

MAC Binder Section 7 – Audits

Table of Contents with Document Summary

Located online at <http://chfs.ky.gov/dms/mac.htm>

1 – KY Medicaid Managed Care EPSDT 2013 Review FINAL_Dec2014:

Kentucky Department for Medicaid Services (DMS) contracted with IPRO to validate that the Managed Care Organizations' administration of EPSDT benefits is consistent with federal and state requirements and expectations. EPSDT programs for each of the four KY Medicaid MCOs participating in 2013 were evaluated, including CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan, and WellCare of Kentucky.

2 – IPRO Validation of Managed Care Provider Network Submissions FINAL_Feb2015:

In October 2014, IPRO, on behalf of the Kentucky Department for Medicaid Services (DMS), conducted its third audit of the Managed Care Assignment Processing System (MCAPS) to validate its accuracy.

Data validation surveys were sent to 100 primary care providers (PCPs) and 100 specialists from the five MCOs. The overall response rate was 62.5%. PCPs responded at a higher rate than specialists, with rates of 67.7% and 57.1%, respectively. The response rates also varied by MCO: ranging from 52.2% for CoventryCares of Kentucky to 70.7% for Anthem Blue Cross Blue Shield. After removing exclusions, 497 providers were available for analysis.

3 – KY Medicaid MC Performance Measures 2014 Validation FINAL_Feb2015:

During calendar year (CY) 2013, under contract to the DMS, four (4) MCOs provided services to Medicaid recipients in Kentucky: CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky. The MCOs were accountable for all covered health services for their members, except long term care and waiver services. These services were carved out to Fee-for-Service (FFS) Medicaid. Kentucky Spirit Health Plan is not included in this report because it withdrew from the Kentucky Medicaid program in July 2013.

As required by Federal Medicaid external quality review (EQR) regulations and requirements, under contract with DMS as the external quality review organization (EQRO), IPRO was tasked with validating the reliability and validity of the MCOs' reported PM rates. The purpose of the validation was to:

- Evaluate the accuracy of the Medicaid PMs reported by the MCOs; and
- Determine the extent to which the Medicaid-specific PMs calculated by the MCOs followed the specifications established by DMS.

This report summarizes the validation activities and findings for the PM rates for the measurement year (MY) 2013 reported by the MCOs in 2014. In addition, IPRO has included recommendations for the reporting year (RY) 2015 and future PM sets.



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

**Kentucky Medicaid Managed Care Early Periodic
Screening, Diagnostic and Treatment Services
(EPSDT) Review of 2013**

Final December 2014

IPRO Corporate Headquarters
Managed Care Department
1979 Marcus Avenue
Lake Success, NY 11042-1002
phone: (516) 326-7767
fax: (516) 326-6177
www.ipro.org

Table of Contents

INTRODUCTION.....	4
Background	4
Purpose	4
Data Sources	5
MEMBER EDUCATION AND OUTREACH.....	8
EPSDT Benefits, Importance and Access to Services.....	8
Right to Appeal EPSDT Service Determinations	10
PROVIDER NETWORK	11
EPSDT Providers	11
EPSDT Provider Education.....	12
Monitoring of EPSDT Provider Compliance with Required EPSDT Services	13
ACCESS TO EPSDT SERVICES	15
EPSDT Screening and Participation	15
EPSDT-Relevant HEDIS® Measures	17
Healthy Kentuckians Measures.....	20
EPSDT Encounter Data Validation Study.....	24
EPSDT Special Services	26
MONITORING AND FACILITATION OF RECEIPT OF EPSDT SERVICES.....	28
Member Monitoring for Receipt of EPSDT Services.....	28
Outreach for Members Overdue for EPSDT Services.....	29
EPSDT Case Management Function	31
PHYSICAL HEALTH/BEHAVIORAL HEALTH COORDINATION.....	33
QUALITY MEASUREMENT AND IMPROVEMENT	34
MEMBER SATISFACTION WITH EPSDT SERVICES	35
CONCLUSION.....	36
Limitations.....	37
RECOMMENDATIONS.....	38
Recommendations for MCOs.....	38
Recommendations for DMS	38
REFERENCES.....	39

List of Tables

Table 1. EPSDT Screening and Participation Rates Reported by Kentucky MCOs (RY 2013)	16
Table 2. EPSDT Screening and Participation Rates by Age Group Across MCOs (RY 2013)	16
Table 3. Kentucky MCO HEDIS [®] 2013 Quality Measure Rates Relative to the 2013 National Medicaid Average (RY 2013).....	18
Table 4. EPSDT-Relevant Healthy Kentuckians Performance Measures (RY 2013)	21
Table 5. Child and Adolescent Individuals with Special Health Care Needs (ISHCN) Access and Preventive Care (RY 2013)	23
Table 6. Documentation of Comprehensive History and Physical Exam	24
Table 7. Documentation of Oral, Mental, Developmental and Behavioral Assessments	25
Table 8. Documentation of Anticipatory Guidance	26

Introduction

Background

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services is a federally mandated health program that provides comprehensive and preventive health care services for children and adolescents up to age 21 who are enrolled in Medicaid. EPSDT services are designed to ensure early identification of conditions that can impede children's health and development, and provide for the diagnosis and treatment of physical and mental health conditions in order to improve health outcomes.ⁱ In addition to a comprehensive health and developmental history, with assessments of both physical and mental health and development, EPSDT services include a comprehensive medical exam, vision, hearing, and dental services, age-appropriate immunizations, laboratory tests including blood lead testing, health education, and anticipatory guidance covering topics such as child development, healthy lifestyles and accident and injury prevention.ⁱⁱ The Centers for Medicare & Medicaid Services (CMS) guidelines for state Medicaid programs include informing eligible children and adolescents of available services, as well as providing or arranging for screening and necessary corrective treatment.ⁱⁱⁱ States have the option to either administer the EPSDT benefit outright or provide oversight to contracted entities that administer the benefit for them, such as managed care entities.^{iv} In Kentucky, Medicaid managed care organizations (MCOs) administer the EPSDT benefit for children and adolescents enrolled in Medicaid managed care (MMC), with oversight by the Kentucky Department for Medicaid Services (DMS).

Purpose

DMS has contracted with Island Peer Review Organization (IPRO), the Kentucky External Quality Review Organization (EQRO), to validate that the MCOs' administration of EPSDT benefits is consistent with federal and state requirements and expectations. This report provides an assessment of Kentucky Medicaid MCOs' activities to ensure that their eligible enrollees receive:

- Education and outreach regarding EPSDT services, and
- Access to comprehensive EPSDT services, including authorization of medically necessary services.

In addition, the MCOs' EPSDT programs were evaluated for:

- EPSDT provider network,
- EPSDT provider training and monitoring,
- Case management for EPSDT-eligible members,
- Physical health and behavioral health coordination,
- Quality measurement and improvement activities, and
- Member satisfaction.

EPSDT programs for each of the four Kentucky Medicaid MCOs participating in 2013 were evaluated, including CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan, and WellCare of Kentucky. The fifth

Kentucky Medicaid MCO, Anthem Blue Cross and Blue Shield, did not begin enrolling child and adolescent members until July 1, 2014, and therefore this MCO was not included in this evaluation.

Data Sources

2013 data and documents received by the end of the first quarter 2014 were included in this evaluation. Key data sources for this comprehensive evaluation of EPSDT services included the following:

- The 2014 EQRO Annual Compliance Review;
- Activities and metrics relevant to EPSDT services reported by MCOs in their 2013 statutory reports to DMS;
- The 2013 EPSDT Encounter Data Validation Study conducted by IPRO on behalf of DMS; and
- The 2013 Healthcare Effectiveness Data and Information Set (HEDIS®) performance measure rates reported in the MCOs' 2013 HEDIS® Audit Review Tables (Measurement Year [MY] 2012) and Healthy Kentuckians performance measure rates reported as part of the MCOs' 2013 (MY 2012) Kentucky Performance Measure Validation submission in Attachment B, a Microsoft Excel spreadsheet that includes numerators, denominators and rates for the Healthy Kentuckians measures.

These key data sources are described below:

1. The 2014 EQRO Annual Compliance Review: The EQRO conducts an annual review of MCO compliance with federal and state contractual requirements on behalf of DMS. The 2014 Annual Compliance Review was an assessment of MCO compliance with requirements for MY 2013. The review included an evaluation of MCO processes, policies and procedures, file reviews and onsite interviews. For Kentucky, EPSDT contractual requirements are specifically reviewed, and other areas that have some relevance to EPSDT are also reviewed. Relevant review areas in the 2014 Annual Compliance Review considered for this report included:
 - EPSDT,
 - Enrollee Rights,
 - Quality Assessment and Performance Improvement: Access,
 - Quality Assessment and Performance Improvement: Measurement and Improvement,
 - Case Management/Care Coordination, including a review of case management files,
 - Grievance Systems, including a review of children's service denials and appeals files, and
 - Behavioral Health Services.

A determination of level of compliance is reported for each contract element in the Annual Compliance Review. In some cases, if the MCO was found to be fully compliant with a particular requirement on the 2013 Annual Compliance Review, the requirement was not reviewed for the 2014 Annual Compliance Review. Annual Compliance Review levels of compliance determinations included:

- Full compliance: met or exceeded requirements;
 - Substantial compliance: met most requirements, but may be deficient in a small number of areas;
 - Minimal compliance: met some requirements, but has significant deficiencies requiring corrective action; and
 - Non-Compliance: has not met element requirements.
2. Kentucky Statutory Reports 2013: Kentucky Medicaid MCOs are required to submit statutory reports on a monthly, quarterly and annual basis. In the 2014 Annual Compliance Review, all four MCOs were found to be fully compliant with submission of EPSDT-related reports. Statutory reports relevant to EPSDT services included:
- Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, which documents quarterly activities for EPSDT outreach, education and case management, as well as EPSDT screening rates;
 - Annual Report #93, EPSDT Annual Participation Report, which documents EPSDT screening and participation ratios for eligible MCO members as reported on CMS Form CMS-416;
 - Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan, which outlines the scope of activities, goals, objectives and timelines for the plan's Quality Assessment and Performance Improvement (QAPI) Program, including activities related to EPSDT;
 - Annual Report #85, Quality Improvement Program Evaluation, which documents the MCO's assessment of the effectiveness of its Quality Improvement (QI) Program and opportunities for improvement;
 - Annual Report #94, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) – Medicaid Child Survey, which is a report of the results of the annual CAHPS® survey, which assesses consumer-reported experience of care, satisfaction and how well health plans are meeting member expectations and goals; and
 - Annual Report #86, Annual Outreach Plan, which provides an overview of member and community education and outreach activities, some of which may be related to EPSDT.
3. The 2013 EPSDT Encounter Data Validation Study: This study was conducted by IPRO on behalf of DMS and was comprised of a medical record review of well-child visits to validate encounter data codes relevant to the receipt of EPSDT screening of children enrolled in Kentucky Medicaid managed care. The study provided an overview of services provided during well-child visits relative to EPSDT recommended services.
4. The 2013 HEDIS® Final Audit Report and HEDIS® Audit Review Table and Attachment B of the Kentucky 2013 Performance Measure Validation submission: Kentucky Medicaid MCOs are required to report quality measures, including HEDIS® measures and Kentucky State-specific Healthy Kentuckians

measures, several of which are relevant to EPSDT. These quality measures were reported in the HEDIS® Final Audit Report, HEDIS® Audit Review Table and in Attachment B of the Kentucky Performance Measure Validation submission; the 2013 documents were reviewed for this report, reflecting MY 2012.

Member Education and Outreach

CMS guidelines for state Medicaid programs indicate that the provision of EPSDT services includes informing Medicaid-eligible children and adolescents under age 21 about available EPSDT services.^v Kentucky's Medicaid managed care (MMC) contractual requirements specify that eligible members and their families should receive education about EPSDT services regarding the benefit of preventive services, availability of screening and medically necessary services, the right to access these services, how to access services, and the right to appeal decisions related to EPSDT services. Information regarding MCOs' outreach and education of members eligible for EPSDT services is evaluated as part of the EQRO Annual Compliance Review, through review of policies and procedures, evaluation of member and provider educational initiatives and materials, and onsite staff interviews. Kentucky MCO Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, and Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan, also include documentation of member educational activities.

EPSDT Benefits, Importance and Access to Services

The 2014 Annual Compliance Review revealed that all four MCOs were fully compliant with federal and state contractual requirements for informing members about available EPSDT services, how to access them and the value of preventive services. Member education was conducted in a variety of formats, including member handbooks, mailings, telephonic outreach, presentation at community events, and home visits. Activities reported in the 2013 KY Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, also validate the provision of a variety of educational communications across all plans through member newsletters, brochures, reminder mailings, and member website postings. While all four MCOs included EPSDT service information in mailings, member handbooks and plan websites, some plans reported additional activities to educate members and families. Such activities included training all plan staff regarding EPSDT, proactive discussion of EPSDT services by care managers, an online library with topics related to EPSDT, promotion of EPSDT services in community settings such as Family Resource and Youth Service Centers (FRYSCs), child care centers, school-based health clinics, homeless advocate meetings, civic organizations and meetings, and events for grandparents raising grandchildren. One plan reported engaging providers to educate members regarding EPSDT services. MCO-specific findings regarding member educational initiatives are further described below.

In the 2013 Annual Compliance Review, WellCare of Kentucky and CoventryCares of Kentucky were found to be fully compliant with all requirements related to member education about available EPSDT services, the value of preventive services and accessing services, and were deemed compliant for these elements in 2014. Therefore, these contractual elements were not reviewed for WellCare of Kentucky and CoventryCares of Kentucky in the 2014 Annual Compliance Review.

WellCare of Kentucky's Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, documented the plan's educational outreach activities, which included reminder letters for required services, website postings, newsletters, and brochures and participation in community events. In 2013, the plan distributed EPSDT Well-Child Visit information and Immunization Growth Charts to EPSDT-eligible members' families. Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, also described the plan's system for generating automated reminders for EPSDT and dental visits based on age and claims data.

As per CoventryCares of Kentucky's Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, plan staff underwent EPSDT training, and case managers were educated to proactively discuss the importance of EPSDT screening with all members with children under age 21 years in 2013. The report also documented the MCO's mailing of reminders to schedule well-child and dental visits to enrollees on their birthdays. CoventryCares of Kentucky's Annual Report #86, Annual Outreach Plan, described the content of educational newsletters and brochures for 2013, which included recommended preventive health services, immunizations, and dental services. The Annual Outreach Plan also described CoventryCares of Kentucky's comprehensive online library, Kidshealth®, which includes medical, developmental and behavioral health related articles with interactive features and offerings in Spanish.

Humana-CareSource demonstrated full compliance for member education and outreach regarding EPSDT services in the 2014 Annual Compliance Review through information provided in the member handbook, Teen First and Children First member annual brochures and the online member portal, which included links to guidelines for preventive services. Humana-CareSource also documented EPSDT education and outreach activities in Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, which included member newsletter mailings related to EPSDT, the participation of care coordination staff in community child health events to promote preventive screenings and the promotion of EPSDT services at school-based health clinics. The EPSDT coordinator and care managers conducted direct outreach to members regarding EPSDT benefits and the value of preventive services, including outreach to children with special health care needs. Humana-CareSource also reported initiating a Provider Clinical Engagement Initiative in 2013, in which the MCO clinical staff works with providers to educate and engage members to facilitate their receipt of EPSDT services.

Passport Health Plan's 2014 Annual Compliance Review revealed full compliance with the provision of education about EPSDT services, with information provided in the member handbook, confirmation letters for members, member newsletters, an EPSDT-specific brochure, quarterly mailings and telephonic outreach to targeted members. Information provided included the availability of benefits, the value of preventive care, recommended age-appropriate preventive screening, and vision, hearing, dental and mental health services. Information regarding expanded EPSDT services, contacting member services for assistance and accessing care connectors for assistance in accessing services was also included in education materials. The plan demonstrated that information was provided to members at community events, and outlined an outreach program in Annual Report #86, Annual Outreach Plan, that included partnering with FRYSCs, child care centers, schools, and local and regional civic organizations to provide information to families. The plan's Community Affairs Department outreach efforts also included attendance at meetings and events for grandparents raising grandchildren and homeless advocate meetings to reach homeless families. Passport Health Plan's Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, documented outreach activities as well, and noted that the plan implemented on hold messages that educated members about EPSDT services in 2013. Passport Health Plan also engaged providers in outreach by indicating in their provider manual that providers' responsibility includes issuing reminders for services as per the American Academy of Pediatrics (AAP) periodicity schedule and the Centers for Disease Control and Prevention (CDC) immunization schedule.

Right to Appeal EPSDT Service Determinations

All four MCOs were found to be fully compliant during the 2014 Annual Compliance Review with informing members regarding their right to appeal decisions related to EPSDT services. This information was provided in member handbooks and member newsletters across MCOs, and a file review of five denials of children's services for all four MCOs included information regarding the right to appeal the decisions.

Provider Network

Kentucky Medicaid MCOs are contractually obligated to provide a sufficient network of trained health care providers to provide EPSDT services to eligible children. Primary care physicians (PCPs) who are assigned to each eligible member are required to provide or arrange for complete assessments at periodic intervals consistent with the AAP periodicity schedules for preventive care, and when medically necessary at other times. PCPs and other providers in the MCOs' network provide diagnosis and treatment, and out-of-network providers may provide treatment if the service is not available within the MCO's provider network. The MCOs' EPSDT provider network was evaluated in the 2014 Annual Compliance Review, and geographic access to PCPs and ratios of PCPs to members were also evaluated. Kentucky Annual Report #85, Quality Improvement Program Evaluation, also refers to network adequacy.

EPSDT Providers

All four MCOs were found to be compliant with providing a sufficient network of EPSDT providers in the 2014 Annual Compliance Review or were deemed compliant by virtue of the 2013 Annual Compliance Review full compliance results. All four MCOs required PCPs to provide EPSDT services. MCOs reported evaluation of network adequacy and monitoring of appropriate appointment availability in Annual Report #85, Quality Improvement Program Evaluation.

CoventryCares of Kentucky and WellCare of Kentucky were found to be fully compliant for EPSDT provider network requirements in the 2013 Annual Compliance Review, and therefore these MCOs were deemed to be compliant and were not reviewed for these requirements in the 2014 review. CoventryCares of Kentucky and WellCare of Kentucky were also deemed compliant for Quality Assessment and Performance Improvement: Access elements related to geographic access and member-to-PCP ratios (not to exceed a ratio of 1500-to-1) and PCP appointment availability based on the 2013 Annual Compliance Review. Passport Health Plan and Humana-CareSource were fully compliant with EPSDT provider network requirements and Quality Assessment and Performance Improvement: Access review elements related to geographic access and member-to-PCP ratios in the 2014 Annual Compliance Review.

MCOs monitored provider access and availability through secret shopper appointment availability surveys, site visits, CAHPS® results and monitoring of grievances. Secret shopper surveys for routine appointments are likely most reflective of appointments for EPSDT screening. CoventryCares of Kentucky Annual Report #85, Quality Improvement Program Evaluation, documented that the plan conducted secret shopper access and availability surveys in 2013 for a small sample of pediatric providers (n = 51), and found that 72.5% of surveyed pediatric providers offered an appointment within four weeks for a routine visit. The plan reached out to non-compliant providers subsequent to the survey and planned to follow these providers. CoventryCares of Kentucky documented initiation of access and availability secret shopper surveys for specialists subsequent to the 2013 Annual Compliance Review. WellCare of Kentucky's Annual Report #85, Quality Improvement Program Evaluation, included a 2013 access and availability survey of 194 pediatricians for routine appointments, which found that over 95% of the pediatricians scheduled a routine appointment in less than 30 days.

Passport Health Plan conducted 106 site visits in 2013 to monitor appointment access as reported in the 2013 Annual QI Program Evaluation; all sites were compliant with access and availability standards; however, results were not specific to pediatric access. Passport Health Plan also reported aggregate grievances related to access in the Annual QI Program Evaluation, and reported monitoring CAHPS® composite results for Getting Care Quickly for children, which was above the national mean. Passport Health Plan specifically addressed EPSDT

appointment timeframes for new enrollees in provider materials, indicating in their provider orientation kit that providers are required to complete age appropriate screens within 30 days of the member's plan enrollment if the member is not up to date. Humana-CareSource, which began enrolling members in January 2013, did not monitor provider access and availability in 2013 as per the plan's 2013 Annual QI Program Evaluation, but documented plans to conduct secret shopper surveys and analyze grievances related to access going forward. Humana-CareSource provided clinicians with an EPSDT form to ensure that all components of EPSDT services were provided. Humana-CareSource did not report CAHPS® in 2013, since enrollment began in January 2013.

EPSDT Provider Education

Kentucky contractual requirements for Medicaid MCOs include maintaining an effective education/information program for providers involved in delivery of EPSDT services. The education/information program should address current guidelines for components of EPSDT screening and special services and emerging health status issues that should be addressed as part of EPSDT services. This requirement was evaluated in the 2014 Annual Compliance Review, and all four MCOs were found to be fully compliant as described below. Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, was reviewed and also contained evidence of EPSDT provider training across MCOs in 2013. The MCOs disseminated information to EPSDT providers in a variety of formats, and one MCO focused on lead screening as a specific area in need of improvement in an educational initiative.

WellCare of Kentucky was found to be fully compliant with maintaining a provider education/information program in the 2013 Annual Compliance Review, and therefore this requirement was not evaluated for WellCare of Kentucky in the 2014 Annual Compliance Review. WellCare of Kentucky's Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, documented that the plan held eight Provider Summits, two large Independent Practice Association (IPA) meetings and a meeting with a high-volume provider in 2013 to review EPSDT requirements.

CoventryCares of Kentucky demonstrated full compliance with provider education during the 2014 Annual Compliance Review, with information distributed to participating providers during 2013 in the plan's provider manual, an EPSDT provider training manual, provider newsletter, and a provider fax blast pertaining to EPSDT promotion and education. As noted in CoventryCares of Kentucky Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, the plan also distributed an EPSDT Provider Reference Book, EPSDT Single Page Overview, EPSDT Program Frequently Asked Questions and an EPSDT Periodicity Table. In June 2013, the plan held an EPSDT training session for provider relations staff, who conduct provider onsite visits to discuss EPSDT requirements. The plan's EPSDT coordinator also hand-delivered the EPSDT Provider Training Manual to providers in some cases. MCO staff visited 15 pediatric offices in 2013 to promote EPSDT services.

