Behavioral health focused studies conducted in 2014 suggest several opportunities for improvement for enhancing care management to susceptible subpopulations based on risk; identifying and sharing best practices among providers; evaluating access to follow-up visits; offering continuing education to providers on clinical guidelines; collaborating with providers to screen for substance abuse and depression; considering new quality performance measures for 2015; and implementing evidence-based interventions in PIPs that target identified behavioral health problem areas.
- To improve member satisfaction among the pediatric behavioral health population, MCOs could consider interventions to educate members about their behavioral health benefits and choice of providers; to improve provider education through interventions to promote communication with the family and encourage family involvement in treatment decisions; and to improve care management for behavioral health.
- QI initiatives used in other states such as taking advantage of the many learning and funding opportunities offered by CMS, initiating VBP or system delivery reform may be of interest to DMS going forward. This report and the previous evaluation cite numerous initiatives from states across the country and provide website links to learn more. Contacting MMC staff in other states could be informative and could provide valuable insight.

## Recommendations

- The Kentucky Quality Strategy should be updated. DMS should consider adding goals and objectives for childhood preventive health and prenatal/postpartum care and should re-evaluate how benchmarks or other targets for improvement can be applied. DMS should include measures in their updated Quality Strategy that address kyhealthnow 2019 goals.
- In collaboration with the EQRO and Uof L, DMS should enhance the statewide collaborative PIP by working with the EQRO to schedule several all-plan conference calls and learning sessions with experts in the field of behavioral health and antipsychotic medication use by children and adolescents. MCOs should be encouraged to engage partners to conduct their interventions. Collaborating partners could include other MCOs, community-based organizations or national organizations that focus on child and adolescent behavioral health.
- DMS needs to continue to collaborate with MCOs in the review of program monitoring and reporting requirements and include a revised schedule of reports effective for the new MCO Model Contract.
- DMS should expand the use of the MCO Quality Dashboard developed by the EQRO as an internal monitoring tool for DMS to a more public version beginning with the HEDIS® 2015 results. This tool will promote quality improvement through publication of each MCO's HEDIS® results compared to other Kentucky MCOs, to statewide averages and to national

benchmarks. Trends over time should also be presented. So as not to be confused with the MCO Dashboard prepared by DMS, the name of this report should be changed to reflect its content and most recent year of the data.

## Attachment A

Table A1. Quality Strategy Initiatives in Other States

State (Program Name)	Year of Strategy	Medicaid Agency	Medicaid and CHIP Enrollment 12/2014 <sup>1</sup>	Quality Strategy Initiatives
Georgia <sup>2</sup> (Georgia Families)	11/2011	Georgia Department of Health, Department of Community Health (DCH)	1,738,810	<ul style="list-style-type: none"> <li>• Three Medicaid MCOs referred to as <b>Care Management Organizations (CMOs)</b></li> <li>• Each CMO conducts <b>9 PIPs during year</b>; all CMOs do the same PIP topics selected by the state, but not all are collaborative</li> <li>• <b>Cross-State Collaborations</b> include: <ul style="list-style-type: none"> <li>- Collaborative PIP topics: “Well-Child Visits During First 15 Months” and “Avoidable ER Use”</li> <li>- Development of standardized case and disease management reports</li> <li>- Adoption of same clinical practice guideline for Diabetes Care and Child and Adolescent Obesity</li> <li>- Strategic Quality Council – state agencies and CMOs partnership to prevent cardiovascular deaths</li> <li>- Improving Birth Outcomes Workgroup – 1115 Demonstration</li> </ul> </li> <li>• <b>Quality-based auto-assignment</b></li> <li>• Focus on complete and accurate encounter data</li> </ul>
New Hampshire <sup>3</sup> (NH Medicaid Care Management Program)	8/2014	Dept. of Health and Human Services (DHHS)	167,330	<ul style="list-style-type: none"> <li>• Three MCOs</li> <li>• Required to conduct <b>4 Quality Incentive Projects (QIPs) of the state’s choosing and 4 PIPs of the MCOs’ choosing</b></li> <li>• QIPs – MCOs given performance thresholds and must report semi-annually on progress in meeting targets</li> <li>• <b>NCQA accreditation required</b></li> <li>• <b>NH Medicaid Quality Indicators</b> – new initiative, selected population-based measures publicly available on NH Medicaid Quality Indicator website – user driven, MCO comparisons</li> <li>• MCOs required to implement <b>payment reform strategies</b> – withhold of 1%</li> </ul>