Humana-CareSource was also found to be fully compliant with provider education requirements during the 2014 Annual Compliance Review, as evidenced by EPSDT information disseminated to providers through the provider manual, newsletters, the online provider portal and onsite visits by the plan's provider representatives. During provider site visits, education was provided on the EPSDT periodicity schedule, and exam components and frequencies were posted on the MCO's website, as was information about the vaccines for children program and blood lead screening program. The plan provided an online checklist for providers to ensure documentation of exam components. EPSDT guidelines, including AAP Bright Futures and CDC-

recommended immunization schedules, were available on the plan's website and were distributed in provider manual updates, newsletters, mail/fax/email and provider representative office visits. Humana-CareSource ensured training for providers by conducting an initial educational orientation for all newly contracted providers within 30 days of the provider becoming active, and providers received periodic and/or targeted education as needed. As per Kentucky Quarterly Report #24, Humana-CareSource included practice guidelines on the provider portal and in newsletters, and in 2013 the plan focused on guidelines and educational materials to improve lead screening.

Passport Health Plan was substantially compliant with educating providers involved in the delivery of EPSDT services, with a robust information program provided through the plan's provider website, provider manual, EPSDT Orientation Kit, New Provider Orientation Packet, workshops and onsite visits by the provider network account manager. However, the plan was found to be lacking evidence of specific training for non-physician providers of EPSDT screening services, and such training was not addressed in Kentucky Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death. The plan contracts with local Departments of Health to provide EPSDT services as well as PCPs, and services could be provided by non-physician providers. The plan's provider network account manager tracked attendance at EPSDT trainings, and the plan provided evidence that providers from multiple specialties attend trainings. Passport Health Plan used AAP guidelines for screening interval recommendations; some of these required updating with the most recently issued AAP guidelines.

Monitoring of EPSDT Provider Compliance with Required EPSDT Services

Monitoring of EPSDT provider compliance with required EPSDT services was evaluated in the 2014 Annual Compliance Review as part of ensuring that eligible members received all necessary services. In addition, MCOs' Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, and Annual Report #85, Quality Improvement Program Evaluation, were reviewed for this report. The four MCOs reported monitoring of provider delivery of EPSDT services during 2013 through provider audits, monitoring of provider-specific rates for relevant performance measures and monitoring members of providers' panels who were lacking age-appropriate screenings.

Humana-CareSource did not monitor provider compliance with primary care clinical practice guidelines, including preventive guidelines for EPSDT in 2013. During the 2014 Annual Compliance Review, the plan indicated that monitoring against guidelines was to begin in 2014, and the plan received a recommendation to monitor primary care records to assess compliance with the DMS's periodicity schedule and EPSDT requirements. Although Humana-CareSource did not monitor clinical practice guidelines in 2013, the MCO did conduct site visits to evaluate compliance with the EPSDT periodicity schedule of exams. Humana-CareSource distributed EPSDT documentation forms to providers to facilitate compliance with all components of EPSDT services. Provider representatives documented that education was provided during site visits regarding items that should be covered in EPSDT visits. Humana-CareSource also tracked provider-specific preventive health services utilization and was to begin tracking of relevant HEDIS® measures in 2014 to monitor compliance with the provision of EPSDT services.

Passport Health Plan's provider manual indicated that the plan will perform annual audits of provider claims for relevant elements of EPSDT services; however, at the time of the 2014 Annual Compliance Review, these audits had not yet been conducted. Passport Health Plan reported conducting an EPSDT compliance audit by the end of 2013 in their 2013 Annual QI Program Evaluation with focused provider education on

documentation of dental exams. Provider offices were also evaluated during Passport Health Plan's onsite provider visits for new providers and when concerns were identified. Providers received monthly reports of members in their panel who are due/overdue for screenings.

The 2014 Annual Compliance Review revealed that WellCare of Kentucky began conducting an annual medical record review in the fall of 2013, which revealed that 62 of 69 provider groups did not meet the compliance goal of 80% for documentation of EPSDT services. WellCare of Kentucky reported in Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, that a database had been created to track, audit and report provider compliance with providing EPSDT services. WellCare of Kentucky noted in Quarterly Report #24 that site visits were conducted to increase compliance with EPSDT required services.

In 2013, CoventryCares of Kentucky reported conducting an EPSDT provider compliance audit through medical record review in the MCO's Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death. The audit reviewed records of 13 providers in 8 regions. CoventryCares of Kentucky reported in their 2013 Annual Program Evaluation that medical record audits revealed that documentation of child immunization status was an area for improvement, and providers were educated onsite. CoventryCares of Kentucky also included documentation of tobacco, alcohol and drug screening for adolescents and body mass index (BMI) documentation as audited elements, and BMI documentation was found to be an area for improvement for one health care practice site.

Access to EPSDT Services

Kentucky Medicaid MCOs are required to provide EPSDT services to all eligible members, and EPSDT services include screening, diagnostic and treatment services. Specific services that are included in EPSDT are a comprehensive history, physical exam, developmental and behavioral health screening, immunizations, dental services, vision screening, hearing screening, lead screening and anticipatory guidance, as well as follow-up of identified risks.^{vi}

The extent to which Kentucky Medicaid managed care-enrolled children received recommended EPSDT services was reflected in the CMS EPSDT report form CMS-416, certain HEDIS® performance measure calculations, and some Kentucky State-specific Healthy Kentuckians performance measures that Kentucky MCOs are required to report. In addition, a retrospective medical record review study was conducted by IPRO on behalf of DMS in 2013 to ascertain which components of EPSDT services children were receiving during well-child primary care visits.

EPSDT Screening and Participation

Kentucky MCOs report EPSDT screening and participation rates using Form CMS-416 in the Kentucky Annual Report #93, EPSDT Annual Participation Report. Form CMS-416 provides basic information that is used by CMS to assess state EPSDT programs in terms of the number of children who are provided child health screening services, as well as other EPSDT services. Child health screening services are defined as initial or periodic screens required to be provided according to a state's screening periodicity schedule, which for the State of Kentucky is consistent with the AAP periodicity schedule.^{vii,viii} Reported elements on Form CMS-416 include a screening ratio, which indicates the extent to which EPSDT-eligible children receive the number of initial and periodic screening services required by the State's periodicity schedule, prorated by the proportion of the year for which they are Medicaid eligible. The screening ratio reflects the proportion of expected screenings received. A participation ratio is also reported, which reflects the extent to which eligible children receive any screening services during the year.

CMS has historically set goals of 80% for EPSDT screening and participation and the most recently reported national EPSDT rates were 86% for screening and 63% for participation in 2013.^{ix} The State of Kentucky reported slightly lower rates in 2013, with a screening rate of 83% and participation rate of 57%.^{xi}

Results reported by the MCOs in the Kentucky Annual Report #93, EPSDT Annual Participation Report, for the reporting period October 1, 2012 through September 30, 2013 are presented in Table 1. As shown in Table 1, there was variability across MCOs in reported rates, with EPSDT screening rate for 2013 ranging from 51% to 100% of expected visits across plans and EPSDT participation rate ranging from 49% to 77% of eligible members across plans. MCOs reported data on Form CMS-416 for the measurement period starting October 1, 2012 through September 30, 2013 in the Annual Report #93, but it should be noted that Humana-CareSource reported incomplete data (January 1, 2013 through September 30, 2013) due to their recent initiation of enrollment. While some plans exceeded the CMS goal of 80% for screening (i.e., CoventryCares of Kentucky and Passport Health Plan), none of the plans met the goal of 80% for participation. Passport Health Plan's participation rate was the highest reported at 77%.

Table 1. EPSDT Screening and Participation Rates Reported by Kentucky MCOs (RY 2013)

Indicator ¹	MCO				Kentucky Statewide Average	National Average
	CoventryCares of Kentucky	Humana-CareSource ²	Passport Health Plan	WellCare of Kentucky		
2013 EPSDT Screening Rate	100%	78%	100%	51%	83%	86%
2013 EPSDT Participation Rate	50%	49%	77%	49%	57%	63%

¹Rates were reported by Kentucky MCOs on Form CMS-416 for the measurement period from October 1, 2012 through September 30, 2013 for reporting year (RY) 2013. Source: Annual Report #93, EPSDT Annual Participation Report.

²Due to initiation of enrollment of enrollment in January 2013, Humana-CareSource's results reflect the measurement period January 1, 2013–September 30, 2013.

Table 2 displays age-group-specific screening and participation rates across MCOs. Again, Humana-CareSource's results were limited due to enrollment beginning in January 2013, which resulted in very small sample sizes for some age groups. For CoventryCares of Kentucky and Passport Health Plan, screening rates appeared to be lower for older age groups, ages 10–20 years, consistent with Kentucky statewide and national rate patterns. WellCare of Kentucky's screening rates were lower in general across age groups, and Humana-CareSource rates were limited as noted above. Participation rates, reflecting the percentage of children who should have received at least one screening in the measurement year, also appeared generally higher, for children aged less than one year and lower for adolescents aged 15–20 years. Participation rates appeared generally lower overall than screening rates in corresponding age groups.

Table 2. EPSDT Screening and Participation Rates by Age Group Across MCOs (RY 2013)

Rates by Age Group ¹	MCO				Kentucky Statewide Average	National Average
	CoventryCares of Kentucky	Humana-CareSource ²	Passport Health Plan	WellCare of Kentucky		
Age-Specific Screening						
< 1 Year	100%	100%	100%	42%	100%	98%
1–2 Years	100%	100%	100%	79%	100%	100%
3–5 Years	100%	83%	99%	70%	86%	87%
6–9 Years	100%	36%	100%	33%	86%	78%
10–14 Years	85%	59%	73%	48%	59%	69%
15–18 Years	57%	51%	61%	35%	44%	58%
19–20 Years	33%	0%	36%	30%	24%	34%
Age-Specific Participation						
< 1 Year	70%	100%	94%	90%	88%	90%
1–2 Years	53%	69%	82%	76%	77%	77%
3–5 Years	63%	61%	83%	61%	66%	68%
6–9 Years	52%	34%	118%	30%	68%	65%
10–14 Years	43%	50%	64%	43%	46%	56%
15–18 Years	29%	37%	53%	30%	33%	46%
19–20 Years	15%	0%	32%	27%	19%	25%

¹Rates were reported by Kentucky MCOs on Form CMS-416 for the measurement period from October 1, 2012 through September 30, 2013 for reporting year (RY) 2013. Source: Annual Report #93, EPSDT Annual Participation Report.

²Due to initiation of enrollment of enrollment in January 2013, Humana-CareSource's results reflect the measurement period January 1, 2013–September 30, 2013.

EPSDT-Relevant HEDIS® Measures

Kentucky MCOs report HEDIS® access, utilization and effectiveness of care quality measures, and several of these measures are relevant to EPSDT services, including measures of children's and adolescents' access to PCPs, well-child visits, and dental visits, as well as measures of specific EPSDT services, such as BMI screening, nutrition and physical activity counseling, and lead screening. Due to Humana-CareSource's initiation of enrollment in January 2013, the plan was unable to report HEDIS® measures for HEDIS® 2013. For CoventryCares of Kentucky and WellCare of Kentucky, HEDIS® 2013 was the first year of reporting for HEDIS® measures.

The National Committee for Quality Assurance (NCQA) publishes national Medicaid performance measure rates annually in Quality Compass. In Table 3, Kentucky MCO HEDIS® 2013 Quality Measure Rates as reported on the MCOs' submitted 2013 HEDIS® Audit Review Tables are compared to the 2013 national Medicaid average. Passport Health Plan, which has had a much longer presence in Kentucky Medicaid than the other MCOs, reported higher rates than CoventryCares of Kentucky and WellCare of Kentucky for many of the measures.

Overall, the vast majority of children aged 12–24 months and 25 months–6 years had a visit with a PCP during the measurement year (Children's Access to Primary Care, CAP). Rates ranged from 89% to nearly 98%, and rates for all plans were above the national Medicaid average (Table 3). Only Passport Health Plan had a sufficient number of eligible enrollees to report rates for older children, and Passport Health Plan rates for children aged 7–11 years and 12–19 years with a PCP visit were both above 91% and above the national Medicaid average.

While the CAP measure reflects any visit with a PCP, the well-child visit measures reflect visits specifically for preventive services, and therefore may be more reflective of visits for EPSDT services. The well-child visit measures include Well-Child Visits in the First 15 Months of Life (W15), Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) and Adolescent Well-Care Visits (AWC). For W15, Table 3 shows MCO reported rates for the numerator reflecting the expected number of visits for children in the first 15 months of life, which is six or more (referred to as "Well-child Visits in the First 15 Months of Life (W15) – 6+ Visits"). For the measures of receipt of appropriate well-care visits, only Passport Health Plan had rates above the national Medicaid average for children turning 15 months and adolescents. Passport Health Plan's rate for children aged 3–6 years was slightly below the Medicaid average, and well-child visit rates for CoventryCares of Kentucky and WellCare of Kentucky were below the national Medicaid average for all three age groups, with adolescent well-care visits offering the greatest opportunity for improvement across MCOs.

The HEDIS® Annual Dental Visit (ADV) measure is a measure of the percentage of children aged 2–21 years of age with at least one dental visit in the measurement year. It should be noted that the ADV measure reflects any visit with a dentist in the measurement year, not just preventive dental visits. For this reason, the reported dental visit rate can include restorative treatment for caries or other oral health problems as well as preventive visits. For all three MCOs, the rates of annual dental visits for members aged 2–21 years were above the national Medicaid average, and were approximately 61% (Table 3).

MCOs' reported rates for the HEDIS® measure Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) revealed opportunities for improvement for CoventryCares of Kentucky and WellCare of Kentucky in providers' documentation of BMI and counseling for nutrition and physical activity, since rates for all three components of the measure were lower than the national Medicaid

average for these plans (Table 3). Passport Health Plan’s rates exceeded the national Medicaid average, although the rate for counseling for physical activity was only slightly above the national average. Given the prevalence of obesity and the health risks it poses, focusing improvement efforts on identifying and addressing childhood obesity would be of value.

The MCOs reported the HEDIS® measure for Childhood Immunization Status (CIS) combination rate-Combination 2, which measures the percentage of 2-year-old children who have received immunizations for diphtheria, tetanus and acellular pertussis (DTaP), polio (IPV), measles, mumps and rubella (MMR), H influenza type-B (HiB), hepatitis B (HepB), and chicken pox (varicella zoster, VZV). The MCOs also reported the HEDIS® Immunizations for Adolescents (IMA)-Combination 1 rate, which includes meningococcal vaccine and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine. Passport Health Plan’s rate for HEDIS® CIS-Combination 2, was above the national average (87.17%), CoventryCares of Kentucky’s very slightly below the national average (75.23%), and WellCare of Kentucky’s rate was well below the national average (63.11%; Table 3). IMA-Combination 1 rates were above the national average for all three MCOs, with rates ranging from approximately 72–77%.

Rates of lead screening for children two years of age, reported in the HEDIS® measure Lead Screening in Children (LSC), ranged from 82.30% for Passport Health Plan, a rate that was above the national average, to rates below the national average for WellCare of Kentucky (59.63%) and CoventryCares of Kentucky (65.51%; Table 3).

Table 3. Kentucky MCO HEDIS® 2013 Quality Measure Rates Relative to the 2013 National Medicaid Average (RY 2013)

HEDIS® Measure ^{1,2}	Measure Description	MCO		
		CoventryCares of Kentucky	Passport Health Plan	WellCare of Kentucky
Access/Availability of Care				
Children’s Access to Primary Care Practitioners (CAP) ³	The percentage of members 12 months–19 years of age who had a visit with a PCP.			
CAP – 12–24 Months	The percentage of · Children 12–24 months who had a visit with a PCP during the MY	97.94% ↑	97.85% ↑	97.72% ↑
CAP – 25 Months–6 Years	The percentage of · Children 25 months–6 years who had a visit with a PCP during the MY	93.93% ↑	89.37% ↑	93.61% ↑
CAP – 7–11 Years	The percentage of · Children 7–11 years who had a visit with a PCP during the MY	N/A	91.95% ↑	N/A
CAP – 12–19 Years	The percentage of · Adolescents 12–19 years who had a visit with a PCP during the MY or the year prior	N/A	91.64% ↑	N/A
Annual Dental Visit-(ADV)	The percentage of members 2–21 years of age who had <u>at least one dental visit</u> during the measurement year.	61.07% ↑	60.95% ↑	61.79% ↑

HEDIS® Measure ^{1,2}	Measure Description	MCO		
		CoventryCares of Kentucky	Passport Health Plan	WellCare of Kentucky
Utilization				
Well-Child Visits in the First 15 Months of Life (W15) – 6+ Visits	The percentage of members who turned 15 months old during the measurement year and who <u>had six (6) or more well-child visits</u> with a PCP during their first 15 months of life.	62.73% ↓	67.98% ↑	42.59% ↓
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	The percentage of members 3–6 years of age who received <u>one or more well-child visits</u> with a PCP during the measurement year.	55.79% ↓	70.68% ↓	61.81% ↓
Adolescent Well-Care Visits (AWC)	The percentage of enrolled members 12–21 years of age who had <u>at least one comprehensive well-care visit</u> with a PCP or an ob/gyn (obstetrics and gynecology) practitioner during the measurement year.	45.83% ↓	52.46% ↑	38.89% ↓
Effectiveness of Care				
Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) ³	The percentage of members 3–17 years of age who had an outpatient visit with a PCP or ob/gyn and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> · BMI percentile documentation, · Counseling for nutrition, and · Counseling for physical activity. 			
WCC – BMI Percentile	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or ob/gyn and who had a <u>BMI percentile/BMI documented</u> during the measurement year.	18.29% ↓	60.49% ↑	25.00% ↓
WCC – Counseling for Nutrition	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or ob/gyn and who had <u>assessment/counseling for nutrition</u> during the measurement year.	30.09% ↓	64.02% ↑	31.02% ↓
WCC – Counseling for Physical Activity	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or ob/gyn and who had <u>assessment/counseling for physical activity</u> during the measurement year.	24.31% ↓	44.37% ↑	29.40% ↓

HEDIS® Measure ^{1,2}	Measure Description	MCO		
		CoventryCares of Kentucky	Passport Health Plan	WellCare of Kentucky
Childhood Immunization Status (CIS) ³	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.			
CIS – Combination 2	DTaP, IPV, MMR, HiB, Hep B, VZV	75.23% ↓	87.17% ↑	63.11% ↓
Immunizations for Adolescents (IMA) ³	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine or one tetanus, diphtheria toxoids (Td) vaccine by their 13 th birthday.			
IMA – Combination 1	Adolescents who received one meningococcal vaccine on or between the members 11 th and 13 th birthday and one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine or one tetanus, diphtheria toxoids (Td) vaccine on or between the member's 10 th and 13 th birthdays.	71.99% ↑	73.45% ↑	77.08% ↑
Lead Screening in Children (LSC)	The percentage of children 2 years of age who had one or more capillary or venous lead <u>blood tests for lead poisoning</u> by their second birthday.	65.51% ↓	82.30% ↑	59.63% ↓

¹Rates were obtained in the measurement year (MY) 2012 and reported for the reporting year (RY) 2013. Rates above national Medicaid average are represented by an upward arrow (↑) and rates below national Medicaid average are represented by a downward arrow (↓). Source: 2013 HEDIS® Audit Review Tables submitted by MCOs.

²Due to Humana-CareSource's initiation of enrollment in January 2013, the MCO was unable to report HEDIS® measures for HEDIS® 2013.

³The measure has rates reported for its specific subparts (reported in rows below) and has no overall reported rate in and of itself (indicated by gray shading).

HEDIS®: The Health Effectiveness Data and Information Set; MCO: managed care organization; N/A: not applicable.

Healthy Kentuckians Measures

Kentucky has developed state-specific performance measures, which provide information that augments the reported HEDIS® measures. These measures are reflective of the State's Healthy Kentuckians goals and objectives, and many are relevant to EPSDT services. Healthy Kentuckians measures that reflect components of EPSDT services include documentation of children's and adolescents' height and weight, the percentage of children and adolescents who are at a healthy weight, adolescent behavioral risk assessment and counseling,

and preventive care for children with special health care needs (CSHCN). Due to enrollment criteria required for the measures, Humana-CareSource did not report Healthy Kentuckians measures for 2013.

Healthy Kentuckians performance measure results as reported in the MCOs' 2013 Kentucky Performance Measure Validation submission in Attachment B (MY 2012) are presented in Table 4. As reported below in Table 4, rates of documentation of the measure Child and Adolescent Height and Weight ranged from nearly 68% for CoventryCares of Kentucky to nearly 89% for Passport Health Plan. Adolescent behavioral risk screening and counseling measures were found to offer opportunities for improvement, with CoventryCares of Kentucky and WellCare of Kentucky reporting particularly low rates. CoventryCares of Kentucky's rates ranged from only 18.83% for screening/counseling for sexual activity to 36.36% for screening/counseling for tobacco use, and WellCare of Kentucky's rates ranged from 18.37% for screening/counseling for sexual activity to 51.02% for tobacco use. Passport Health Plan, which has been enrolling members in Kentucky for the longest period of time, reported higher rates ranging from 55.48% for screening/counseling for sexual activity to 71.92% for tobacco use. In 2013, only WellCare of Kentucky was able to report screening for adolescent depression, with a rate of only 15.65%; CoventryCares of Kentucky and Passport Health Plan were unable to report rates for the depression screening numerator because of failure of medical record validation for this measure. Upon review of the failed medical record validation for adolescent depression screening, specifications for adolescent depression screening numerator compliance were clarified for 2014 reporting to ensure consistent reporting among all MCOs.

Kentucky Medicaid MCOs report the percentage of children with healthy weight for height for tracking purposes only; as shown in Table 4, the plans reported that a substantial proportion of children did not have healthy weight for height, underscoring the need to focus on BMI assessment and counseling for nutrition and physical activity.

Table 4. EPSDT-Relevant Healthy Kentuckians Performance Measures (RY 2013)

Healthy Kentuckians Measure ^{1,2}	Description	MCO		
		CoventryCares of Kentucky	Passport Health Plan	WellCare of Kentucky
Child and Adolescent Height and Weight	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or ob/gyn and who had <u>both a height and weight documented</u> on the same date of service during the measurement year. <i>REPORTING ONLY.</i>	67.59%	88.96%	69.68%
Child and Adolescent Healthy Weight for Height	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or ob/gyn who had <u>healthy weight for height</u> during the measurement year. <i>REPORTING ONLY.</i>	12.29%	55.83%	13.20%
Adolescent Screening/Counseling – Tobacco Use	The percentage of adolescents 12–17 years of age who had a well-care/preventive visit in measurement year and received <u>screening/counseling for tobacco use.</u>	36.36%	71.92%	51.02%

Healthy Kentuckians Measure ^{1,2}	Description	MCO		
		CoventryCares of Kentucky	Passport Health Plan	WellCare of Kentucky
Adolescent Screening/Counseling – Alcohol/Substance Abuse	The percentage of adolescents 12–17 years of age who had a well-care/preventive visit in measurement year and received <u>screening/counseling for alcohol/substance use.</u>	28.57%	63.70%	30.61%
Adolescent Screening/Counseling – Sexual Activity	The percentage of adolescents 12–17 years of age who had a well-care/preventive visit in measurement year and received <u>screening/counseling for sexual activity.</u>	18.83%	55.48%	18.37%
Adolescent Screening/Counseling – Depression	The percentage of adolescents 12–17 years of age who had a well-care/preventive visit in measurement year and had <u>screening for depression.</u>	NR	NR	15.65%

¹Rates were obtained in measurement year (MY) 2012 for reporting year (RY) 2013. Source: Healthy Kentuckians performance measure results as reported in the MCOs' 2013 Kentucky Performance Measure Validation submission in Attachment B (MY 2012).

²Due to enrollment criteria required for the measures, Humana-CareSource did not report Healthy Kentuckians performance measures for RY 2013.

MCO: managed care organization; NR: not reportable.

In order to assess for possible disparities in care, Kentucky MCOs report HEDIS® PCP, dental and well-care access measures for the subpopulation of CSHCN, as defined by eligibility for Supplemental Security Income (SSI), foster care or adoption assistance, in the Healthy Kentuckians measure set as the measure titled Child and Adolescent Individuals with Special Health Care Needs (ISHCN) Access and Preventive Care. Healthy Kentuckians 2013 (MY 2012) rates for ISHCN Access and Preventive Care as reported in the MCOs' 2013 Kentucky Performance Measure Validation submission in Attachment B (MY 2012) and revised in December 2014 are presented in Table 5. MCO reported rates for CSHCN are compared to the national average reported in the 2013 Quality Compass for the general Medicaid population, since there are no Quality Compass benchmarks specific to CSHCN. Among CSHCN, rates for the CAP measure were similar to rates reported for the overall population, and exceeded the national average across MCOs for all reported age groups. Only Passport Health Plan had a sufficient eligible population to report CAP rates for CSHCN aged 7–11 years and 12–19 years; both of these rates exceeded the national Medicaid general population average, although the adolescent CAP rate for CSHCN (88.33%) was only slightly above the national Medicaid average for the general Medicaid population. Rates for ADV reported by each MCO for CSHCN exceeded the national Medicaid average for the general population.

Only Passport Health Plan and WellCare of Kentucky were able to report the receipt of appropriate well-child visits for children aged 15 months (6 or more visits) for CSHCN, and both MCOs' rates were below the national Medicaid average for the general population (Table 5). CoventryCares of Kentucky did not have an eligible population for this measure. As seen for the overall population, reported rates for Passport Health Plan for well-child visits for CSHCN aged 3–6 years and adolescents exceeded the national Medicaid average for the general Medicaid population, while rates reported by CoventryCares of Kentucky and WellCare of Kentucky for these age groups were below the national Medicaid average for the general Medicaid population.

Table 5. Child and Adolescent Individuals with Special Health Care Needs (ISHCN) Access and Preventive Care (RY 2013)

Healthy Kentuckians Measure ^{1,2}	Description	MCO		
		Coventry-Cares of Kentucky	Passport Health Plan	WellCare of Kentucky
Child and Adolescent Individuals with Special Health Care Needs (ISHCN) Access and Preventive Care				
Children's and Adolescents Access to Care (CAP) ³	The percentage of members 12 months–19 years of age who had a visit with a PCP.			
CAP – 12–24 Months	The percentage of · Children 12–24 months who had a visit with a PCP during the MY	98.26% ↑	96.19% ↑	97.71% ↑
CAP – 25 Months–6 Years	The percentage of · Children 25 months–6 years who had a visit with a PCP during the MY	95.45% ↑	90.98% ↑	94.61% ↑
CAP – 7–11 Years ⁴	The percentage of · Children 7–11 years who had a visit with a PCP during the MY	N/A	90.56% ↑	N/A
CAP – 12–19 Years ⁴	The percentage of · Adolescents 12–19 years who had a visit with a PCP during the MY or the year prior	N/A	88.33% ↑	N/A
Annual Dental Visit (ADV)	The percentage of members 2–21 years who had at least one dental visit during the MY.	60.76% ↑	56.76% ↑	58.48% ↑
Utilization				
Well-Child Visits 15 Months – 6+ Visits	The percentage of members who turned 15 months old during the MY and who had six (6) or more well-child visits with a PCP during their first 15 months of life.	N/A	45.55% ↓	16.67% ↓
Well-Child Visit 3–6 Years	The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	63.18% ↓	72.61% ↑	63.45% ↓
Adolescent Well-Care Visit (AWC)	The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an ob/gyn practitioner during the measurement year.	41.17% ↓	51.38% ↑	37.48% ↓

¹Rates were obtained in measurement year (MY) 2012 for reporting year (RY) 2013. Rates above national Medicaid average for the general Medicaid population are represented by an upward arrow (↑) and rates below national Medicaid average for the general population are represented by a downward arrow (↓). Source: Healthy Kentuckians performance measure results as reported in the MCOs' 2013 Kentucky Performance Measure Validation submission in Attachment B

(MY 2012) and revised in December 2014. (Note that these data were revised for the Annual Technical Report when it was noted that WellCare of Kentucky and CoventryCares of Kentucky entered erroneous calculations for the totals for the ISHCN measures, overwriting the total Microsoft Excel worksheet field. The corrected results are included in the EPSDT report.)

²Due to enrollment criteria required for the measures, Humana-CareSource did not report Healthy Kentuckians performance measures in 2013.

³The measure has rates reported for its specific subparts (reported in rows below) and has no overall reported rate in and of itself (indicated by gray shading).

⁴Due to lack of eligible ISHCN population for CoventryCares of Kentucky and WellCare of Kentucky, only Passport Health Plan reported this rate.

HEDIS®: The Health Effectiveness Data and Information Set; MCO: managed care organization; MY: measurement year; N/A: not applicable.

EPSDT Encounter Data Validation Study

While access to well-child visits and screening can be assessed by evaluating relevant MCO-reported HEDIS® and Healthy Kentuckians performance measures and EPSDT screening and participation rates, the content of well-child screening visits is more difficult to ascertain. In order to more completely evaluate the scope of EPSDT services that children received during visits in 2013, a retrospective medical record review study was undertaken to validate that the content of well-child visits was consistent with EPSDT required screenings, diagnostics and treatment services. Well-child visits that occurred between January 1, 2013 and April 30, 2013 were included in the validation study. All MCOs participated in this EPSDT encounter data validation study by providing medical records for review based on submitted claims for well-child visits.

As shown in Table 6, study findings revealed that across all plans, most visits included review of past medical history (89%) and social history (71%), but family history and review of systems were less frequently documented (55% and 59%, respectively). Physical exams were most often comprehensive, and included an evaluation of eyes, ears/nose/throat, respiratory, cardiovascular and gastrointestinal systems in over 90% of cases. Neurologic exams were conducted in 79% of cases, while the examination of the spine and genitalia were documented less frequently (49% and 64% respectively). A total of 90% of records of children aged 3 years and older included documentation of blood pressure measurement.

Table 6. Documentation of Comprehensive History and Physical Exam

Component of Well-Child Visit ¹	Age 1–4 Years	Age 5–11 Years	Age 12–20 Years	Total
Comprehensive History				
Past Medical History	87%	88%	93%	89%
Family History	52%	57%	57%	55%
Social History	68%	75%	72%	71%
Review of Systems	54%	60%	69%	59%
Comprehensive Physical Exam				
Head	81%	78%	70%	78%
Eyes	91%	96%	88%	92%
Ears/Nose/Throat	92%	97%	88%	92%
Lungs/Respiratory	92%	99%	93%	94%
Heart/Cardiovascular	93%	96%	93%	93%
Abdomen/Gastrointestinal	93%	95%	91%	93%
Skin	83%	82%	75%	80%
Spine/Back	41%	58%	53%	49%
Neurologic	81%	83%	70%	79%

Component of Well-Child Visit ¹	Age 1–4 Years	Age 5–11 Years	Age 12–20 Years	Total
Extremities/Musculoskeletal	61%	68%	58%	62%
Genitalia	74%	63%	46%	64%
Oral Health Assessment	55%	48%	44%	50%
Measurements				
Blood Pressure ²	83%	88%	96%	90%
Height/Length and Weight	92%	96%	96%	94%
Body Mass Index	47%	56%	58%	53%

¹Measurement period: January 1, 2013–April 30, 2013. Source: 2013 EPSDT Encounter Data Validation Study conducted by IPRO on behalf of DMS.

²Denominator comprised of children age 3 years and older only

Rates of assessment/screening for oral health, mental health, behavioral risks, vision, hearing and development are presented in Table 7. The EPSDT validation study revealed that oral health assessment was documented in only 50% of cases across all age groups, and mental health assessment in school-aged children aged 5 years and older was documented in only 56–60% of cases. While there was reference to at least one component of developmental assessment in most records (79–85% across age groups), formal developmental screening among young children was rarely documented, with only 14% of children aged 1–4 years receiving formal developmental screening.

Vision screening was documented in only 34% of records of children younger than 3 years old and in 38% of records of children aged 3 years and older, while hearing screening was documented in only 15% of records of children younger than 3 years old and 28% of records of children aged 3 years and older (Table 7). Consistent with the Healthy Kentuckians Adolescent Screening/Counseling measure, adolescents were screened for tobacco use in only 51% of cases, and they were screened for alcohol and drug use in only 36% and 28% of cases, respectively.

Table 7. Documentation of Oral, Mental, Developmental and Behavioral Assessments

Component of Well-Child Visit ¹	Age 1–4 Years	Age 5–11 Years	Age 12–20 Years	Total
Oral Health Assessment	55%	48%	44%	50%
Mental Health Assessment	35%	56%	60%	47%
Adolescent Depression Screening	N/A	N/A	38%	38%
Developmental Assessment	85%	79%	80%	82%
Formal Developmental Screening	14%	N/A	N/A	14%
Vision Screening < 3 Years Old	34%	N/A	N/A	34%
Vision Screening ≥ 3 Years Old	43%	42%	32%	38%
Hearing Screening < 3 Years Old	15%	N/A	N/A	15%
Hearing Screening ≥ 3 Years Old	17%	38%	25%	28%
Tobacco Use Screening	N/A	N/A	51%	51%
Alcohol Use Screening	N/A	N/A	36%	36%
Drug Use Screening	N/A	N/A	28%	28%

¹Measurement period: January 1, 2013–April 30, 2013. Source: 2013 EPSDT Encounter Data Validation Study conducted by IPRO on behalf of DMS.

N/A: not applicable; indicator is not relevant for age group.

Rates of documented anticipatory guidance, which is part of EPSDT services, are displayed in Table 8. Rates of anticipatory guidance for nutrition (55%) and physical activity (51%) across all age groups were somewhat higher than rates reported for counseling in HEDIS®, but counseling in these areas still offer opportunity for improvement. Anticipatory guidance for safety/injury prevention was somewhat higher than anticipatory guidance for nutrition and physical activity at 64%.

Table 8. Documentation of Anticipatory Guidance

Component of Well-Child Visit ¹	Age 1–4 Years	Age 5–11 Years	Age 12–20 Years	Total
Nutrition and Diet	64%	51%	44%	55%
Safety/Injury Prevention	76%	56%	49%	64%
Physical Activity/Screen Time	57%	51%	44%	51%

¹Measurement period: January 1, 2013–April 30, 2013. Source: 2013 EPSDT Encounter Data Validation Study conducted by IPRO on behalf of DMS.

EPSDT services include diagnostic and treatment services as well as screening. There were few children documented as identified with problems as a result of EPSDT screening, and the record review was limited to one visit. It was therefore difficult to evaluate diagnostic and/or treatment follow-up of identified risks. However, there were some children with documented mental health and behavioral risks for whom follow-up was not documented, and this is an area that warrants further study.

EPSDT Special Services

Kentucky MCOs are required to provide EPSDT special services, which are medically necessary services not covered elsewhere in Medicaid, for eligible members. These services can include preventive, diagnostic, treatment or rehabilitative services. MCOs are required to identify providers who can deliver these services, and must develop procedures for authorization and payment for such services. MCO members have the right to appeal EPSDT service denials.

As part of assessing compliance with provision of medically necessary services, the 2014 Annual Compliance Review included a review of a sample of denial and appeal files for children’s services. This review provided a snapshot of MCOs’ provision of medically necessary services for children, and complemented a review of policies and procedures for the provision of EPSDT special services that was also conducted in the Annual Compliance Review. MCO specific results are outlined below.

CoventryCares of Kentucky and WellCare of Kentucky were found to be fully compliant with the provision of EPSDT special services during the 2013 Annual Compliance Review, which included a review of a sample of utilization management (UM) denial files, all found to be compliant. Therefore, these elements were not reviewed in 2014 for CoventryCares of Kentucky and WellCare of Kentucky. During the 2014 Annual Compliance Review, a sample of five member appeals for children’s services was reviewed for both CoventryCares of Kentucky and WellCare of Kentucky, and all were found to be timely and appropriate.

Humana-CareSource was found to be fully compliant with the provision of EPSDT special services in the 2014 Annual Compliance Review. Five UM and five appeals files were reviewed for Humana-CareSource in the 2014 Annual Compliance Review, and all were found to be completed timely and compliant with requirements, except for the inclusion of information regarding state fair hearings in UM file letters and information regarding member liability for the cost of services in the event that a fair hearing finds in favor of the plan in appeal resolution letters. Humana-CareSource is revising the letters.

Passport Health Plan was found to be fully compliant with the provision of medically necessary services to eligible children, and establishing procedures for authorization and payment in the 2014 Annual Compliance Review. The review of Passport Health Plan's five UM files and five appeals files related to children's services revealed that all files were compliant with contractual requirements.

MCOs' reported efforts to facilitate the provision of EPSDT special services in 2013 (Note: WellCare was deemed compliant for the 2014 Annual Compliance Review. Reporting of additional activity for EPSDT special services was not required, and WellCare reported no additional activity for EPSDT special services in 2013.):

- Humana-CareSource considers referrals for care of children with chronic conditions and CSHCN to be standing referrals lasting for one or more years. Prior authorizations that are required for referrals of out-of-network specialists can be submitted online or by email/fax/mail/phone.
- Passport Health Plan includes a description of EPSDT expanded services and the process for provider submission of a request to the plan's UM department for determination of medical necessity and authorizations in their provider manual and EPSDT orientation packet. Passport Health Plan requires referrals from PCPs to specialists to indicate if the referral is based on a result from EPSDT screening. Passport Health Plan has a desktop procedure for EPSDT special services that is intended to ensure compliance and provide any medically necessary health care that falls within the scope of EPSDT services. Passport Health Plan procedure includes authorization of school health services including authorized individual education program (IEP), considering them to be medically necessary and not subject to further Medicaid prior authorization requirements. Passport Health Plan policy defines individuals with special health care needs as including members who require EPSDT expanded services.
- CoventryCares of Kentucky's Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, documented that the MCO distributed revised prior authorization forms for providers in 2013 that indicate that requested services are EPSDT special services to facilitate authorization.

Monitoring and Facilitation of Receipt of EPSDT Services

To ensure that eligible members receive required EPSDT services, Kentucky MCOs must establish an effective and ongoing member services case management function to provide education and counseling regarding compliance with EPSDT visits and prescribed treatment. MCOs must also provide support such as transportation and scheduling assistance and follow up with members when recommended assessment and treatment are not received. Outreach efforts, information received from providers, scheduling assistance and follow up with referral compliance should be tracked in a consolidated record.

In order to ensure that eligible children are receiving appropriate EPSDT services, Kentucky MCOs are required to establish and maintain a tracking system and conduct outreach to those in need of services. The system must monitor acceptance and refusal of EPSDT services, whether eligible members are receiving recommended health assessments and all necessary diagnosis and treatment, including EPSDT special services.

EPSDT monitoring systems, MCO outreach to members in need of services, and efforts to facilitate receipt of services were evaluated in the 2014 Annual Compliance Review, and were also reported in Kentucky Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, and in Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan.

Member Monitoring for Receipt of EPSDT Services

All four MCOs have established tracking systems for monitoring members' receipt of EPSDT services. Monitoring systems were evaluated in the 2014 Annual Compliance Review, and MCO-specific monitoring initiatives are described below.

Humana-CareSource has established a clinical practice registry that tracks members' receipt of required EPSDT services. The registry is updated daily with claims history, diagnoses, and utilization and services history, including PCP visits and preventive-health-related services. The clinical practice registry is used by the care management, provider relations, and HEDIS® staff, as well as EPSDT providers. Providers can access the clinical practice registry on the provider portal and are given monthly reports of members due/overdue for EPSDT services. The plan also has a member profile tool, with which the MCO monitors members' compliance with EPSDT services requirements including visits according to the periodicity schedule. Member profiles generated by the tool provide an overview of services delivered to members; services for CSHCN are also tracked in this database. Reports from the member profile tool can be accessed by care management and provider relations staff to facilitate services for members in need. During the 2014 Annual Compliance Review, the plan reported plans to enhance the member profile system to include HEDIS®-measure-based alerts to enhance the identification of members' needs. Care managers' outreach and follow-up efforts are tracked in the Dashboards in CareAdvance, a care management documentation system, which also provides member-specific reports of gaps in care.

Passport Health Plan has established a tracking database for EPSDT services and a separate database for tracking referrals; during the 2014 Annual Compliance Review, onsite staff indicated that plans were underway to merge the two systems to establish one complete record for each member. Passport Health Plan's EPSDT call center application tracking database shows the status of screens due, screens completed and screens pending. This database also tracks MCO outreach calls to members and results of the outreach calls, such as disposition and date and time of appointments made. Written refusals of EPSDT services, which are required to opt out, are scanned and maintained in the database. Passport Health Plan generates reports in their EPSDT

Department to track the number of comprehensive screens, on time screens, routine evaluation of hemoglobin/hematocrit levels, referrals made during EPSDT screening visits, immunizations and automated outreach for members. Passport Health Plan has a separate referral database for children requiring referrals for diagnosis or treatment. The plan's Navinet system includes electronic referrals from providers, including diagnosis codes, and allows for identification of EPSDT referrals and receipt of referral services. Behavioral health services are included in the referral tracking database. The plan also monitors applicable HEDIS® rates and outreach attempts quarterly, as documented in Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan.

CoventryCares of Kentucky tracks EPSDT services through its NavCare system, which includes data fields for tracking of EPSDT coordinator outreach and follow-up phone-based conversations with families; however, a sample report was not available for review in the 2014 Annual Compliance Review. A consolidated record is maintained in the NavCare system for each member, and CoventryCares of Kentucky was deemed compliant with maintaining a consolidated record of outreach and facilitation for each member for 2014 by virtue of full compliance in 2013.

WellCare of Kentucky was found to be fully compliant in the 2014 Annual Compliance Review with monitoring of receipt of EPSDT services, and the plan includes EPSDT monitoring in policy and procedure documents and the EPSDT program description. WellCare of Kentucky demonstrated that the plan has established an EPSDT tracking database to monitor receipt and non-receipt of services that met requirements for EPSDT monitoring systems in the 2014 Annual Compliance Review.

Outreach for Members Overdue for EPSDT Services

Kentucky MCOs are required to facilitate EPSDT services for eligible members who are in need of services. The MCOs reported outreach to members overdue for EPSDT services and facilitation of services in a broad range of initiatives. Outreach efforts included telephonic outreach, mailings and home visits. All MCOs have identified an EPSDT coordinator to facilitate receipt of services and outreach to members requiring services, and MCOs have contracted with local Departments of Health to conduct home visits for non-compliant members. MCOs also reported engaging providers to facilitate services and ensure follow-up. MCO-specific outreach initiatives are described below.

Humana-CareSource's care management and provider relations staff use reports from the member profile tool in the plan's clinical practice registry to facilitate services for members in need. During the 2014 Annual Compliance Review, Humana-CareSource reported plans to enhance the member profile tool to include HEDIS®-measure-based alerts to enhance the identification of members' service needs. Humana-CareSource's Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, identified the role of the plan's EPSDT coordinator to include outreach to members overdue for services, and the report documents outreach in 2013 to non-compliant members, including telephonic outreach and home visitation by contracted local Departments of Health. Care managers' outreach and follow-up efforts were tracked in the Dashboards in CareAdvance, a care management documentation system, which also provides member-specific reports of gaps in care.

Passport Health Plan's 2013 QI Work Plan and Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, demonstrated robust EPSDT outreach through telephonic outreach, postpartum visits, home visits for non-compliant members by contracted local Departments of

Health, mailings, messages and community outreach. Members overdue for screens and those non-compliant with periodic participation were prioritized for phone outreach and for home visits, if phone outreach was unsuccessful. Passport Health Plan notifies members in their member handbook and EPSDT brochure that members should access the MCO's care connectors for assistance with accessing services.

CoventryCares of Kentucky Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, included a description of the plan's automated reminders for EPSDT and dental visits based on age intervals and claims data, and the report described outreach for missed appointments. Members with missed screenings were assigned to outreach specialists or case managers for mailings and other outreach. During the 2014 Annual Compliance Review, CoventryCares of Kentucky cited policy for ensuring timely member compliance through identification of members needing services using the Cognos PCP Member Detail Report for well-child visits and EPSDT coordinator follow-up of members who have not been compliant with referral appointments for EPSDT services.

WellCare of Kentucky reported that it monitors its EPSDT tracking database and notifies members if they have not received required services. In addition to mailed reminders for missed services, the plan documented providing assistance with scheduling appointments in 2013, using their centralized telephonic outreach system to outreach to members who had not received services and to schedule needed appointments.