State (Program Name)	Year of Strategy	Medicaid Agency	Medicaid and CHIP Enrollment 12/2014 <sup>1</sup>	Quality Strategy Initiatives
				<p>of total capitation payment can be recouped when implementation milestones are achieved</p> <ul style="list-style-type: none"> <li>• <b>CMS Adult Medicaid Quality Grant</b> – CMS Adult and Pediatric Program</li> <li>• Participant in second round, <b>SIM</b> – Model Design Award</li> </ul>
Pennsylvania <sup>4</sup> (HealthChoices)	2014	Office of Medical Assistance (OMAP)	2,403,656	<ul style="list-style-type: none"> <li>• <b>Ten physical health MCOs (PH-MCOs) and five behavioral health organizations (BH-MCOs)</b></li> <li>• <b>VBP Program</b> sets 2 goals: <ul style="list-style-type: none"> <li>- Improve access to pediatric dental services by 10 percentage points over 5 years</li> <li>- Reduce unnecessary hospitalizations by 1 percentage point over time</li> <li>- <b>Two PIPs</b> required using VBP goals as topics</li> </ul> </li> <li>• PH-MCOs required to implement <b>Community-Based Care Management</b> Programs that include face-to-face encounters with members in need of more focused outreach</li> <li>• <b>P4P</b> for 2015 is based on 7 HEDIS® rates and 1 PA PM encompassing chronic care, preventive and early detection, prenatal care and utilization. P4P payout structure based on PH-MCO meeting designated benchmarks for the measures. Additional opportunity to reward for incremental improvement performance. Offset penalty applied for performance that does not meet the benchmarks</li> <li>• PH-MCOs must offer a <b>Provider P4P</b> Program using same measures. In addition, PH-MCOs are encouraged to incent providers who electronically extract and submit data for quality measures</li> <li>• <b>Obstetrical Needs Assessment Form (ONAF)</b><sup>5</sup> providers are encouraged to submit completed form to PH-MCOs to facilitate member enrollment in appropriate MCO maternity program as early as possible. The form is also used to capture obstetrics-related HEDIS® and P4P data.</li> <li>• Physical health and behavioral health MCOs are coordinating and sharing data for their common PIP topic, “unnecessary hospitalizations.” A</li> </ul>

State (Program Name)	Year of Strategy	Medicaid Agency	Medicaid and CHIP Enrollment 12/2014 <sup>1</sup>	Quality Strategy Initiatives
				<p>bidirectional information exchange was implemented to share behavioral health claims (from the BH-MCOs) and pharmacy encounters from the PH-MCOs.</p> <ul style="list-style-type: none"> <li>• Participates in <b>CMS’ SIM Initiative</b> for developing and testing innovative models for payment and health care delivery transformation</li> </ul>
Tennessee <sup>6</sup> (TennCare Medicaid)	2014	Bureau of TennCare	1,417,954	<ul style="list-style-type: none"> <li>• <b>Three MCOs</b>; state also operates a Prepaid Inpatient Health Plan (PIHP), for children who are in foster care, receive Supplemental Security Income (SSI), or receive care in particular institutional settings</li> <li>• <b>NCQA accreditation required</b></li> <li>• <b>Two clinical (behavioral health and child health or perinatal care) and 3 non-clinical PIPs</b> (2 must be on long-term services and supports) required annually</li> <li>• Child Health Focus Study beginning in 2014 – BMI topic</li> <li>• Other chart review studies: Abortion, Sterilization and Hysterectomy medical record reviews; Long-Term Services and Supports chart reviews; and quarterly chart reviews for coordination of benefits for members in an MCO, and home and community-based services</li> <li>• <b>Coordination of care program for enrollees with Medicare and Medicaid</b></li> <li>• Quarterly provider data validation study</li> <li>• <b>Collaborative workgroups:</b> <ul style="list-style-type: none"> <li>- Collaborated with Department of Mental Health and Substance Abuse Services, U.S. Drug Enforcement Administration, TN Bureau of Investigation and state agencies of Health, Safety and Homeland Security, Corrections and Children’s Services to prepare report: Prescription for Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee</li> <li>- EPSDT collaborative meetings (including publication of Teen Newsletter); Prenatal and Postpartum Collaborative Workgroup, Children and Youth Continuum Workgroup; and Children’s Special Workgroup (issues related to foster care)</li> </ul> </li> </ul>