All four MCOs documented efforts to engage providers in facilitation of EPSDT services by distributing reports of providers' panel members who are in need of services. Many elements related to providers were deemed compliant for CoventryCares' 2014 Annual Compliance Review. Reporting of additional provider activities was not required, and CoventryCares reported no additional provider activities in 2013. rAdditional specific activities reported by the other MCOs include:

- Passport Health Plan engaged providers to facilitate receipt of services by distributing monthly reports listing members who were due/overdue for recommended services, including screens and immunizations, and providers were responsible for issuing reminders for visits and immunizations due. Providers could access the plan's Navinet system to check for due/overdue screening, as well. Providers were required to attempt to outreach to non-compliant members three times before contacting the Passport Health Plan EPSDT outreach team.
- WellCare of Kentucky's Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, documented the provision of care gap reports to providers to engage them in facilitating access and scheduling of appointments.
- Humana-CareSource provided access to their clinical practice registry on the provider portal, and gave providers monthly reports of members due/overdue for EPSDT services. Humana-CareSource has a Provider Clinical Engagement Initiative that involves MCO clinical staff working with providers to educate and engage members to complete EPSDT services. Humana-CareSource also required PCPs to contact referral specialists on members' behalf and follow-up to ensure they were receiving care. WellCare of Kentucky also documented distribution of lists of members in need of required EPSDT services to providers in 2013.

EPSDT Case Management Function

To ensure that eligible members receive required services, Kentucky MCOs must establish an effective and ongoing member services case management function to provide member education and counseling regarding compliance with recommended EPSDT visits and prescribed treatment, as well as follow-up with eligible members and families when services are not received. Case management is particularly important for CSHCN, who may have particular challenges to accessing preventive services and may require special services. CSHCN include clients of the Department for Community Based Services (DCBS), such as children in foster care. MCOs are contractually required to identify an EPSDT coordinator with adequate staff to arrange for and assist with scheduling of required EPSDT services. This requirement was evaluated in the 2014 Annual Compliance Review, which included a review of files for a sample of DCBS clients for claims and outreach for EPSDT services, along with the Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death.

All four MCOs have identified an EPSDT coordinator and EPSDT case management function, and Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, documented activities carried out by the MCOs' EPSDT care management teams in 2013. Most DCBS clients had documented EPSDT services upon review of case management files in the 2014 Annual Compliance Review. One MCO, Humana-CareSource, was not able to demonstrate outreach attempts for two files that contained no documented evidence of EPSDT services; the other eight files reviewed for Humana-CareSource contained documented evidence of EPSDT services.

Humana-CareSource was found to be fully compliant with establishing a case management program to provide education and counseling regarding EPSDT services in the 2014 Annual Compliance Review. The plan conducted direct outreach by the EPSDT coordinator and care managers, including outreach to CSHCN and those in need of services. Humana-CareSource's care manager is an additional level of support and monitoring for members needing EPSDT/preventive services, and particularly provides assistance to CSHCN. Care managers identify gaps in care using Dashboards in CareAdvance, a care management documentation system, and use this information to coordinate visits and address barriers to care. Care manager outreach and follow-up efforts are tracked in this system. The care management team can also access the MCO's clinical practice registry to develop a care plan and remind members of preventive health services. The care manager serves as a point of contact to coordinate care between PCPs and specialists. Two of the ten case management files that were reviewed in the 2014 Annual Compliance Review for EPSDT services for DCBS clients did not have evidence of EPSDT services, and MCO's outreach to these members was also not documented.

WellCare of Kentucky was deemed to be fully compliant for establishing an EPSDT case management function in the 2013 Annual Compliance Review, and this element was not reviewed for WellCare of Kentucky in the 2014 review. WellCare of Kentucky's Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, documented outreach calls to members in need of services and assistance with visit scheduling. In the 2014 Annual Compliance Review, the review of ten DCBS case management files for evidence of EPSDT services, all files for which EPSDT services were applicable were found to have documentation of receipt of services.

CoventryCares of Kentucky was also found to be fully compliant in the 2013 Annual Compliance Review with establishing a case management program for EPSDT services. As per CoventryCares of Kentucky's Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, members

who missed appropriate screenings were assigned to an outreach specialist and/or case manager for further outreach in 2013. The CoventryCares of Kentucky EPSDT coordinator's role includes assisting families with accessing providers and follow-up for children lacking important EPSDT visits. In the 2014 Annual Compliance Review, CoventryCares of Kentucky was found to be non-compliant with tracking indicators for DCBS clients. The MCO responded with plans to implement tracking and analysis of performance measures for child and adolescent enrollees in the SSI and Foster categories of aid, and those who received services from the Commission for Children with Special Health Care Needs (CCSHCN). Of the ten case management files of DCBS clients reviewed in the 2014 Annual Compliance Review, one file did not contain evidence of required EPSDT services; however, this file contained evidence of MCO outreach to facilitate services. CoventryCares of Kentucky highlighted a case of coordinating multiple services, including mental health evaluation, EPSDT special services, and the development of an Individual education plan for one member in their Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death.

Passport Health Plan was fully compliant in the 2014 Annual Compliance Review with establishing and maintaining a case management program for education and counseling of members regarding EPSDT services. Passport Health Plan identifies a manager of care coordination, rapid response and EPSDT who is responsible for day to day operations of the EPSDT outreach program and coordination of the EPSDT Home Visit Outreach Program. Passport Health Plan members who are overdue for screens and/or non-compliant with periodic participation are prioritized for telephonic outreach by policy and for a home visit, if telephonic contact is unsuccessful. The EPSDT Team initiates outreach, and case management services are triggered if attempts to reach members fail. Passport Health Plan has developed a formal process for communication between the EPSDT team and case managers when a need for services is identified. Passport Health Plan has established care coordination procedures for assisting members to obtain needed services and lists specific pediatric diagnoses and conditions that may require specialized case management. Individuals with special health care needs are defined in policy as including members who require EPSDT expanded services. All ten case management files of DCBS clients reviewed for the 2014 Annual Compliance Review contained evidence of EPSDT services received.

Physical Health/Behavioral Health Coordination

Kentucky MCOs are required to establish and maintain a protocol for coordination of physical health services and behavioral health services for members with behavioral health or developmentally disabling conditions. This requirement was reviewed as part of the review of EPSDT services in the 2014 Annual Compliance Review.

WellCare of Kentucky and CoventryCares of Kentucky were fully compliant with physical health and behavioral health coordination of care in the 2013 Annual Compliance Review, and were not reviewed for this requirement in 2014. CoventryCares of Kentucky's Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, describes the process of physical health and behavioral health coordination by highlighting care coordination for a member with complex needs. Both WellCare of Kentucky and CoventryCares of Kentucky demonstrated coordination of physical health and behavioral health care for DCBS clients for all applicable files in the 2014 Annual Compliance Review of case management files.

Beacon Health Strategies, a managed behavioral health organization contracted by Humana-CareSource and Passport Health Plan, has a policy regarding a clinical referral and triage process and a policy for collaboration and referral of medical and behavioral health cases between Beacon and partner MCOs, which was documented by Humana-CareSource and Passport Health Plan in the 2014 Annual Compliance Review.

Humana-CareSource documented a process of collaboration with Beacon Health Strategies during the 2014 Annual Compliance Review, and the plan also described a process for referrals between medical and behavioral health providers. By protocol, Beacon Health Strategies contacts Humana-CareSource care management for members with frequent emergency department utilization or for members requiring medical assessment outside of Beacon's scope. The MCO has a full time behavioral health manager and health services manager to oversee integration of behavioral health and physical health services. Humana-CareSource also meets with DCBS and its liaisons in targeted service areas, and performs needs assessments with the health services director and CSHCN. The plan's care management staff provides coordination of services including early intervention and services for students with disabilities such as the development of an IEP. Care management staff has access to community resource information through the plan's SharePoint site. Humana-CareSource demonstrated coordination of physical health and behavioral health care for DCBS clients for all applicable files in the 2014 Annual Compliance Review of case management files.

Passport Health Plan has an identified behavioral health liaison, whose role includes coordinating the assessment and treatment of behavioral health conditions for members. Passport Health Plan provided evidence of coordination with Beacon Health Strategies during the 2014 Annual Compliance Review, and has established a referral form from Passport Health Plan to Beacon. The MCO and Beacon coordinate in a joint operations committee to address clinical and utilization member updates for members with physical health and behavioral health needs. Passport Health Plan has established processes for information sharing to facilitate coordination. Beacon representatives must complete documentation to indicate whether PCPs were alerted about their patient's inpatient stay by the facility. Submission of EPSDT data is included in Passport Health Plan's behavioral health provider agreements, and Passport Health Plan includes behavioral health services in its referral tracking database. Passport Health Plan's provider manual includes a behavioral health section that outlines processes for clinical coordination between behavioral health providers and PCPs, with a requirement that behavioral health providers communicate with PCPs if members consent to information sharing. Passport Health Plan demonstrated coordination of physical health and behavioral health care for DCBS clients for all applicable files in the 2014 Annual Compliance Review of case management files.

Quality Measurement and Improvement

Kentucky MCOs are required to submit annual reports of EPSDT services using Form CMS-416, as well as quarterly reports of EPSDT activities, to DMS. All four MCOs were compliant with submission of statutory EPSDT reports for 2013, including Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, and Annual Report #93, EPSDT Annual Participation Report, which includes CMS Form 416. Most MCOs included EPSDT as a focus area in their Annual Report #85, Quality Improvement Program Evaluation, and tracked progress in their QI Work Plans. All plans include performance measures related to EPSDT, i.e. HEDIS® and Healthy Kentuckians measures, in their Annual QI Program Evaluations and QI Work Plans. There was evidence that MCOs identified focus areas for improvement in their performance measure data and implemented interventions to address them in these documents. MCO-specific highlights are outlined below.

Passport Health Plan conducts an annual EPSDT evaluation as outlined in Annual Report #85, Quality Improvement Program Evaluation. The 2013 QI Program Evaluation, which assessed improvement in member and clinical adherence to EPSDT services and the overall effectiveness of the EPSDT program, documented barriers identified and interventions planned to improve screening and participation rates. Interventions detailed in the 2013 Annual QI Program Evaluation included provider incentives for increasing EPSDT screening and participation, member incentives for completing immunizations, community initiatives and targeted efforts to improve dental care access. The plan's QI Work Plan documented review and discussion of EPSDT activities in quality committee meetings. Passport Health Plan conducted a Performance Improvement Project (PIP) focused on improving dental care for CSHCN that was reported in 2013, and included dental care in its audit of provider EPSDT services.

CoventryCares of Kentucky identified EPSDT services as a priority for improvement in their 2013 QI Program Evaluation. CoventryCares of Kentucky's Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, documented the MCO's trending of screening and participation rates and tracking of rates by geographical region. CoventryCares of Kentucky's Quarterly Report #24 documented that the plan was implementing an initiative to work with providers on developing strategies to increase dental care compliance. CoventryCares of Kentucky did not specifically identify EPSDT as a focus area in their 2013 Annual QI Program Evaluation.

Humana-CareSource's QI Plan and Evaluation included a focus area on improving children's health and EPSDT. This document outlined quality improvement activities designed to improve well visits through both member and provider outreach and ongoing trending of measures. For this first year of reporting, Humana-CareSource established a baseline and conducted a preliminary barrier analysis as outlined in the Evaluation. Humana-CareSource reported in Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, that the plan is focusing on improving lead screening and has developed strategies and initiatives to address this priority for improvement.

WellCare of Kentucky's 2013 Annual Program Evaluation included an analysis of the MCO's EPSDT-related performance measures and provider medical record audits for EPSDT documentation. Activities for improvement were highlighted in the QI Program Evaluation.

Member Satisfaction with EPSDT Services

As part of the 2014 Annual Compliance Review, CAHPS® Medicaid Child Survey results and member grievances are reviewed. Although they are not necessarily EPSDT-specific, member satisfaction with children's services can provide some indirect insight into access and appropriateness of EPSDT services. Humana-CareSource did not conduct a 2013 CAHPS® survey due to initiation of enrollment in January 2013. One of the MCOs, Passport Health Plan, specifically monitors dissatisfaction with the plan's EPSDT services by tracking complaints and grievances as described below.

Passport Health Plan's 2013 CAHPS® Medicaid Child survey revealed composite items above the national average that may be relevant to EPSDT services, such as rating of personal doctor, getting care needed and how well doctors communicate. Passport Health Plan collects complaints and grievances grouped by topic, and dissatisfaction with the plan's Mommy and Me/EPSDT Programs is one category collected under the Attitude/Service category. Specific data for dissatisfaction with Passport Health Plan's EPSDT program was not included in the Annual QI Program Evaluation.

CoventryCares of Kentucky's 2013 CAHPS® Medicaid Child Survey results revealed an above average rating for personal doctors, getting needed care, how well doctors communicate and coordination of care and health promotion and education.

WellCare of Kentucky's CAHPS® Medicaid Child Survey results for 2013 also revealed above average composite ratings for personal doctors, getting needed care and how well doctors communicate.

Humana-CareSource did not report CAHPS® for 2013, as their member enrollment was initiated in 2013. Humana-CareSource reported grievances related to access in their 2013 Annual QI Program Evaluation, but the MCO did not identify if any were related specifically to children's services.

Shared decision-making rates were lower than other EPSDT-relevant reported CAHPS® rates for all three MCOs that reported CAHPS® for 2013 (Passport Health Plan, CoventryCares of Kentucky and WellCare of Kentucky). This measure evaluates health care provider communication about prescription medication, which could be relevant to EPSDT treatment services. All three MCOs documented planned interventions to address CAHPS® rates with opportunity for improvement.

Conclusion

A review of Kentucky MCOs' Annual Compliance Review findings, reported performance measures, and statutory reports provided an overview of Kentucky Medicaid managed care-enrolled children and adolescents' receipt of EPSDT services and MCOs' initiatives to ensure and facilitate age-appropriate EPSDT services in 2013. The four MCOs have varying tenure in Kentucky Medicaid. Data for Humana-CareSource, which began enrollment in 2013, were limited, while Passport Health Plan, which has participated in Kentucky Medicaid managed care the longest, demonstrated higher rates for receipt of EPSDT-related services and, in some cases, more robust initiatives to educate and outreach to members and providers.

The 2014 Annual Compliance Review revealed that all four MCOs were fully compliant with most review elements related to EPSDT services and were found to be substantially compliant with the few elements that were not fully compliant. Specific findings of opportunity for improvement in the 2014 Annual Compliance Review included maintenance of a consolidated record for Passport Health Plan due to separate databases for referrals and screenings, provision of an example of a consolidated record for the review for CoventryCares of Kentucky, monitoring of providers through medical record audits for Passport Health Plan and Humana-CareSource, inclusion of potential liability for adverse fair hearing decisions in appeal resolution letters for Humana-CareSource, and education of non-physician EPSDT providers and updated AAP guidelines for Passport Health Plan.

Expected EPSDT screenings among eligible children and adolescents were below 80% for Humana-CareSource and WellCare of Kentucky. Screening rates were above 80% among eligible children/adolescents for Passport Health Plan and CoventryCares of Kentucky. Overall, all four plans fell below 80% for participation in EPSDT services by eligible members, and older age groups appeared to have more challenges in participation. Reported HEDIS[®] measures also revealed opportunity for improvement in the percentage of children who received expected well-child visits, which would be consistent with EPSDT screening visits, for both the general population and CSHCN. Overall, similar patterns were seen for both the general population and CSHCN. Given that not all children were participating in EPSDT services in 2013, education and outreach are particularly important. The four MCOs implemented a variety of initiatives to educate and outreach to members, educate providers, and facilitate EPSDT services. Some innovative member outreach, such as promoting EPSDT services at schools, meetings of grandparents raising grandchildren, and homeless advocacy groups are promising practices that should be monitored. All MCOs engage providers in outreaching to members in need of services, and all MCOs actively track receipt of services by member and by provider panel. Case management outreach and service coordination for members needing services was well documented across MCOs, and most eligible members in case management had received EPSDT services. Provider education was also conducted in a variety of formats across MCOs.

All four MCOs showed evidence of providing a sufficient network of EPSDT providers, but efforts to monitor providers' delivery of EPSDT services varied across plans. Monitoring of services actually provided in EPSDT visits through medical record audit was not uniformly conducted by the MCOs. Results of the EPSDT validation study and HEDIS[®] and Healthy Kentuckians measures revealed 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. Although the HEDIS[®] Annual Dental Visit measure was above the national Medicaid average across MCOs, oral health assessment was lacking in well-child visits; considering that the HEDIS[®] measure includes restorative as well as preventive dental services, oral health assessment remains an area of improvement in EPSDT services.

Follow-up of risks identified in EPSDT screenings, through further diagnostic services or treatment, could not be adequately evaluated in the EPSDT validation study, and is an area for future study. Similarly, evaluation of EPSDT special services was limited.

While all MCOs documented quality improvement initiatives to address EPSDT-related indicators, methods for monitoring quality and satisfaction varied. In addition to inconsistent monitoring of provider documentation of specific EPSDT components, not all plans reported trending grievances related to children's services or conducting access and availability surveys of EPSDT providers. Satisfaction with the plan's EPSDT services was monitored by only one plan.

Some of the plans reported quality initiatives focused on specific components of EPSDT services, such as lead screening and dental care. Focus areas for improvement suggested by this report include oral health care, adolescent EPSDT services, developmental screening, mental health screening, services related to obesity identification and prevention, and vision and hearing screening. Oral health assessment was lacking in well-child visits, and a measure of preventive dental services specifically has not been reported among MCOs. Adolescents were found to have the lowest rates of EPSDT participation, well-child visits and dental visits, and the content of adolescent visits was found to lack behavioral risk and depression screening in both the validation study and Healthy Kentuckians measure results. Since there is substantial risk for developmental and mental health problems among Medicaid-eligible children as highlighted by CMS, developmental and mental health screenings in EPSDT services are also important areas of focus.^{xii} Finally, with a substantial proportion of children and adolescents reported to have other than healthy weight for height, a focus on BMI measurement and counseling for nutrition and physical activity are of prime importance.

Limitations

In addition to limited data for Humana-CareSource due to initiation of enrollment in January 2013, this review was limited by variation in the content of the MCOs' statutory reports, which did not appear to follow a standardized format. MCO comparisons should therefore be interpreted with caution.

Recommendations

Recommendations for MCOs

- In light of opportunity for improvement in screening and participation rates, MCOs should evaluate the effectiveness of member education and outreach initiatives and formulate strategies to enhance outreach efforts.
- MCOs should actively track access and availability of EPSDT providers through specific access and availability surveys, monitoring grievances related to access to EPSDT services, monitoring denials and appeals related to EPSDT special services, and evaluation of satisfaction with EPSDT services.
- MCOs should actively monitor the content of EPSDT visits through medical record audits, and ensure the provision of mental health and developmental screenings, behavioral risk assessment, oral health assessment, immunization status and age-appropriate anticipatory guidance.
- MCOs should evaluate their MCO-specific data for focus areas for improvement and initiate improvement activities to address these areas. Focus areas suggested by this review include identification and prevention of obesity, dental care, mental health and developmental screening, adolescent EPSDT services, and vision and hearing screening.

Recommendations for DMS

- DMS should continue to evaluate EPSDT services through validation studies of services provided in well-child visits, with a focus on areas identified to be in need of improvement, including evaluation of follow-up services received.
- Given the percentage of children and adolescents reported to have a weight category other than healthy and the lack of documented monitoring and counseling, a focused study to evaluate the prevention, identification and management of childhood obesity would be of benefit to MCOs in addressing this topic.
- MCO reporting of preventive dental services specifically, through measures such as the Children's Health Insurance Program Reauthorization Act (CHIPRA) core measure "Percentage of Eligibles that Received Preventive Dental Services," would facilitate monitoring of preventive dental visits as part of EPSDT services.
- Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, Pregnant Women, Maternal and Infant Death, appeared to vary in content across MCOs. Establishing parameters for the content of this report would facilitate comparative evaluation of MCO initiatives related to EPSDT.
- DMS could consider file review of denials and appeals of specific services related to EPSDT special services in upcoming annual compliance reviews, rather than general children's services, if feasible to better evaluate EPSDT special services.

References

- ⁱ Kaiser Commission on Medicaid and the Uninsured. Early and Periodic Screening, Diagnostic and Treatment Services. October 2005. Available at <http://www.kff.org/medicaid/upload/Early-and-Periodic-Screening-Diagnostic-and-Treatment-Services-Fact-Sheet.pdf>. Accessed March 12, 2013.
- ⁱⁱ United States General Accounting Office, 2001. <http://www.gao.gov/new.items/d01749.pdf>.
- ⁱⁱⁱ Centers for Medicare & Medicaid Services. EPSDT-A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents. June 2014. Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>.
- ^{iv} Centers for Medicare & Medicaid Services. EPSDT-A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents. June 2014. Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>
- ^v Centers for Medicare & Medicaid Services. EPSDT-A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents. June 2014. Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>.
- ^{vi} Centers for Medicare & Medicaid Services. EPSDT-A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents. June 2014. Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>
- ^{vii} The American Academy of Pediatrics. Periodicity Schedule - Schedule of Screenings & Assessments Recommended at Each Well-Child Visit from Infancy through Adolescence. Available at <http://www.aap.org/en-us/professional-resources/practice-support/Pages/PeriodicitySchedule.aspx>
- ^{viii} Kentucky Cabinet for Health and Family Services. Department for Medicaid Services. Early Periodic Screening, Diagnostic and Treatment Services (EPSDT). Available at <http://chfs.ky.gov/dms/epsdt.htm>
- ^{ix} United States General Accounting Office, Report to Congressional Requesters. Medicaid: stronger efforts needed to ensure children's access to health screening services. July 2001; GAO-01-749. Available at <http://www.gao.gov/new.items/d01749.pdf>.
- ^x Centers for Medicare & Medicaid Services. Early Periodic Screening, Diagnostic and Treatment Services. 2013 National Data. Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>
- ^{xi} Annual EPSDT Participation Report, Form CMS 416 (National), Fiscal Year 2013. Available at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/early-and-periodic-screening-diagnostic-and-treatment.html>
- ^{xii} Department of Health and Human Services, Centers for Medicaid and Medicare Services, Center for Medicaid and CHIP Services. CMCS Informational Bulletin, March 27, 2013. Prevention and Early Identification of Mental Health and Substance Use Conditions. Available at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-03-27-2013.pdf>.



Improving Healthcare
for the Common Good

**Commonwealth of Kentucky
Department for Medicaid Services
Division of Program Quality & Outcomes**

**Validation of Managed Care Provider
Network Submissions: Audit Report**

**Final
February 2015**

IPRO Corporate Headquarters
Managed Care Department
1979 Marcus Avenue
Lake Success, NY 11042-1002
phone: (516) 326-7767
fax: (516) 326-6177
www.ipro.org

Table of Contents

EXECUTIVE SUMMARY	3
INTRODUCTION	4
OBJECTIVES	4
METHODOLOGY	4
SAMPLING.....	4
SURVEY.....	4
MAILING	5
DATA ANALYSES	5
METHODOLOGICAL CONSIDERATIONS.....	6
SURVEY RESULTS	7
RESPONSE RATE CALCULATIONS	7
ACCURACY RATE CALCULATIONS.....	7
COMPARISON BETWEEN MAY 2014 AND OCTOBER 2014 RESULTS	8
FINDINGS.....	9
RECOMMENDATIONS	13
APPENDIX A – RESPONSE RATE BY PLAN	14
APPENDIX B – OVERALL ACCURACY BY PLAN	15
APPENDIX C.....	16
SAMPLE OF SPECIALIST SURVEY SENT TO PROVIDERS	16
SAMPLE OF PCP SURVEY SENT TO PROVIDERS.....	17

List of Tables

Table 1: Fields for Validation by Provider Type	5
Table 2: Missing MCAPS Data	6
Table 3: Survey Responses by PCP/Specialist.....	7
Table 4: Status of Surveys by Provider Type	8
Table 5: Statewide Rates of Accuracy for May 2014 and October 2014.....	8
Table 6: Provider Identification Elements – Statewide	9
Table 7: Specialty – Statewide and by Provider Group	10
Table 8: Reporting of Languages – Statewide	11
Table 9: Provider Group Summary on Survey Items	12
Table A1: Response Rate by Plan	14
Table B1: Overall Accuracy by Plan.....	15

EXECUTIVE SUMMARY

In October 2014, Island Peer review Organization (IPRO), on behalf of the Kentucky Department for Medicaid Services (DMS), conducted its third audit of the Managed Care Assignment Processing System (MCAPS) to validate its accuracy. There are five managed care organizations (MCOs) operating in Kentucky: Anthem Blue Cross Blue Shield, WellCare of Kentucky, CoventryCares of Kentucky, Passport Health Plan, and Humana-CareSource.

Data validation surveys (**Appendix C**) were sent to 100 primary care providers (PCPs) and 100 specialists from the five MCOs. The overall response rate was 62.5% (**Appendix A**). PCPs responded at a higher rate than specialists, with rates of 67.7% and 57.1%, respectively. The response rates also varied by MCO: ranging from 52.2% for CoventryCares of Kentucky to 70.7% for Anthem Blue Cross Blue Shield. After removing exclusions, 497 providers were available for analysis.

Highlights of the Audit Findings

- A total of 213 (42.9%) providers who returned surveys included at least one revision. A higher percentage of PCP records had revisions than specialist records, although differences were not statistically significant.
- Four survey items had a substantial percentage of providers with missing data in the MCAPS data file: License number, Secondary Specialty, Spanish, and Other Languages Spoken. Overall accuracy and error rates excluded additions to the Spanish field, as well as additions of “English” to the Languages field.
- While the least accurate field was “Spanish” with a 60.2% rate of accuracy, most of the revisions were additions, because the original MCAPS data were blank. As such, this finding should be interpreted with caution.
- The fields with the most accurate rates were “Last Name” with a 99.8% rate, “State” with a 99.6% rate, “First Name” with a 99.4% rate, “National Provider ID (NPI)” with a 99.0% rate, whether the provider has a contract to accept Medicaid patients with a 98.4% rate, “PCP Panel Size” with a 97.3% rate, “City” with a 97.2% rate, “Provider Type” with a 96.4% rate, “Secondary Specialty” with a 96.2% rate, “PCP, Specialist, or Both” with a 95.8% rate, “Primary Specialty” with a 95.4% rate, and “Zip Code” with a 95.2% rate.
- There was an average of 1.77 revisions per provider for the 213 providers that submitted surveys with changes.
- The “Street Address” element had an accuracy rate of 91.5%. The “Phone Number” element had an accuracy rate of 87.9%, although approximately half the revisions coincided with a change in address. The accuracy rate for “PCP Open or Closed Panel” was 92.4%.
- The “License Number” field was reported correctly in 81.9% of records among the 432 providers licensed in Kentucky, partially due to the high number of missing data in the original data file.
- The “Languages Spoken” element was underreported, and had an accuracy rate of 79.5%. At least one language was added by 101 providers.
- A comparison of the statewide rates of overall accuracy, between the last audit conducted in May 2014 and the current audit, revealed a significant increase from 50.1% to 57.1%. Two data elements, “Provider Type” and “PCP, Specialist, or Both,” increased, while one data element, “Spanish,” decreased in accuracy over time.

The remainder of this report provides details on the background, objectives, and methodology of the study. In addition, the report analyzes the results for each data element and discusses differences in reporting between PCPs and specialists.

INTRODUCTION

MCO provider networks must include a sufficient number of providers and types to deliver contracted services to their target Medicaid populations and meet state accessibility standards. DMS requires the contractor, IPRO, to verify the provider information submitted by Kentucky MCOs to the MCAPS, Kentucky's database for collecting provider panel information. MCOs must submit provider data monthly for all plan enrolled providers electronically to Kentucky's secure MCAPS. Kentucky uses MCAPS data to evaluate the adequacy of the MCO's networks, assess capacity, create Performance Measures related to the MCO's provider networks, and conduct access and availability studies; hence, the accuracy of the source data is essential.

IPRO conducted a two-phase mailing to validate the accuracy of the MCAPS data submissions for PCPs and specialists participating with any of the five MCOs operating in Kentucky with a Medicaid product line. Responses are compared to information in the MCAPS and an error rate is computed for each data element that is validated.

This report is a summary of the third audit of the accuracy of MCO submissions to the MCAPS conducted by IPRO for the DMS. The last audit, conducted in May 2014, demonstrated that most data fields were correct over 90% of the time, and errors were more likely due to underreporting. The audited population for this survey mirrors that of the prior two surveys in which PCPs and specialists who participate in Medicaid were audited. This year, however, Anthem Blue Cross Blue Shield was new to the study.

OBJECTIVES

The objectives of this study were to:

- Validate the accuracy of MCO MCAPS data submissions for Medicaid participating PCPs and specialists,
- Further the accuracy of MCO data submission through furnishing MCO-specific reports to the health plans for correction, and
- Compare the findings of the May 2014 and October 2014 survey studies.

METHODOLOGY

Sampling

In October 2014, DMS sent IPRO five files containing each MCO's MCAPS submission for the most recent monthly provider data. The combined files contained a total of 282,171 records. IPRO excluded selected providers, such as providers whose address was not in Kentucky or any of its bordering states, providers not included in the directory and provider types such as pharmacies. After removing duplicate providers, the file contained 23,285 providers. Random sampling of 100 PCPs and 100 specialists was performed for each plan, resulting in a total sample size of 1,000 providers. Providers who were denoted as "both" for the PCP/Specialist field were categorized as PCPs. A listing of participating MCOs can be found in **Appendix A**.

Survey

The survey sent to PCPs and specialists requested the validation of data fields outlined in **Table 1**. Because the required data fields vary by provider classification, two versions of the survey tool were designed. The tool for specialists did not include the two fields (Open or Closed Panel and Panel Size) for which reporting is not required for them.

All providers were asked an initial screening question as to whether they participated in the named MCO. The 16 providers who responded that they did not participate or did not recognize the named MCO were excluded from analysis.

Table 1: Fields for Validation by Provider Type

Field Names	PCPs	Specialists
Last Name	X	X
First Name	X	X
License Number	X	X
National Provider ID (NPI)	X	X
Street	X	X
City	X	X
State	X	X
Zip Code	X	X
Phone Number	X	X
Accepts Medicaid	X	X
Provider Type	X	X
PCP, Specialist, or Both	X	X
Primary Specialty	X	X
Secondary Specialty	X	X
PCP Open or Closed Panel	X	
PCP Panel Size	X	
Spanish	X	X
Other Languages Spoken*	X	X
MCO – whether provider participates with the plan sampled for survey	X	X

*Up to four languages can be submitted for each provider.

To ensure the accuracy of responses for “Provider Type,” providers were sent a listing of codes for provider type and corresponding provider type labels to facilitate their response to this item.

Mailing

The audit was conducted as a two-phase mail survey. A total of 1,000 providers were sent a survey on November 5, 2014. The second mailing was sent on December 8, 2014 to the 546 providers who did not respond to the first mailing, excluding surveys that were returned as undeliverable. The analysis was started in late January 2015.

The mailing included a cover letter explaining the purpose of the survey, the survey containing auto-populated provider-specific information to be validated, instructions on how to complete the survey with an explanation of each survey item, a listing of provider types, and an envelope to return the survey with pre-paid postage. A database was developed to track the status of all surveys and record provider responses.

Data Analyses

The following analyses were conducted to address the objectives of this study:

- Response rate calculations,
- Accuracy rates on all survey items,
- Comparison of May 2014 and October 2014 results, and
- Comparisons of PCPs and specialists on all applicable survey items.

To test for any differences in proportions, chi-square analyses were employed for all comparative analyses. Statistical significance was established using a p value of .05. Chi square tests produce p values, which help determine whether differences in rates are statistically significant.

Methodological Considerations

PCP/Specialist Categorization

Because the survey contains an item to validate whether the provider is a “PCP,” “Specialist,” or “Both,” the comparisons between PCPs and specialists on accuracy rates incorporate the revisions made by providers to this field. For instance, if a provider was categorized as a PCP in the MCAPS, and changed the item to specialist on the survey, that provider was considered a specialist for most analyses in this report. The only section that retains the original categorizations is the response rate calculation section. As a result, the total counts of PCPs and specialists appearing in this report differ depending on the analysis.

Missing Data in the MCAPS Data File

Among the survey items, there were four items that had a substantial percentage of providers with missing data in the MCAPS data file (**Table 2**). This resulted in higher error rates, since providers recorded their responses because there was no data on the survey. License number was only required for providers licensed in Kentucky. Among the 432 providers licensed in Kentucky, 16.9% were missing license number in the MCAPS file. A total of 97.2% of the providers had no secondary specialty in the MCAPS file, even though IPRO captured specialties from different rows in the file prior to conducting the survey. The Spanish field was missing for 60.6% of the providers. The MCAPS data dictionary specifies only “Y” for yes. However, some plans entered Y and N (“N” for no), and the analysis was conducted as if the requirement includes both Y and N. The Language field was missing for 74.2% of the rows in the MCAPS file.

Table 2: Missing MCAPS Data

Survey Item	n	%
License Number*	73	16.9%
Secondary Specialty	483	97.2%
Spanish	301	60.6%
Other Languages Spoken	369	74.2%

*License Number is limited to providers licensed in Kentucky.

The survey validation results on the missing items listed in **Table 2** were:

- Among the 73 missing data for License number, 52 providers added a License number, while 21 left the field blank;
- Among the 483 missing data for Secondary Specialty, 16 providers added a specialty, while 467 left the field blank, most likely because they do not have a secondary specialty;
- Among the 301 missing data for Spanish, 189 added a response, while 112 left the field blank; and
- Among the 369 missing data for Language, 88 added a response (most frequently English), while 281 left the field blank.

Due to the high number of providers with missing data in the MCAPS file, and the high percentage of revisions reflecting additions instead of changes, the overall accuracy and error rates exclude two types of revisions. For the Spanish field, additions were excluded, but changes were included. For

the Languages field, additions of “English” were excluded, although other language additions or changes were retained. Further information is provided below in the report.

SURVEY RESULTS

Response Rate Calculations

The response rates for the survey are displayed in **Table 3**. Results are itemized by PCP and specialist surveys, and include the total number of surveys mailed, undeliverable surveys due to inaccurate addresses, adjusted populations, number of exclusions, and completed surveys.

A total of 128 surveys were returned to IPRO as “undeliverable” due to inaccurate addresses. Specialists had a slightly higher rate of undeliverable surveys than PCPs (14.2% vs. 11.4%). The undeliverable rate was lower in this audit than the last audit (12.8% vs. 16.0%).

There were 545 returned surveys, yielding a response rate of 62.5%. PCPs responded at a higher rate than specialists, at 67.7% and 57.1%, respectively. As seen in **Appendix A**, response rates ranged from 52.2% for CoventryCares of Kentucky to 70.7% for Anthem Blue Cross Blue Shield. A total of 48 returns were excluded from the analysis because:

- 16 providers did not participate in the named MCO or did not recognize the MCO, and
- 32 providers were not at that site.

Humana-CareSource had the highest number of exclusions with 20, followed by CoventryCares of Kentucky (10 exclusions), Passport Health Plan (7 exclusions), WellCare of Kentucky (7 exclusions), and Anthem Blue Cross Blue Shield (4 exclusions).

As a result, 497 completed surveys were available for analysis.

Table 3: Survey Responses by PCP/Specialist

Survey Responses	PCPs	Specialists	Total
Surveys Mailed	500	500	1,000
Undeliverable	57	71	128
Adjusted Population	443	429	872
Returned Surveys	300	245	545
Response Rate	67.7%	57.1%	62.5%
<i>Exclusions</i>	25	23	48
Completed Surveys	275	222	497

Accuracy Rate Calculations

Among the completed surveys, **Table 4** displays the number and percent of providers who reported at least one revision on their surveys across all items, itemized by PCPs and specialists. Overall, 42.9% of completed surveys included at least one revision. PCPs were more likely than specialists to return surveys with revisions (46.3% vs. 38.9%), although differences were not statistically significant. Note that the PCP survey included two more fields than the specialist survey. As mentioned previously, the error rates exclude instances where a provider added a response for Spanish if one did not exist and/or added English as a response for Languages. Also, corrections to License number were limited to providers in Kentucky.

There was an average of 1.77 revisions per provider, among the 213 providers that had at least one correction. **Appendix B** provides a list of revisions per provider by health plan. Accuracy rates ranged from 42.2% for Passport Health Plan to 71.0% for WellCare of Kentucky.

Table 4: Status of Surveys by Provider Type

Completed Surveys	Total (n = 497)		PCPs (n = 268)		Specialists (n = 229)		Significance
	n	%	n	%	n	%	
With Revisions	213	42.9%	124	46.3%	89	38.9%	n.s.
Without Revisions	284	57.1%	144	53.7%	140	61.1%	n.s.

Note: n.s. denotes not significant at $p < 0.05$.

Comparison Between May 2014 and October 2014 Results

Table 5 provides a summary and comparison of May 2014 and October 2014 statewide rates of accuracy. Overall accuracy increased by 7 percentage points from 50.1% in May 2014 to 57.1% in October 2014. Among the individual items, correct reporting of “Provider Type” and “PCP, Specialist, or Both” saw significant increases in accuracy. “Spanish” was the only data element that saw a significant decrease in accuracy from 67.2% to 60.2%.

Table 5: Statewide Rates of Accuracy for May 2014 and October 2014

Field Name	May 2014 Statewide Results	October 2014 Statewide Results	Significance
Last Name	98.9%	99.8%	
First Name	98.7%	99.4%	
License Number	81.9%	81.9%	
National Provider ID (NPI)	98.7%	99.0%	
Street Address	89.3%	91.5%	
City	98.1%	97.2%	
State	100.0%	99.6%	
Zip Code	95.7%	95.2%	
Phone Number	85.9%	87.9%	
Accepts Medicaid	98.1%	98.4%	
Provider Type	93.3%	96.4%	▲
PCP, Specialist, or Both	91.5%	95.8%	▲
Primary Specialty	93.3%	95.4%	
Secondary Specialty	96.3%	96.2%	
Open or Closed Panel (PCPs Only)	92.3%	92.4%	
Panel Size (PCPs Only)	96.4%	97.3%	
Spanish	67.2%	60.2%	▼
Other Languages Spoken	81.3%	79.5%	
Overall Accuracy	50.1%	57.1%	▲

* October 2014 rate significantly higher (▲) or significantly lower (▼) than October 2014 rate at $p < 0.05$.

Findings

The following sections detail the findings with respect to each element validated.

Provider Identification

Table 6 displays the percentage of correct records (i.e., records that did not require revising) for each of the provider identification elements at the statewide level and by provider classification. The provider identification element most likely to be corrected was “License Number” with an accuracy rate of 81.9%, partially due to the high number of missing data in the original data file. Note that License number is only based on the 432 providers who were licensed in Kentucky. “Phone Number” was the next element most likely to be revised with an accuracy rate of 87.9%. Among the 60 providers who revised “Phone Number,” 31 also revised their “Street Address.”

The error rates for the address-related fields do not include surveys that were returned as “undeliverable,” which in effect could also represent incorrect addresses. While the exclusion of undeliverable surveys should be considered when interpreting the provider address fields’ (Street Address, City, State, and Zip Code) error rates, they were not factored into the analysis because the undeliverable surveys may represent other issues (e.g., provider not at site or retired). Undeliverable surveys by plan ranged from 10.0% to 16.5% with an overall rate of 12.8% (**Appendix A**).

With the exception of “Street Address,” “Phone Number,” and “License Number,” the remaining provider identification elements were correct in at least 95% of returned surveys, (i.e., “Last Name,” “First Name,” “NPI,” “City,” “State,” and “Zip Code”). For “License Number,” 78 providers recorded a change. However, for 52 of these providers, the MCAPS data file did not contain a License Number, so these represent both an addition and revision.

No significant differences between PCPs and specialists were identified for any of the Provider Identification elements.

Table 6: Provider Identification Elements – Statewide (n = 497)

Provider Identification Elements	Total Records without Revisions	Total Records with Revisions	% Correct			Significance
			Total Records	PCPs	Specialists	
Last Name	496	1	99.8%	100.0%	99.6%	n.s.
First Name	494	3	99.4%	99.6%	99.1%	n.s.
License Number*	354	78	81.9%	80.7%	83.5%	n.s.
NPI	492	5	99.0%	98.9%	99.1%	n.s.
Street Address	455	42	91.5%	91.8%	91.3%	n.s.
City	483	14	97.2%	96.6%	97.8%	n.s.
State**	495	2	99.6%	99.6%	99.6%	n.s.
Zip Code***	473	24	95.2%	94.8%	95.6%	n.s.
Phone Number	437	60	87.9%	89.6%	86.0%	n.s.

Note: n.s. denotes not significant at $p < 0.05$.

* Of these revisions, 52 were for records that did not have a License number in the data file.

** Of these revisions, both (2) were for records that also were revised for Street Address.

*** Of these revisions, all (24) were for records that also were revised for Street Address.

Accepts Medicaid

This item asked whether the provider has a contract to accept Medicaid patients, and was coded as ‘Yes’ or ‘No’. This field was reported correctly in 98.4% (489 out of 497) of surveys. In all eight cases with corrections, a Yes was changed to a No response. Accuracy rates were 97.8% for PCPs and 99.1% for specialists.

Provider Type

Provider type is identified by a 2-digit code and a corresponding provider type description. A listing of codes and corresponding provider type descriptions was enclosed in the survey packet, and providers were asked to use one of the codes on the list if a correction was necessary. This field was reported correctly in 96.4% (479 out of 497) of providers. Among the 18 corrections, 12 were changed from “Physician Individual” to “Physician Group.” Provider type was accurate for 95.5% of PCPs and 97.4% of specialists.

PCP, Specialist, or Both

Providers were asked to validate whether they were a PCP, a specialist, or both. The accuracy rate for this field was 95.8% (476 out of 497). Among the 21 who recorded a change, the most common changes were from “PCP” to “Specialist” (n = 11) and “PCP” to “Both” (n = 5). Rates were similar for PCPs and specialists (96.3% and 95.2%, respectively).

Provider Specialty

Physicians were requested to verify their primary and secondary specialties. **Table 7** presents correct rates for these fields statewide and by provider group. “Primary Specialty” was correctly reported in 474 (95.4%) records. “Secondary Specialty” was correctly reported in 478 (96.2%) records. Of the 19 records with corrections, 16 were originally blank and the provider added a specialty.

Accuracy rates for “Primary Specialty” were 95.9% for PCPs and 94.8% for specialists. Accuracy rates for “Secondary Specialty” were similar for PCPs and specialists (96.3% and 96.1%, respectively).

Table 7: Specialty – Statewide and by Provider Group (n = 497)

Specialty	Records without Revisions	Records with Revisions	% Correct			Significance
			Total Records	PCPs	Specialists	
Primary Specialty	474	23	95.4%	95.9%	94.8%	n.s.
Secondary Specialty	478	19	96.2%	96.3%	96.1%	n.s.

Note: n.s. denotes not significant at $p < 0.05$.

PCP Open or Closed Panel

This is a required field for PCPs only. Valid entries were “O” for Open or “C” for Closed. Of the 268 PCPs, 4 providers were excluded from this analysis, since they were originally classified as specialists (but corrected their data to PCP on the previous item), so this item did not appear on their survey. Among the 264 PCPs with data for this field, 244 (92.4%) were returned with no revisions to the element. Among the 20 PCPs with corrections, 18 revised their panel from “Open” to “Closed,” while 2 revised their panel from “Closed” to “Open.”

Panel Size

“Panel Size” is a required field for PCPs only. Providers were requested to validate the number of Medicaid enrollees last reported by the named health plan as being assigned to that provider and practice site. Of the 264 completed PCP surveys, 257 (97.3%) were returned with no revisions to the panel size element.

Spanish

Providers were asked to validate whether the provider or clinical staff can speak Spanish. While accuracy rates were low (60.2%), 189 out of the 198 revisions were additions, because the original data for the field were blank in the MCAPS file. Accuracy rates on this field did not significantly differ between PCPs and specialists (63.4% and 56.3%, respectively). Due to the high number of providers with missing data in the MCAPS file, and the high percentage of revisions reflecting additions instead of changes, additions for this field were excluded in computing overall accuracy and error rates. However, the 9 revisions that were provider changes to this field were utilized in the calculations.

Languages Spoken

This element reflects the languages that a provider or clinical staff member has the ability to speak with patients. There are four possible language fields in the file. This element was correct in 79.5% of records (**Table 8**).

Provider revisions to this field indicated that the element is underreported. Of the 497 completed surveys, 102 (20.5%) providers reported revisions to the “Languages Spoken” field. A total of 101 (20.3%) providers added at least one language, while 4 (0.8%) providers dropped at least one language. Staff turnover at physicians’ practices may contribute to why this field was one of the least accurate elements. English was the most commonly added language on the survey. Excluding Spanish, no other languages were reported more than twice by providers.

PCPs were more likely to make corrections than specialists ($p < 0.05$), with accuracy rates of 75.7% and 83.8%, respectively.