State (Program Name)	Year of Strategy	Medicaid Agency	Medicaid and CHIP Enrollment 12/2014 <sup>1</sup>	Quality Strategy Initiatives
				<ul style="list-style-type: none"> <li>- MCO Diabetes Collaborative expanded to include support for obesity, heart attack and stroke initiatives</li> <li>- Emergency Department Utilization Workgroup initiated in 2014</li> <li>• <b>P4P</b> – quality incentive payments, 18 MCO-specific selected HEDIS® measures with greatest need for improvement</li> <li>• Annual Quality Awards to MCOs based on performance, best practices and outstanding initiatives</li> <li>• <b>Redesigned Disease Management Program</b> to a more comprehensive Population Health model</li> </ul>
Utah <sup>7</sup>	2014	Utah Dept. of Health Division of Medicaid and Health Financing (DMHF)	291,889	<ul style="list-style-type: none"> <li>• <b>Four ACOs</b> provide physical health services – full-risk capitation. Other services provided through mental health plans, dental plans and one Medicaid mental and physical health plan (H.O.M.E) Enrollment from urban counties primarily</li> <li>• <b>Quality Improvement Council (QIC)</b>, made up of internal and external stakeholders, established performance targets for 25 HEDIS® and CAHPS® measures</li> <li>• Evaluating incentive programs such as quality auto-assignment and capitation withholds to drive quality improvement</li> <li>• NCQA or URAC accreditation standard reviews deemed applicable</li> <li>• ACOs required to conduct clinical and non-clinical PIPs</li> <li>• <b>Restriction Program</b> to identify inappropriate and excessive use of Medicaid services. Members are identified and placed in the program based on criteria for inappropriate or excessive use of PCPs, pharmacies, prescriptions for abuse potential medications, or ED services. Members in the program must use a PCP who participates in the program who will provide primary care medical services and case management.</li> <li>• Participates in <b>CMS’ SIM Initiative</b> for developing and testing innovative models for payment and health care delivery transformation. Utah innovation plan focuses on behavioral health integration, geriatric advance care planning, diabetes and obesity reduction and value-based financing</li> </ul>

State (Program Name)	Year of Strategy	Medicaid Agency	Medicaid and CHIP Enrollment 12/2014 <sup>1</sup>	Quality Strategy Initiatives
				strategies. <ul style="list-style-type: none"> <li>• <b>Children’s Healthcare Improvement Collaborative (CHIC)</b> with Idaho to improve outcomes for children with special health care needs</li> <li>• Medicaid and CHIP members automatically enrolled in a <b>Clinical Health Information Exchange (CHIE)</b> – information shared among 4 major health care systems, large clinics, rural hospitals and independent MD practices</li> </ul>

<sup>1</sup>Source: Centers for Medicare and Medicaid Services, accessed 2/26/2015. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html>

<sup>2</sup>[http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit\\_1210/1/1/180496026QSP\\_Update\\_for\\_November\\_2011\\_12-08-11\\_FINAL.pdf](http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/1/1/180496026QSP_Update_for_November_2011_12-08-11_FINAL.pdf)

<sup>3</sup><http://governor.nh.gov/commissions-task-forces/medicaid-care/documents/mm-09-05-2013-medicaid-quality-strategy.pdf>

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<sup>6</sup><http://www.tn.gov/tenncare/forms/qualitystrategy.pdf>

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