Note that although the accuracy rate appears high for this field, with no changes for 395 providers, a total of 281 of these providers did not have any languages in the original MCAPS file and did not add a language, so they are included in the count of 395. Also, because “English” was added by 89 providers, but most providers left the “Language Spoken” field blank, all “English” additions were excluded from the overall accuracy and error rates.

Table 8: Reporting of Languages – Statewide

Languages	n = 497	%
Same languages	395	79.5%
At least one language added	101	20.3%
At least one language dropped	4	0.8%

Note: Three providers added and dropped at least one language, and were therefore counted in the added and dropped counts.

Summary of Accuracy Rates Statewide and by Provider Group

Table 9 displays the accuracy rates for each survey item by provider group category.

Table 9: Provider Group Summary on Survey Items

Survey Item	PCP (n = 268)	Specialist (n = 229)	Total (n = 497)
Last Name	100.0%	99.6%	99.8%
First Name	99.6%	99.1%	99.4%
License Number	80.7%	83.5%	81.9%
National Provider ID (NPI)	98.9%	99.1%	99.0%
Street Address	91.8%	91.3%	91.5%
City	96.6%	97.8%	97.2%
State	99.6%	99.6%	99.6%
Zip Code	94.8%	95.6%	95.2%
Phone Number	89.6%	86.0%	87.9%
Accepts Medicaid	97.8%	99.1%	98.4%
Provider Type	95.5%	97.4%	96.4%
PCP, Specialist, or Both	96.3%	95.2%	95.8%
Primary Specialty	95.9%	94.8%	95.4%
Secondary Specialty	96.3%	96.1%	96.2%
PCP Open or Closed Panel	92.4%	N/A	N/A
PCP Panel Size	97.3%	N/A	N/A
Spanish	63.4%	56.3%	60.2%
Other Languages Spoken	75.7%	83.8%	79.5%
Overall Accuracy	53.7%	61.1%	57.1%

N/A: not applicable.

MCO variation in accuracy rates for each survey item was evaluated (data not shown). Most fields did not vary much among the five health plans. The four fields with the widest range in accuracy rates were: “License number,” “Primary Specialty,” “Spanish,” and “Languages Spoken.”

Limitations

The major limitations in interpreting the results of this audit center on the missing data in the MCAPS data file, especially for the fields “Spanish” and “Languages Spoken.” The overall rates were adjusted to discount any additions made by the providers to the “Spanish” field and additions of “English” to the “Languages Spoken” field. However, these additions were retained in the error rates for the two fields to present an accurate representation of the issues with these fields. Treating provider additions as errors when the MCAPS data were blank increased the error rates for these fields. On the other hand, as noted above, many providers did not record a response on the survey when the original MCAPS data were blank. A lack of response was treated as no change, which consequently contributed to the accuracy rate. These limitations also applied to the “License number” field. In general, rates for these fields should be interpreted with caution. Validation surveys are much more informative when the original data file contains some data to validate, so plans should be encouraged to provide complete data, including a response for every field.

RECOMMENDATIONS

Based on the findings of this audit, IPRO recommends that:

DMS

- Follows up with health plans to correct provider records for the errors identified by this audit;
- Works with plans to enhance the accuracy and completion of critical fields in the MCAPS, especially fields relating to license number, phone number, address, and languages spoken;
- Expands the data dictionary to include more specificity in the definitions of the data elements to help facilitate plans' submission of accurate and complete data. For example, for the language fields, codes are provided without further instruction to ensure that each provider report at least one language;
- Considers adding data elements to the MCAPS that collect information about wheelchair access, hours at site, provider usage of Health Information Technology (such as electronic medical records (EMR) systems), and providers' Patient-Centered Medical Home (PCMH) certification status and level;
- Considers removing the field "Spanish" and incorporating it into the Language field. If "Spanish" is retained as a separate field, it would be preferable to revise the data dictionary and ask plans to enter "Y" or "N," so that missing data are not presumed to be No;
- Considers recording "Secondary Specialty" on the same row as "Primary Specialty" instead of on separate rows; and
- Considers adding interpreter services/translation services as codes to the data dictionary of the language field, since some providers noted this on the survey, but there is no code to capture such services in the MCAPS.

IPRO

- Furnishes the names and addresses of the surveys that were undeliverable to the health plans for further research.

Appendix A – Response Rate by Plan

Table A1: Response Rate by Plan

Plan	Initial Sample Size	Undeliverable Surveys	Adjusted Sample Size	Returns	Response Rate
Anthem Blue Cross Blue Shield	200	33	167	118	70.7%
CoventryCares of Kentucky	200	22	178	93	52.2%
Humana-CareSource	200	26	174	111	63.8%
Passport Health Plan	200	27	173	109	63.0%
WellCare of Kentucky	200	20	180	114	63.3%
TOTAL	1,000	128	872	545	62.5%
ALL PCPs	500	57	443	300	67.7%
ALL Specialists	500	71	429	245	57.1%

Appendix B – Overall Accuracy by Plan

Table B1: Overall Accuracy by Plan

Plan	Completed Surveys	Returned with Revisions	Returned without Revisions	% Survey without Revisions	Average Revisions
Anthem Blue Cross Blue Shield	114	48	66	57.9%	1.73
CoventryCares of Kentucky	83	31	52	62.7%	1.71
Humana-CareSource	91	44	47	51.6%	1.93
Passport Health Plan	102	59	43	42.2%	1.73
WellCare of Kentucky	107	31	76	71.0%	1.77
TOTAL	497	213	284	57.1%	1.77
ALL PCPs*	268	124	144	53.7%	1.77
ALL Specialists*	229	89	140	61.1%	1.79

*Provider revisions to the field “PCP, Specialist, or Both” were incorporated to identify the correct category for PCP or Specialist.

Appendix C

Sample of Specialist Survey Sent to Providers

**Commonwealth of Kentucky
Department for Medicaid Services**

Provider Network Data Survey

The health plan to the left has provided the following to DMS for the provider listed below. If you do not participate in this plan, please check the box to the right and return the survey.

1. Please verify that the following information is correct.

2. Make necessary corrections.

Last Name				
First Name				
License #				
Natl Provider Id (NPI)				
Street				
City				
State / Zip Code				
Phone				
Accepts Medicaid	<input type="checkbox"/>	Y=Yes, N=No	<input type="checkbox"/>	Y=Yes, N=No
Provider Type				
PCP, Specialist, or Both	<input type="checkbox"/>	P=PCP, S=SPECIALIST, B=BOTH	<input type="checkbox"/>	P=PCP, S=SPECIALIST, B=BOTH
Specialty:				
Primary				
Secondary				
Spanish	<input type="checkbox"/>	Y=Yes, N=No	<input type="checkbox"/>	Y=Yes, N=No
Languages spoken by Physician and/ or Clinical staff at this site:				

Check here if no corrections required

THANK YOU!

Sample of PCP Survey Sent to Providers

**Commonwealth of Kentucky
Department for Medicaid Services**

Provider Network Data Survey

The health plan to the left has provided the following to DMS for the provider listed below. If you do not participate in this plan, please check the box to the right and return the survey.

1. Please verify that the following information is correct.

2. Make necessary corrections.

Last Name				
First Name				
License #				
Natl Provider Id (NPI)				
Street				
City				
State / Zip Code				
Phone				
Accepts Medicaid	<input type="checkbox"/>	Y=Yes, N=No	<input type="checkbox"/>	Y=Yes, N=No
Provider Type				
PCP, Specialist, or Both	<input type="checkbox"/>	P=PCP, S=SPECIALIST, B=BOTH	<input type="checkbox"/>	P=PCP, S=SPECIALIST, B=BOTH
Specialty:				
Primary				
Secondary				
PCP Open or Closed Panel	<input type="checkbox"/>	O=Open, C=Closed	<input type="checkbox"/>	O=Open, C=Closed
PCP Panel Size				
Spanish	<input type="checkbox"/>	Y=Yes, N=No	<input type="checkbox"/>	Y=Yes, N=No
Languages spoken by Physician and/ or Clinical staff at this site:				

Check here if no corrections required

THANK YOU!



Validation of Reporting Year 2014 Kentucky Medicaid Managed Care Performance Measures

**FINAL
FEBRUARY 2015**

**Prepared on Behalf of
The Commonwealth of Kentucky
Department for Medicaid Services
Division of Program Quality and Outcomes**

**IPRO Corporate Headquarters
Managed Care Department
1979 Marcus Avenue
Lake Success, NY 11042-1002
phone: (516) 326-7767
fax: (516) 326-6177
www.ipro.org**

Table of Contents

BACKGROUND AND INTRODUCTION	4
METHODOLOGY.....	7
VALIDATION ACTIVITIES.....	8
DATA AND INFORMATION REQUEST	8
INFORMATION SYSTEMS CAPABILITIES ASSESSMENT	8
DENOMINATOR VALIDATION.....	9
DATA COLLECTION VALIDATION.....	10
MEDICAL RECORD TOOLS AND INSTRUCTIONS AND PROCESSES REVIEW	10
MEDICAL RECORD REVIEW VALIDATION.....	10
ADMINISTRATIVE RECORD REVIEW.....	10
NUMERATOR VALIDATION.....	10
SUMMARY OF VALIDATION FINDINGS.....	12
INFORMATION SYSTEMS CAPABILITIES ASSESSMENT	12
DENOMINATOR VALIDATION.....	12
DATA COLLECTION VALIDATION.....	12
<i>Medical Record Tools and Instructions and Processes Review</i>	12
<i>Medical Record Review Validation</i>	14
<i>Administrative Record Review</i>	15
MEASURE RATES AND REPORTING DESIGNATIONS.....	16
RECOMMENDATIONS	24
FUTURE DIRECTIONS	25
REFERENCES	26
APPENDIX A – VALIDATION FINDINGS FOR COVENTRYCARES OF KENTUCKY	27
APPENDIX B – VALIDATION FINDINGS FOR HUMANA-CARESOURCE	35
APPENDIX C – VALIDATION FINDINGS FOR PASSPORT HEALTH PLAN	41
APPENDIX D – VALIDATION FINDINGS FOR WELLCARE OF KENTUCKY	49

List of Tables

Table 1: Kentucky Medicaid Managed Care Performance Measures – RY 2014	5
Table 2: Kentucky-Specific Performance Measures – RY 2014	6
Table 3: State-Specific Performance Measure Rates – RY 2014	18
Table A1: CoventryCares of Kentucky – RY 2013 and 2014 Performance Measure Rates	29
Table B1: Humana-CareSource – RY 2014 Performance Measure Rates.....	36
Table C1: Passport Health Plan – RY 2013 and 2014 Performance Measure Rates.....	43
Table D1: WellCare of Kentucky – RY 2013 and 2014 Performance Measure Rates	51

BACKGROUND AND INTRODUCTION

A goal of the Medicaid program is to improve the health status of Medicaid recipients. Statewide health care outcomes, health indicators and goals have been designed by the Kentucky Department of Medicaid Services (DMS). Federal Medicaid Managed Care regulations, 438.24 (C)(1) and (C)(2) Performance Measurement, require that the Medicaid managed care organizations (MCOs) measure and report to the State its performance, using standard measures required by the State and/or submit to the State data that enables the State to measure the MCOs' performance. As a result, requirement of the Kentucky Medicaid MCO contract is the annual reporting of performance measures (PMs). These PMs, selected by DMS, include both the Healthcare Effectiveness Data and Information Set (HEDIS®)¹ and State-specific PMs which are based upon the Healthy Kentuckians 2010 and Healthy Kentuckians 2020 goals and health care priorities identified by DMS. Together, the measures address the access to, timeliness of, and quality of care provided for children, adolescents and adults enrolled in Managed Care with a focus on preventive care, health screenings, prenatal care, as well as special populations (e.g., adults with hypertension, children with special health care needs (CSHCN)).

During calendar year (CY) 2013, under contract to the DMS, four (4) MCOs provided services to Medicaid recipients in Kentucky: CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky. The MCOs were accountable for all covered health services for their members, except long term care and waiver services. These services were carved out to Fee-for-Service (FFS) Medicaid. Kentucky Spirit Health Plan is not included in this report because it withdrew from the Kentucky Medicaid program in July 2013.

As required by Federal Medicaid external quality review (EQR) regulations and requirements, under contract with DMS as the external quality review organization (EQRO), IPRO was tasked with validating the reliability and validity of the MCOs' reported PM rates. The purpose of the validation was to:

- § Evaluate the accuracy of the Medicaid PMs reported by the MCOs; and
- § Determine the extent to which the Medicaid-specific PMs calculated by the MCOs followed the specifications established by DMS.

This report summarizes the validation activities and findings for the PM rates for the measurement year (MY) 2013 reported by the MCOs in 2014. In addition, IPRO has included recommendations for reporting year (RY) 2015 and future PM sets.

The required measures are listed in Table 1 and Table 2.

¹ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Table 1: Kentucky Medicaid Managed Care Performance Measures – RY 2014

HEDIS® Performance Measures
<p>HEDIS® <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i>² The percentage of members 2–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, assessment/counseling for nutrition and assessment/counseling for physical activity during the measurement year.</p>
<p>HEDIS® <i>Adult BMI Assessment</i> The percentage of members 18–74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year.³</p>
<p>HEDIS® <i>Controlling High Blood Pressure</i> The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year.</p>
<p>HEDIS® <i>Annual Dental Visit</i> The percentage of members 2–21 years of age who had at least one dental visit during the measurement year.</p>
<p>HEDIS® <i>Lead Screening in Children</i> The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.</p>
<p>HEDIS® <i>Well-Child Visits in the First 15 Months of Life</i> The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.</p>
<p>HEDIS® <i>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life</i> The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.</p>
<p>HEDIS® <i>Adolescent Well-Care Visits</i> The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.</p>
<p>HEDIS® <i>Children's and Adolescents' Access to Primary Care Practitioners</i> The percentage of members 12 months–19 years of age who had a visit with a primary care practitioner (PCP). The organization reports four separate numerators: § Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year. § Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.</p>

² See the related Kentucky-specific measure: Height and Weight Documented; Appropriate Weight for Height

³ See the related Kentucky-specific measures: Counseling for Nutrition and Physical Activity for Adults and Height and Weight Documented; Appropriate Weight for Height

Table 2: Kentucky-Specific Performance Measures – RY 2014

Kentucky-Specific Performance Measures ⁴
<p><i>Prenatal and Postpartum Risk Assessment and Education/Counseling</i></p> <p>The percentage of pregnant members who delivered between November 6 of the year prior to the measurement year and November 5 of the measurement year who had a prenatal/postpartum visit and received the following prenatal/postpartum services:</p> <ul style="list-style-type: none">§ Tobacco use screening, positive screening for tobacco use, intervention for positive tobacco use screening;§ Alcohol use screening, positive screening for alcohol use, intervention for positive alcohol use screening;§ Drug use screening, positive screening for drug use, intervention for positive drug use screening;§ Assessment and/or education/counseling for OTC/prescription medication use;§ Assessment and/or education/counseling for nutrition;§ Screening for depression; and§ Screening for domestic violence, each during the first two prenatal visits or the first two prenatal visits after enrollment in the MCO.§ Screening for postpartum depression during the postpartum visit. <p>(Note these are reported as fourteen separate numerators)</p>
<p><i>Cholesterol Screening for Adults</i></p> <p>The percentage of male enrollees age > 35 years and female enrollees age > 45 years who had an outpatient office visit during the measurement year and appropriate LDL-C/cholesterol screening documented during the measurement year or the four years prior.</p>
<p><i>Height and Weight Documented; Appropriate Weight for Height for Adults</i></p> <p>The percentage of members 18–74 years of age who had an outpatient visit and who had their height and weight documented and appropriate weight for height during the measurement year or the year prior to the measurement year. (Note: these are reported as two separate numerators and are for reporting purposes only; achievement of improvement is not assessed.)</p>
<p><i>Counseling for Nutrition and Physical Activity for Adults</i></p> <p>The percentage of members 18–74 years of age who had an outpatient visit and who had counseling for nutrition and physical activity. (Note these are reported as two separate numerators)</p>
<p><i>Height and Weight Documented and Appropriate Weight for Height for Children and Adolescents</i></p> <p>The percentage of members 2–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had height and weight documented and appropriate weight for height. (Note: these are reported as two separate numerators and are for reporting purposes only; achievement of improvement is not assessed.)</p>
<p><i>Adolescent Preventive Screening/Counseling</i></p> <p>The percentage of adolescents 12–17 years of age who had at least one well-care/preventive visit during the measurement year with a PCP or OB/GYN practitioner and received preventive screening/counseling for: tobacco use; alcohol/substance use; and sexual activity and screening/assessment for depression. (Note: these are reported as four separate numerators.)</p>
<p><i>Individuals with Special Health Care Needs' (ISHCNs) Access to Preventive Care</i></p> <p>The percentage of child and adolescent members, ages 12 months through 19 years, in the SSI and Foster categories of aid or who received services from the Commission for Children with Special Health Care Needs, who received the specified services as defined in the HEDIS® specifications.</p> <p><u>Access to Care:</u></p> <ul style="list-style-type: none">§ Children's and Adolescents' Access to Primary Care Practitioners <p><u>Preventive Care Visits:</u></p> <ul style="list-style-type: none">§ Well-Child Visits in the First 15 Months of Life§ Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life§ Adolescent Well-Care Visits§ Annual Dental Visit (Ages 2–21)

⁴ Copies of the full specifications for each of the Kentucky-specific PMs are available by request.

METHODOLOGY

In the protocol, *Validating Performance Measures: A protocol for use in conducting Medicaid External Quality Review Activities* (updated 2012), the Centers for Medicare and Medicaid Services (CMS) specifies the activities to be undertaken by an EQRO for purposes of validating MCO-reported PMs. The activities defined in the protocol include assessment of:

- § The structure and integrity of the MCO's underlying information system (IS);
- § MCO ability to collect valid data from various internal and external sources;
- § Vendor (or subcontractor) data and processes, and the relationship of these data sources to those of the MCO;
- § MCO ability to integrate different types of information from varied data sources (e.g., member enrollment data, claims data, pharmacy data, vendor data) into a data repository or set of consolidated files for use in calculating PMs; and
- § Documentation of the MCO's processes to: collect appropriate and accurate data, manipulate the data through programmed queries, internally validate results of the operations performed on the data sets, follow specified procedures for calculating the specified PMs, and report the measures appropriately.

While the protocol provides methods of evaluation, tools and worksheets, and activities to be performed, it also specifies that other mechanisms and methods of assessment may be used, as long as they are consistent with the protocol objectives and outcomes.

Note that several of the PMs are adopted from HEDIS[®], including: *Adult BMI Assessment, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Controlling High Blood Pressure, Annual Dental Visit, Lead Screening for Children, Well-Child Visits in the First 15 months of Life, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Adolescent Well-Care Visits, and Children's and Adolescents' Access to PCPs*. These measures were independently audited by the National Committee for Quality Assurance (NCQA)-licensed audit organizations as part of the MCOs' annual HEDIS[®] Compliance Audits^{™5}. Therefore, in accordance with the CMS EQRO provisions for non-duplication of activities, IPRO did not specifically address those measures in its validation process. Rather, the focus was on validating the State-specific measures.

⁵ HEDIS[®] Compliance Audit[™] is a registered trademark of the National Committee for Quality Assurance (NCQA).

VALIDATION ACTIVITIES

IPRO conducted validation activities consistent with the CMS protocols.

Data and Information Request

IPRO requested and received from the MCOs the following documentation related to PM calculation:

- § Data and field definitions;
- § Documentation of the steps taken to:
 - Integrate the data into the health outcome measure data set,
 - Query the data to identify denominators, generate samples, and apply the proper algorithms to the data in order to produce valid and reliable PMs, and
 - Conduct statistical testing of results;
- § Procedures used to determine the measure denominators from the HEDIS® denominator base, and how any additional criterion were applied (where applicable);
- § Documentation of the qualifications, training, and inter-rater reliability testing for medical record abstraction staff;
- § All data abstraction tools and associated materials;
- § Data entry and data verification processes;
- § List of members identified to have numerator positive findings (for sample selection for MRR and administrative validation);
- § HEDIS® Interactive Data Submission System (IDSS), Medicaid Product Line, 2014;
- § HEDIS® Compliance Audit™⁶ Final Audit Report, Medicaid Product Line, 2014;
- § Table of measures including measure/numerator name, denominator value, numerator value and rate (called "Attachment B").

IPRO reviewed the documentation and verified that prior recommendations were implemented and that other processes were methodologically sound.

Information Systems Capabilities Assessment

In accordance with standards for non-duplication of activities, CMS protocols specify that in lieu of conducting a full onsite IS assessment, the State/EQRO may review a recent assessment of the MCO's IS conducted by another party. IPRO continues to conduct encounter data validation activities annually as a part of the EQR compliance review and optional activities, including member-level data validation between MCO data and the encounter data warehouse. In addition, a full IS assessment is conducted annually as part of the MCOs' annual HEDIS® Compliance Audits. Therefore, the results of the MCOs' HEDIS® audits, as well as the ongoing encounter data validation activities, were used to provide information for this validation.

The MCOs' HEDIS® 2014 *Final Audit Report for the Medicaid Product Line* was reviewed to determine compliance with HEDIS® IS standards, including:

- § Sound coding methods for medical data: use of industry standard codes; capture of principal and secondary codes; and mapping of non-standard codes where applicable.

⁶ HEDIS® Compliance Audit is a trademark of NCQA, the National Committee for Quality Assurance.

- § Data capture, transfer and entry of medical and service data: use of standard claims submission forms; capture of fields relevant for reporting; effective and efficient data receipt and entry; electronic transmission procedures conform to industry standards; assessment of data completeness by the MCO and monitoring of vendors, where applicable.
- § Data capture, transfer, and entry of membership data: procedures for ensuring accurate, complete, and timely entry of membership data; effective, efficient, timely and accurate data entry; accurate transmission of electronic membership data; assessment of data completeness by the MCO; and monitoring of vendor performance, where applicable.
- § Data capture, transfer and entry of practitioner data: documentation of provider specialties; procedures for ensuring accurate, timely, and complete entry of practitioner data; accurate transmission of electronic practitioner data; assessment of data completeness by the MCO; and monitoring of vendor performance, where applicable.
- § Medical record review processes: forms capture fields relevant to HEDIS® reporting; abstraction from medical records is reliably and accurately performed; data entry processes are timely and accurate; sufficient edit checks are incorporated; and assessment of data completeness by the MCO.
- § Supplemental data: non-standard coding schemes are fully documented and mapped; data entry procedures are effective and electronic transmissions of data undergo checking procedures; data entry processes are timely and accurate; assessment of data completeness by the MCO; and monitoring of vendor performance, where applicable.
- § Data integration required to meet the demands of accurate reporting: accurate data transfers to reporting repository; accurate file consolidations, extracts, and derivations; suitable repository structure and formatting to enable required programming efforts; report production is managed effectively; HEDIS® reporting software is managed effectively; and physical control procedures ensure data integrity.

Denominator Validation

Some of the PM denominators are derived utilizing the HEDIS® measure specifications. Others are derived using specifications created by the EQRO, based on criteria that are the same as or similar to HEDIS®. Once the final sample of members is identified for the hybrid measures, the MCOs prepare abstraction forms for data collection from medical records.

In addition to the EQRO Validation Activities, the identification of the eligible population, sampling, and denominator selection, as well as the medical record review processes, were independently audited by an NCOA-licensed audit organization as part of the annual HEDIS® audit.

The HEDIS® 2014 *Final Audit Reports* were reviewed to determine if the MCOs were compliant with HEDIS® standards for denominator creation, including:

- § Denominator Identification: Eligible populations were properly identified by product and product line, based on use of certified software, or review of source code for measures outside of certification. Members were correctly categorized into subgroups and continuous enrollment criteria were properly applied. Medical and service events were accurately considered according to HEDIS®-eligible population specifications.
- § Sampling: Samples were drawn using a systematic sampling method as specified in the HEDIS® technical specifications either through use of certified software or review of MCO-created programs.

For some State-specific PMs, additional criteria (e.g., a PCP visit during the measurement year) are applied to identify the measure denominators. The EQRO reviewed the MCOs processes to evaluate whether the denominators were defined as prescribed by the specifications.

Data Collection Validation

A medical record review (MRR) validation is conducted to ensure that medical record abstraction performed by the MCOs meets the measure specifications and that the abstracted medical record data is accurate. In the case of HEDIS® hybrid measures, the HEDIS® compliance auditor conducted an assessment of the medical record review process and validation. IPRO's MRR validation process focused on the State-specific PMs and included review of medical record abstraction tools and instructions, as well as validation of medical record abstraction findings for a sample of records that the MCOs identified as having numerator positive events.

Medical Record Tools and Instructions and Processes Review

The medical record tools and instructions are reviewed for inclusion of general documentation, numerator requirements and exclusion criteria based on measure specifications. In addition, the reviewer qualifications and processes for training and quality monitoring as well as the monitoring results were reviewed.

Medical Record Review Validation

According to CMS protocols, as part of the PM validation, IPRO conducts an MRR validation for State-specific measures. The goal of the MRR validation is to determine whether the MCOs made any medical record abstraction errors that may have significantly biased the final reported rates. The maximum amount of bias allowed for the final rate to be considered reportable is +/- five (5) percentage points.

The MRR validation consisted of a review of a random sample of up to fifteen (15) numerator positive events for four (4) numerators from two (2) measures. The numerators selected for MRR validation included: *Adolescent Preventive Screening and Counseling: Screening for Depression* numerator; *Prenatal and Postpartum Screening and Counseling: Nutrition* numerator; and *Prenatal and Postpartum Risk Assessment and Education/Counseling: Alcohol Screening, Positive Alcohol Use, and Intervention for Alcohol Use* numerators.

The preliminary findings for each measure, with case specific results, were provided to the MCOs for review and response. The MCOs were permitted to submit additional documentation and/or clarification of the existing documentation and this was reviewed by IPRO. The final findings were tabulated and assessed for material bias.

Administrative Record Review

In addition to the medical record review validation, IPRO selected twenty (20) records for the measure *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)* for CSHCN population for administrative validation. The MCOs were asked to submit evidence for the denominator and numerator components of the measure, e.g., member name, date of birth, enrollment; category of aid; provider participation; and claim for the numerator service.

Numerator Validation

For the State-specific measures, IPRO conducted numerator validation. This was accomplished by a review of the member-level data and confirmation the MCOs followed the specifications for numerator calculation including:

- § Qualifying medical and service events are evaluated correctly in terms of time and services;
- § Claims/encounter, membership, practitioner and vendor data are analyzed properly in assessing numerator qualifications;
- § Rate calculations (member-level) are arithmetically correct and are made with acceptable levels of precision; and

§ Data and processes used to collect, calculate and report measures are completely and accurately documented.

SUMMARY OF VALIDATION FINDINGS

This section summarizes the validation findings. The MCO-specific validation findings can be found in Appendices A, B, C and D.

Information Systems Capabilities Assessment

I PRO reviewed each of the four (4) MCOs' HEDIS® 2014 Final Audit Reports (FAR) to determine compliance with IS standards. The final audit reports revealed that all four MCOs met all IS standards.

Denominator Validation

The MCOs' processes for determining the denominators for the applicable State-specific PMs were evaluated to ensure that the additional criterion of a PCP visit during the measurement year was applied, where applicable.

All four (4) MCOs defined the denominator(s) as prescribed by the specifications.

Data Collection Validation

Medical Record Tools and Instructions and Processes Review

I PRO reviewed the MCOs medical record reviewer qualifications/experience, tools, instructions and processes for each of the four (4) MCOs – CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky.

For three of the four (3 of the 4) MCOs, I PRO confirmed that the reviewer pool was well-qualified. Reviewers were comprised of Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Registered Health Information Administrators (RHAs) and other medical abstraction professionals and most were experienced in medical record review for HEDIS®/performance measures. One (1) of the MCOs did not specify the type and credentials of the reviewer pool staff. However, the MCO's policy stated that clinical or non-clinical staff may be used to abstract data, as long as s/he has successfully achieved the expected thresholds.

Training materials generally consisted of introduction to HEDIS® performance measurement; measure technical specifications and the medical record abstraction tools and accompanying instructions; instructions on use of database tools/data entry; "tip sheets" and reference materials. For two of four (2 of 4) MCOs, the training materials were provided by a vendor.

The training sessions were comprised of introduction to HEDIS® /performance measurement; review of specifications ; walkthrough of abstraction tools and measure-specific instructions; discussion of sample medical records; training on tool use/data entry; practice review of medical records and testing for proficiency. For two of four (2 of 4) MCOs, the training sessions were provided by a vendor.

I PRO reviewed the processes for quality monitoring of record abstractions and the monitoring results for each of the four (4) MCOs. The standard for proficiency in abstraction was 95% for three (3) MCOs and Pass/Fail for one (1) MCO. For the three (3) MCOs that used numeric scoring, quality monitoring results ranged from 95% to 100%. For all three (3) MCOs, in instances where a reviewer scores less than 95%, the reviewer is retrained and retested. If the reviewer does not pass the re-testing, the reviewer is not assigned to abstract records for the affected measure(s) or removed from the project.

I PRO reviewed each of the four (4) MCO's medical record tools and instructions for inclusion of general documentation, numerator requirements and exclusion criteria based on measure specifications. Specific findings

across all four (4) MCOs for each of the measures appear below. It is important to note that, since all MCOs passed the medical record validation for both performance measures, the findings did not impact the validity and reliability of the abstracted data.

Adolescent Preventive Screening and Education/Counseling: All Numerators

- § The tool and training materials for two (2) MCOs did not specify that the visit must be with a primary care or OB/GYN practitioner.
- § The tool and training materials for three (3) MCOs specified that the numerator services (screening/counseling for tobacco use, alcohol use, substance use, sexual activity or screening for depression) must occur at a preventive visit, when in fact, the service may occur at any type of visit (well/preventive or sick) with a PCP or OB/GYN practitioner.

Prenatal and Postpartum Risk Assessment and Education/Counseling: All Numerators

- § For one (1) MCO, the tool/instruction did not specify the required provider type. To meet the numerator requirements, the servicing provider must be midwife, OB/GYN, Family Practitioner or PCP for the Kentucky-specific numerators. For two (2) MCOs, the tool did not include a field for the type of practitioner (PCP or OB/GYN). It is important to note, however, that in most cases, the MCO's chart retrieval process will direct reviewers to only providers relevant to the measure requirements (e.g., OB/GYN for prenatal measures).
- § The tool for one (1) MCO did not include the member's enrollment date or the first trimester dates to identify time frame for review. This is not a required field but can assist the reviewer in locating the correct timeframe for review and help the reviewer identify which are compliant service dates. It is important to note that many MCOs assess the dates for numerator compliance with a programmed edit or calculation or subsequent to abstraction.
- § The tool for one (1) MCO did not contain any data collection fields for the Kentucky-specific numerators (substance use screening, positive substance use screening, intervention for substance use; assessment/education for OTC/prescription medication use; assessment/education for nutrition; screening for depression (prenatal); and screening for domestic violence). The tool did, however, contain overall results fields for these Kentucky-specific numerators.
- § The tool for one (1) MCO omitted the *screening for tobacco use* numerator (only collected if the member was a smoker). Additionally the date of the event was not collected; therefore, it was not clear how the appropriate timeframe could be assessed.
- § The tool for one (1) MCO did not specifically address the intervention for positive tobacco use numerator. The field was labeled "*Did they receive education or counseling?*" which could apply to either advice to stop smoking or general warnings on the dangers of smoking during pregnancy for a non-smoker. Additionally the date of the event was not collected; therefore, it was not clear how the appropriate timeframe could be assessed.
- § The tool for one (1) MCO did not specifically address the intervention for positive substance abuse numerator. The field was labeled "*Did they receive education or counseling?*" which could apply to either advice to stop substance abuse or general warnings on the dangers of substance abuse during pregnancy. Additionally the date of the event was not collected; therefore, it was not clear how the appropriate timeframe could be assessed.
- § The tool for one (1) MCO did not specifically address the intervention for positive alcohol use numerator. The field was labeled "*Did they receive education or counseling?*" which could apply to either advice to stop drinking or general warnings on the dangers of alcohol use during pregnancy. Additionally the date of the event was not collected; therefore, it was not clear how the appropriate timeframe could be assessed.
- § For two (2) MCOs, in the vendor presentation slide, a positive prenatal screening for tobacco is defined as "*an assessment of being a positive smoker during the first two prenatal visits or one of the first two*

prenatal visits following enrollment.” The definition of a member positive for tobacco use should include all forms of tobacco use (i.e., cigarettes, cigars, chew, smokeless tobacco, etc.).

- § For two (2) MCOs, in the vendor presentation slide, interventions are defined as “*being for a member positively identified as a smoker during the member's first prenatal visits or one of the first two prenatal visits following enrollment.*” The interventions should be defined as for members with a positive screening for any form of tobacco use (i.e., cigarettes, cigars, chew, smokeless tobacco, etc.).
- § The vendor training materials for two (2) MCOs indicated that viewing a video or provision of written information would meet the numerator requirements for *tobacco use screening* and *tobacco use intervention*. However, this may or may not meet the numerator requirements in different circumstances. For example, video viewing or reading written materials would not meet the requirements for conducting *screening* for tobacco use. Additionally, the tool would not accommodate recording the specific date(s) and topic(s) for each member if educational materials (brochure, video, and packet) are provided. Finally, the tool listed only “smoking” when all forms of tobacco use are encompassed in this numerator.
- § The vendor training materials for two (2) MCOs indicated that viewing of video or provision of written information would meet the numerator requirements for *alcohol use screening*. This may or may not meet the numerator requirements in different circumstances. For example, video viewing or reading written materials would not meet the requirements for conducting *screening* for alcohol use. Additionally, the tool would not accommodate recording the specific date(s) and topic(s) for each member if educational materials (brochure, video, and packet) are provided.
- § The vendor training materials for two (2) MCOs indicated that viewing of video or provision of written information would meet the numerator requirements for *substance/drug use screening*. This may or may not meet the numerator requirements in different circumstances. For example, video viewing or reading written materials would not meet the requirements for conducting *screening* for substance use. Additionally, the tool would not accommodate recording the specific date(s) and topic(s) for each member if educational materials (brochure, video, and packet) are provided.
- § The vendor training materials for two (2) MCOs indicated that viewing of video or provision of written information would meet the numerator requirements for *nutrition assessment and/or education/counseling* and *OTC/prescription drug use assessment and/or education/counseling*. The tool would not accommodate recording the specific date(s) and topic(s) for each member if educational materials (brochure, video, and packet) are provided.
- § The vendor training materials for two (2) MCOs indicated that education/counseling would meet the numerator requirements for *depression screening* (prenatal and postpartum). This would not meet numerator requirements for conducting a *depression screening*.
- § The vendor training materials for two (2) MCOs indicated that education/counseling would meet the numerator requirements for *screening for domestic violence*. This would not meet numerator requirements for conducting *screening* for domestic violence.

Medical Record Review Validation

I PRO conducted a medical record validation (MRR validation) for State-specific measures. As previously stated, the purpose of the MRR validation is to determine whether the MCOs made any medical record abstraction errors that could significantly bias the final reported rates.

The MRR validation encompassed a validation review of a random sample of fifteen (15) records for members identified numerator positive events by the MCOs’ medical record abstraction.

The numerators selected for MRR validation included:

- § *Adolescent Preventive Screening and Education/Counseling: Screening for Depression*
- § *Prenatal and Postpartum Risk Assessment and Education/Counseling: Screening and Intervention for Alcohol Use*

§ *Prenatal and Postpartum Risk Assessment and Education/Counseling: Screening or Counseling/Education for Nutrition*

Preliminary findings were provided to the MCOs. The MCOs were given the opportunity to submit additional documentation or clarify the documentation previously submitted. IPRO reviewed the additional documentation provided and made a final validation determination for each record. The final medical record validation results for each MCO were assessed for material bias. The maximum amount of bias allowed for the final rate to be considered reportable was +/- five (5) percentage points. The combined findings for the four (4) MCOs for each of the selected numerators are described below.

Adolescent Preventive Screening and Education/Counseling: Screening for Depression

All four (4) MCOs passed the medical record validation for this measure. For one (1) MCO, all sampled records passed the validation. For three (3) MCOs, some medical records failed the validation, however it was determined that it did not significantly bias the final reported rates. Reasons that individual records failed the validation included:

- § No documentation of screening in the medical record submitted.
- § General statements regarding mental status with no specific mention of depression: cooperative, alert and oriented, affect normal, normal mood, normal judgment/insight, orientation to person/place/time, mood and affect, coordination, attention span and concentration, psychiatric/behavior (negative).
- § Medication was listed, but no associated diagnosis of depression.
- § The assessment was for mental health in general or another behavioral health condition, e.g., anxiety.
- § The screening was done by a specialist, not a PCP.

Prenatal and Postpartum Risk Assessment and Education/Counseling: Screening and Intervention for Alcohol Use

All four (4) MCOs passed the medical record validation for this measure with all sampled records passing the validation.

Prenatal and Postpartum Risk Assessment and Education/Counseling: Screening or Counseling/Education for Nutrition

All four (4) MCOs passed the medical record validation for this measure. For three (3) MCOs, all sampled records passed the validation. For one (1) MCO, one medical record failed the validation, however it was determined that it did not significantly bias the final reported rate. The reason the one (1) record failed the validation was that nutrition education handouts were provided to the member but the provider did not specifically document the date and that nutrition education was provided.

Administrative Record Review

IPRO conducted an administrative validation for twenty (20) records for the measure *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)* for CSHCN for members in the Foster Care category of eligibility and those who received services from the Commission for Children with Special Health Care Needs (CCSHCN). The MCOs were asked to submit evidence for the denominator and numerator components of the measure:

- § Member name and ID number,
- § Member date of birth consistent with the measure requirements for age,
- § Member enrollment during the measurement period,
- § Category of aid consistent with Foster Care OR Evidence of services provided by the CCSHCN,
- § Service provider network participation during the measurement period,
- § Claim for the numerator service with the billing code for the required service, and
- § Claim for the numerator service with a date within the measurement period.

All four (4) MCOs passed the administrative record review validation.

MEASURE RATES AND REPORTING DESIGNATIONS

Table 3 displays the PM rates for each of the four (4) MCOs and the average rate for all MCOs reporting for MY 2013 for each of the State-specific PMs. If an MCO was not able to report a measure due to the lack of eligible population, "N/A" (not applicable) appears in the table.

The average rates for the MCOs that reported were calculated by adding the MCOs' denominators, adding the MCOs' numerators, and then dividing the combined numerator by the combined denominator. If one or more MCOs were not able to report the measure (designation "N/A"), the data for the MCOs that did report were used. Rates are not generally reported if an MCO has a denominator < 30. If one (1) or more MCOs had a denominator of < 30 for a measure, the data (numerator and denominator) were included in the calculation.

It is important to note that the MCOs' performance is difficult to compare. During MY 2013, one (1) MCO had been serving the Kentucky Medicaid population for over twenty (20) years within a limited, more urban/suburban service area (Kentucky Region 3). Two (2) MCOs served the Kentucky Medicaid population for less than three years (as of June 2014) with larger, statewide service areas encompassing more rural counties. A fourth MCO entered the Kentucky Medicaid market in January 2013 and served only one predominantly urban/suburban region (Kentucky Region 3). Due to initiating enrollment in 2013, this MCO was limited in reporting due to small numbers of members who met the measures' continuous enrollment criteria. Discussion of each MCO's individual performance is presented in the Appendices.

General observations of performance at the aggregate level (average rates for all MCOs) include:

- § Performance was very good for documentation of height and weight for both children & adolescents and adults, with rates above 75% for both.
- § Only (approximately) 25% of adults and 33% of children and adolescents had a healthy weight for height reported. This measure is currently for reporting purposes only; MCOs are not held accountable for improvement.
- § The rates for the related measures, counseling for nutrition and physical activity for adults, were quite low at 31.13% for adults and 29.92% for children and adolescents.
- § The rate for cholesterol screening for adults was very good, at 82.63%.
- § Adolescent screening and counseling rates ranged from a low of 23.27% (screening for depression) to a high of 55.42% (screening/counseling for tobacco use), with screening/counseling for alcohol/substance use and sexual activity falling in between (41.03% and 33.75%, respectively).
- § For screening and counseling during the perinatal period, screening for tobacco was most often found (37.19%), followed by screening for alcohol use (35.19%) and substance use (34.30%).
 - § Of the 195 women identified as tobacco users, only 54.36% had evidence of intervention.⁷
 - § Of the 42 women identified as alcohol users, only 14.29% had evidence of intervention.
 - § Of the 55 women identified as substance users, only 27.27% had evidence of intervention.
- § Prenatal assessment/counseling for nutrition was found in 16.94% of records and counseling for use of prescription and/or over-the-counter medications was reported 29.82% of the time.
- § There is a substantial opportunity for improvement in screenings for domestic violence and depression. Rates were 14.39% for prenatal domestic violence screening, 21.69% for prenatal depression screening, and slightly higher at 34.89% for postpartum depression screening.

⁷ For purposes of the performance measure, intervention was defined as documentation of a claim code identifying cessation services or program/therapy or documentation in the medical record of in-person counseling/education or provision of cessation materials; referral for cessation counseling, quit line, or cessation program; or prescription for cessation medication (for tobacco use, alcohol use or substance use, as applicable).

- § Related to access to care for CSHCN, performance on measures of preventive services ranged from 66.50% for well-child visits for children 3–6 years of age to 42.02% for adolescent well-care visits.
- § As for access to care⁸ for CSHCN, all rates exceeded 90%. Rates were highest for those 12–24 months of age (96.25%) and lowest for those 25 months–6 years of age (90.08%) with both rates for members 7–11 and 12–19 years of age slightly above 94%.

⁸ Access to care is defined as any visit with a PCP during the measurement year for those aged 12–24 months and 25months–6 years and any PCP visit during the measurement year or year prior for those aged 7–11 years and 12–19 years.

Table 3: State-Specific Performance Measure Rates – RY 2014

Performance Measure Domain	Age Group	Admin/Hybrid	Measure Name	Measure Description	Passport Health Plan Rate	CoventryCares of Kentucky Rate	Humana-CareSource Rate	WellCare of Kentucky Rate	Average All MCOs
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had their <u>height and weight</u> documented during the measurement year or the year prior to the measurement year.	89.85%	55.79%	N/A	84.72%	76.99%
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had a <u>healthy weight for height</u> documented during the measurement year or the year prior to the measurement year (as identified by appropriate BMI).	23.59%	26.56%	N/A	25.53%	25.02%
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had <u>counseling for nutrition</u> documented during the measurement year or the year prior to the measurement year.	43.05%	21.99%	N/A	27.78%	31.13%
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had <u>counseling for physical activity</u> documented during the measurement year or the year prior to the measurement year.	40.40%	15.51%	N/A	33.33%	29.92%
Preventive Care	Adult	A	Cholesterol Screening	The percentage of male enrollees age ≥ 35 years and female enrollees age ≥ 45 years who had an outpatient visit and had <u>LDL-C/cholesterol screening</u> in the measurement year or during the four years prior.	87.79%	77.56%	76.90%	80.86%	82.63%
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–11 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of <u>both a height and weight</u> on the same date of service during the measurement year.	92.03%	62.29%	70.23%	78.49%	75.77%
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 12–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of <u>both a height and weight</u> on the same date of service during the measurement year.	92.11%	57.04%	68.75%	82.35%	76.09%

Performance Measure Domain	Age Group	Admin/Hybrid	Measure Name	Measure Description	Passport Health Plan Rate	CoventryCares of Kentucky Rate	Humana-CareSource Rate	WellCare of Kentucky Rate	Average All MCOs
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of <u>both a height and weight</u> on the same date of service during the measurement year.	92.05%	60.65%	69.83%	79.86%	75.87%
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–11 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a <u>healthy weight for height</u> during the measurement year.	59.21%	17.84%	29.28%	21.62%	34.22%
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 12–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a <u>healthy weight for height</u> during the measurement year.	48.57%	20.25%	32.56%	15.75%	30.56%
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a <u>healthy weight for height</u> during the measurement year.	55.64%	18.56%	30.19%	19.48%	33.03%
Preventive Care	Child	H	Adolescent Screening/Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and who had <u>screening/counseling for tobacco</u> .	74.85%	30.37%	58.04%	54.90%	55.42%
Preventive Care	Child	H	Adolescent Screening/Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and who had <u>screening/counseling for alcohol/substances</u> .	59.51%	17.04%	47.32%	37.91%	41.03%
Preventive Care	Child	H	Adolescent Screening/Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and had <u>screening/counseling for sexual activity</u> .	53.99%	14.07%	41.07%	24.18%	33.75%
Preventive Care	Child	H	Adolescent Screening/Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and who had <u>screening for depression</u> documented.	28.83%	11.85%	31.25%	21.57%	23.27%

Performance Measure Domain	Age Group	Admin/ Hybrid	Measure Name	Measure Description	Passport Health Plan Rate	CoventryCares of Kentucky Rate	Humana-CareSource Rate	WellCare of Kentucky Rate	Average All MCOs
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for tobacco use</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	64.10%	26.48%	8.50%	40.96%	37.19%
				The percentage of pregnant members who had <u>positive screening for tobacco use.</u>	28.57%	54.26%	42.31%	36.31%	35.91%
				The percentage of pregnant members who had positive screening for tobacco use and received <u>intervention for tobacco use.</u>	60.53%	43.14%	36.36%	59.65%	54.36%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for alcohol use</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	64.10%	22.54%	4.58%	40.16%	35.19%
				The percentage of pregnant members who had <u>positive screening for alcohol use.</u>	4.14%	33.75%	0.00%	2.63%	8.20%
				The percentage of pregnant members who were found positive for alcohol use and received <u>intervention for alcohol use.</u>	36.36%	3.70%	N/A	25.00%	14.29%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for substance/drug use</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	64.10%	21.97%	4.90%	36.97%	34.30%
				The percentage of pregnant members who had <u>positive screening for substance/drug use.</u>	5.64%	34.62%	0.00%	9.29%	11.02%
				The percentage of pregnant members who were found positive for substance/drug use and received <u>intervention for drug/substance use.</u>	40.00%	7.41%	N/A	53.85%	27.27%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>assessment of and/or education/counseling for nutrition</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	30.12%	10.99%	4.90%	17.82%	16.94%

Performance Measure Domain	Age Group	Admin/Hybrid	Measure Name	Measure Description	Passport Health Plan Rate	CoventryCares of Kentucky Rate	Humana-CareSource Rate	WellCare of Kentucky Rate	Average All MCOs
Perinatal Care	N/A	H	Prenatal Screening/Counseling	The percentage of pregnant members who had evidence of <u>assessment of and/or education/ counseling for OTC/ prescription medication</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	63.86%	12.11%	3.27%	30.59%	29.82%
Perinatal Care	N/A	H	Prenatal Screening/Counseling	The percentage of pregnant members who had evidence of <u>screening for domestic violence</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	20.72%	9.30%	4.25%	20.48%	14.39%
Perinatal Care	N/A	H	Prenatal Screening/Counseling	The percentage of pregnant members who had evidence of <u>screening for depression</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	39.04%	11.27%	2.61%	27.93%	21.69%
Perinatal Care	N/A	H	Prenatal Screening/Counseling	The percentage of pregnant members who had evidence of <u>screening for depression during a postpartum visit</u> .	39.02%	40.81%	14.10%	44.16%	34.89%
Children with Special Health Needs: Access to Care and Preventive Care Services									
Preventive Care	Child CSHCN Cohort	A	HEDIS® Annual Dental Visit	The percentage of members 2–21 years of age who had <u>at least one dental visit</u> during the measurement year.					
				SSI Total(B, BP, D, DP, K, M)	57.02%	55.33%	40.03%	55.60%	55.34%
				SSI Blind (B, BP, K)	60.00%	40.00%	N/A	58.50%	57.58%
				SSI Disabled (D, DP, M)	57.01%	55.37%	40.20%	55.60%	55.34%
				Foster (P,S, X)	76.71%	68.98%	44.33%	74.20%	72.68%
				CCSHCN (provider type 22 and 23)	64.86%	66.67%	43.11%	70.40%	67.84%
Total ADV (2–21 years)					63.00%	63.48%	41.29%	61.81%	61.56%
Preventive Care	Child CSHCN Cohort	A	HEDIS® Well-Child Visits in the First 15 Months of Life (6+ Visits)	The percentage of members who turned 15 months old during the measurement year and who had <u>6 or more well-child visits</u> with a PCP during their first 15 months of life.					
				SSI Total(B, BP, D, DP, K, M)	37.37%	N/A	N/A	40.00%	38.55%
				SSI Blind (B, BP, K)	0.00%	N/A	N/A	100.00%	100.00%
				SSI Disabled (D, DP, M)	37.37%	N/A	N/A	39.20%	38.20%
				Foster (P, S, X)	68.75%	N/A	N/A	59.10%	62.64%
				CCSHCN (provider type 22 and 23)	0.00%	N/A	N/A	54.20%	54.24%
Total WC15mo					49.69%	N/A	N/A	52.27%	51.38%

Performance Measure Domain	Age Group	Admin/ Hybrid	Measure Name	Measure Description	Passport Health Plan Rate	CoventryCares of Kentucky Rate	Humana-CareSource Rate	WellCare of Kentucky Rate	Average All MCOs
Preventive Care	Child CSHCN Cohort	A	HEDIS® Well-Child Visits in the 3 rd , 4 th , 5 th & 6 th Years of Life	The percentage of members 3–6 years of age who received <u>one or more well-child visits</u> with a PCP during the measurement year.					
				SSI Total(B, BP, D, DP, K, M)	73.18%	55.25%	53.85%	58.00%	62.63%
				SSI Blind (B, BP, K)	80.00%	0.00%	N/A	60.00%	70.00%
				SSI Disabled (D, DP, M)	73.13%	55.25%	53.33%	58.00%	62.57%
				Foster (P, S, X)	78.27%	67.51%	67.74%	67.60%	70.66%
				CCSHCN (provider type 22 and 23)	0.00%	82.61%	66.67%	67.50%	69.09%
Total WC34	75.19%	65.88%	59.76%	62.77%	66.50%				
Preventive Care	Child CSHCN Cohort	A	HEDIS® Adolescent Well-Care	The percentage of enrolled members 12–21 years of age who had <u>at least one comprehensive well-care visit</u> with a PCP or an OB/GYN practitioner during the measurement year.					
				SSI Total(B, BP, D, DP, K, M)	52.16%	28.28%	32.55%	31.70%	37.33%
				SSI Blind (B, BP, K)	45.45%	33.33%	N/A	25.90%	31.71%
				SSI Disabled (D, DP, M)	52.19%	28.26%	32.72%	31.70%	37.37%
				Foster (P, S, X)	62.56%	48.76%	32.41%	52.70%	53.62%
				CCSHCN (provider type 22 and 23)	56.67%	43.75%	40.68%	41.70%	42.37%
Total AWC	54.96%	38.81%	33.39%	36.97%	42.02%				
Preventive Care	Child CSHCN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 12 months–19 years of age who had <u>a visit with a primary care practitioner (PCP)</u> .					
Preventive Care	Child CSHCN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 12–24 months of age who had <u>a visit with a primary care practitioner (PCP)</u> during the measurement year.					
				SSI Total(B, BP, D, DP, K, M)	97.25%	89.74%	N/A	96.80%	95.96%
				SSI Blind (B, BP, K)	0.00%	0.00%	N/A	100.00%	100.00%
				SSI Disabled (D, DP, M)	97.25%	89.74%	N/A	96.70%	95.93%
				Foster (P, S, X)	98.82%	98.31%	N/A	95.70%	97.17%
				CCSHCN (provider type 22 and 23)	0.00%	100.00%	N/A	95.60%	96.00%
Total CAP 12–24 months	97.94%	95.76%	93.33%	95.94%	96.25%				
Preventive Care	Child CSHCN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 25 months–6 years of age who had <u>a visit with a primary care practitioner (PCP)</u> during the measurement year.					
				SSI Total(B, BP, D, DP, K, M)	92.58%	27.94%	79.59%	94.50%	87.74%
				SSI Blind (B, BP, K)	80.00%	0.00%	N/A	83.30%	81.82%
				SSI Disabled (D, DP, M)	92.66%	27.94%	79.38%	94.50%	87.76%
				Foster (P, S, X)	92.15%	91.54%	77.50%	90.50%	91.00%
				CCSHCN (provider type 22 and 23)	0.00%	100.00%	91.80%	94.30%	94.76%

Performance Measure Domain	Age Group	Admin/ Hybrid	Measure Name	Measure Description	Passport Health Plan Rate	CoventryCares of Kentucky Rate	Humana-CareSource Rate	WellCare of Kentucky Rate	Average All MCOs
				Total CAP 25 months–6 years	92.40%	76.78%	82.91%	93.36%	90.08%
Preventive Care	Child CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 7–11 years of age who had a visit with a primary care practitioner (PCP) during the measurement year, or the year prior.					
				SSI Total(B, BP, D, DP, K, M)	94.62%	51.14%	N/A	97.90%	93.34%
				SSI Blind (B, BP, K)	100.00%	50.00%	N/A	100.00%	87.50%
				SSI Disabled (D, DP, M)	94.60%	51.15%	N/A	97.90%	93.35%
				Foster (P, S, X)	96.05%	95.83%	N/A	94.40%	95.27%
				CCSHCN (provider type 22 and 23)	100.00%	100.00%	N/A	98.60%	98.78%
				Total CAP 7–11 years	94.90%	84.42%	N/A	97.09%	94.27%
Preventive Care	Child CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 12–19 years of age who had a visit with a primary care practitioner (PCP) during the measurement year, or the year prior.					
				SSI Total(B, BP, D, DP, K, M)	92.38%	95.18%	N/A	95.50%	94.13%
				SSI Blind (B, BP, K)	100.00%	96.02%	N/A	100.00%	96.48%
				SSI Disabled (D, DP, M)	92.35%	94.79%	N/A	95.50%	94.04%
				Foster (P, S, X)	94.06%	94.39%	N/A	94.00%	94.15%
				CCSHCN (provider type 22 and 23)	96.43%	100.00%	N/A	97.60%	97.75%
				Total CAP 12–19 years	92.68%	94.85%	N/A	95.29%	94.30%

N/A: not applicable (plan did not have any eligible members for this rate); H: hybrid measure; A: administrative measure; RY: reporting year.

RECOMMENDATIONS

Annually, DMS and IPRO review the PM set. This task involves choosing measures to retire, refining existing measure specifications and introducing new measures related to topics of interest to DMS. The guiding principles are to develop a PM set that is:

- § Clinically and methodologically valid;
- § Consistent with accepted clinical practice guidelines; and
- § Consistent with the DMS priorities for Medicaid program health outcomes.

Other important considerations include:

- § Assuring that measures are not duplicative (not already obtained from current reporting requirements, e.g., HEDIS®, Consumer Assessment of Healthcare Providers and Systems (CAHPS®));
- § Assuring that measures provide actionable information; and
- § Developing measures that can be validly calculated using administrative data, if possible.

For RY 2014, the following changes were made to the measure set:

PMs Retired in RY 2014:

- § No measures were formally retired.
- § The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) hearing and vision screening measures remained on hold for RY 2014, since an EPSDT validation study was conducted as part of the EQRO encounter data validation activities.

PM Specifications Refined in RY 2014:

- § All measures were updated, including dates, codes and per HEDIS® specifications, where applicable.
- § Specifications were clarified, where needed, based upon findings from the prior validation results and the MCO input.

PMs Continued in RY 2014:

HEDIS® Measures

- § *Well-Child Visits in the First 15 Months of Life (6 or more visits)*
- § *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
- § *Adolescent Well-Care Visits*
- § *Children's Access to PCPs – Ages 12–24 months, 25 months–6 years, 7–11 years, and 12–19 years*
- § *Annual Dental Visit*
- § *Lead Screening for Children*
- § *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*
- § *Adult BMI*
- § *Controlling High Blood Pressure*

Kentucky-Specific Measures

- § *Height and Weight Documented and Healthy Weight for Height for Adults*
- § *Counseling for Nutrition and Physical Activity for Adults*
- § *Adult Cholesterol Screening*
- § *Height and Weight Documented and Healthy Weight for Height for Children and Adolescents*
- § *Adolescent Preventive Screening and Counseling (screening/counseling for tobacco use, alcohol/substance use, sexual activity and screening for depression)*
- § *Prenatal and Postpartum Risk Assessment and Education/Counseling (tobacco use screening/positive screening/intervention, alcohol use screening/positive screening/intervention, substance use screening/positive screening/intervention, nutrition education/counseling, OTC/prescription drug use education/counseling, screening for domestic violence, prenatal and postpartum screening for depression)*

§ *CSHCN's Access to Care and Preventive Care Services*

Future Directions

For RY 2015, each of the measures was reviewed, including MCO experiences and lessons learned from calculating the measures, the results of the PM validation findings and DMS priorities.

Refinement of Current Measures for RY 2015:

- § All measures were updated, including dates, codes and per HEDIS® specifications, where applicable.
- § Specifications for all measures were clarified based upon findings from the prior validation results and MCO input.

Development of New Measures for RY 2015:

- § At DMS's direction, a PM based on the CMS-416 Form EPSDT Services – Dental Services was adopted. The following numerators will be reported:
 - § Members under age 21 who received any dental services;
 - § Members under age 21 who received preventive dental services;
 - § Members under age 21 who received dental treatment services;
 - § Members ages 6 – 9 years and 10 – 14 years who received sealant(s) on a permanent molar(s);
 - § Members under age 21 who received diagnostic dental services;
 - § Members under age 21 who received oral health services by a non-dentist provider; and
 - § Members under 21 who received any dental or oral health service.

Next Steps:

- § For future PM sets, IPRO plans to evaluate performance measures for the adult population and/or the Adult and Child CHIPRA (Children's Health Insurance Program Reauthorization Act) core measure sets and propose measures for DMS consideration.

REFERENCES

Healthy Kentuckians 2010, Kentucky Cabinet for Health and Family Services, Department for Public Health, <http://chfs.ky.gov/dph/hk2010.htm>, accessed 6/24/2014.

Healthy Kentuckians 2020, Kentucky Cabinet for Health and Family Services, Department for Public Health, <http://chfs.ky.gov/NR/rdonlyres/20BB6896-A602-426B-9F5F-E6230A9CAAC4/0/HealthyKentuckians2020FINAL62013.pdf>, accessed 6/24/2014.

HEDIS® 2014 Volume 2: Technical Specification, National Committee for Quality Assurance, 2013.

HEDIS® 2014 Volume 5: Compliance Audit: Standards, Policies and Procedures, National Committee for Quality Assurance, 2013.

Contract for Medicaid Managed Care between the Commonwealth of Kentucky Department for Medicaid Services and University Health Care, Inc. dba Passport Health Plan; October 2012 – June 2014.

Medicaid Managed Care Contract Coventry Health and Life Insurance Company; July 2011 – June 2014.

Medicaid Managed Care Contract Humana Health Plan, Inc.; through June 2014.

Medicaid Managed Care Contract WellCare of Kentucky, Inc.; July 2011–June 2014.

NCQA HEDIS® Compliance Audit: Final Audit Report for Coventry Health & Life Insurance Company dba CoventryCares of Kentucky, HealthcareData.com, LLC, July 2014.

NCQA HEDIS® Compliance Audit: Final Audit Report for Humana Health Plan, Inc., HealthcareData.com, LLC, July 2014.

NCQA HEDIS® Compliance Audit: Final Audit Report for University Health Care, Inc. dba Passport Health Plan, HealthcareData.com, LLC, July 2014.

NCQA HEDIS® Compliance Audit: Final Audit Report for WellCare Health Insurance of Illinois, Inc. dba WellCare of Kentucky, Inc., HealthcareData.com, LLC, July 2014.

NCQA HEDIS® Interactive Data Submission System, Coventry Health & Life Insurance Company dba CoventryCares of Kentucky – Medicaid Product Line, June 2014.

NCQA HEDIS® Interactive Data Submission System, Humana Health Plan, Inc., Medicaid Product Line, June 2014.

NCQA HEDIS® Interactive Data Submission System, University Health Care, Inc. dba Passport Health Plan - Medicaid Product Line, June 2014.

NCQA HEDIS® Interactive Data Submission System, WellCare Health Insurance of Illinois, Inc. dba WellCare of Kentucky, Inc. – Medicaid Product Line, June 2014.

Validating Performance Measures: A protocol for use in conducting Medicaid External Quality Review Activities, Department of Health and Human Services, Centers for Medicare and Medicaid Services, September 2012.

Appendix A – Validation Findings for CoventryCares of Kentucky

Medical Record Tools, Instructions and Processes

Key findings from the review of CoventryCares' medical record review tools and instructions revealed that:

- § All tools included general documentation requirements, i.e., review date, reviewer, member name, member plan identification number and member date of birth
- § All tools included exclusion criteria where appropriate.

It is important to note that, since CoventryCares passed the medical record validation for both performance measures, the findings below did not impact the validity and reliability of the abstracted data.

IPRO findings included:

General

- § CoventryCares should consider pre-loading administrative dates (delivery date, enrollment date) on the tools as cues for the reviewers.

Adolescent Preventive Screening/Counseling: All Numerators

- § CoventryCares should consider pre-loading the member's age as of December 31 of the measurement year on the tool as a cue for the reviewers.

Prenatal and Postpartum Risk Assessment and Education/Counseling: All Numerators

- § CoventryCares might consider adding fields to the abstraction tool for the delivery date and range of dates for review as well as a field for the reviewer to enter the abstracted delivery date for confirmation or if it differs. An automated error check in the tool could alert the reviewer when a date entered falls outside the appropriate time frame.
- § The Kentucky-specific numerators for prenatal and postpartum care were not fully addressed in the tools and instructions. For example, abstraction fields for the following numerators were not present on some of the abstraction tools despite having a positive result indicated in the tool: screening for substance use, positive substance use, intervention for substance use; assessment/counseling for nutrition; assessment/counseling for OTC/prescription medication use; prenatal screening for depression; screening for domestic violence. *Note, however, that the abstraction instructions state that the results section of the abstraction tool is populated based upon the data entered by the reviewer in the data entry section of the tool and that the reviewer cannot change the results.*
- § The abstraction tool included an option to select the provider type for the HEDIS® numerator items but; when the Kentucky-specific numerators were present, there was no option to select the provider type. Coventry Cares should ensure that the tools, instructions and training materials for this measure fully address the Kentucky-specific numerators, including the required provider type(s).

MRR Validation

The results were as follows:

Adolescent Preventive Screening/Counseling: Depression Screening – PASSED VALIDATION

13 of 15 records passed validation

The reasons two (2) records failed validation were:

- § There was no documentation of screening in the medical record submitted.
- § The record contained only general statements regarding mental status with no specific mention of depression: cooperative, alert and oriented, affect normal.
- § A medication was listed in the record, but no diagnosis of depression was documented.

Prenatal and Postpartum Risk Assessment and Education/Counseling: Screening and Intervention for Alcohol Use (Prenatal) – PASSED VALIDATION

15 of 15 records passed validation.

Prenatal and Postpartum Risk Assessment and Education/Counseling: Screening for Nutrition (Prenatal) – PASSED VALIDATION

15 of 15 records passed validation.

Performance Trends RY 2013 to RY 2014

CoventryCares performance for RYs 2013 and 2014 is presented in Table A-1, along with the change in rate (increase or decrease) from year to year.

Overall observations regarding CoventryCares' performance include:

- § Performance improved for both documentation of adult height and weight and healthy weight for height (2.99 and 0.14 percentage points, respectively). The rates, however, remain low at near 56% for documentation of height and weight and near 27% for healthy weight. Recall that the healthy weight for height measure is currently for reporting purposes only; MCOs are not held accountable for improvement.
- § The rates for the related measure, counseling for nutrition for adults, improved 4.47 percentage points but remained quite low at almost 22%. The rate for adults counseling for physical activity for adults increased slightly to 15.51%.
- § For children and adolescents 3 – 17 years of age, documentation of height and weight declined almost 7 percentage points, from 67.59% to 60.56%, while those with a healthy weight for height, while still quite low, improved over 6 percentage points to 18.56%.
- § The rate for cholesterol screening for adults was very good, at 77.56%, up from 73.89% in RY 2013.
- § Related to adolescent screening and counseling, all three (3) rates that were reportable in both RY 2013 and RY 2104 declined; for tobacco from 36.36% to 30.37%; for alcohol/substances from 28.57% to 17.04%; and for sexual activity from 18.83% to 14.07%. Screening for depression was not reportable in RY 2013; as a result no comparison can be made. The RY 2014 rate is 11.85%.
- § For screening and counseling during the perinatal period, screening for postpartum depression was most often found (40.81%) and improved from a rate of 0 in RY 2013. Rates for the other numerators in RY 2014 ranged from 26.48% (tobacco screening) to a low of 9.30% (screening for domestic violence).
- § Other observations regarding CoventryCares' performance in this area:

- § Rates for screenings for tobacco use (26.48%), alcohol use (22.54%) and substance use (21.97%) each improved, as did assessment/counseling for nutrition (10.99%). The increases ranged from 0.2 to 1.78 percentage points.
- § Comparisons could not be made for positive screenings and interventions for tobacco, alcohol and substances since these rates were found not reportable in RY 2013.
- § Rates for assessment/counseling for OTC/prescription medication (12.11%) and screenings for domestic violence (9.30%) and prenatal depression (11.27%) remained low and all declined (0.3 – 2.91 percentage points) between RY 2013 and RY 2014.
- § Regarding access to care for CSHCN, performance ranged from a high of 95.76% (for *Children’s Access to PCPs (CAP), ages 12 – 24 months*) to 38.81% (*Adolescent Well-Care Visits (AWC)*). However, both these rates declined by just over 2 percentage points from RY 2013.
- § Other observations for this set of measures include:
 - § *Well-Child Visits in the First 15 Months of Life* could not be reported in both RY 2013 and RY 2014 due to lack of eligible members.
 - § Performance could not be trended for the following since the rates were N/A in RY 2013: CAP, ages 7 – 11 years (84.42%) and CAP, 12 – 19 years (94.85%).
 - § Rates for the following two (2) measures improved from RY 2013 to RY 2014: Annual Dental Visits (60.76% to 63.48%); *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life* (63.18% to 65.88%).
 - § Rates for the following three (3) measures declined between RY 2013 to RY 2014: AWC (41.17% to 38.81%); CAP, ages 12 – 24 months (98.26% to 95.76%) and CAP, ages 25 months to 6 years dropped substantially (18.67 percentage points), from 95.45% to 76.78%.

Table A1: CoventryCares of Kentucky – RY 2013 and 2014 Performance Measure Rates

Performance Measure Domain	Age Group	Admin/Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change from RY 2013 to RY 2014
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had their <u>height and weight</u> documented during the measurement year or the year prior to the measurement year.	52.80%	55.79%	2.99
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had a <u>healthy weight for height</u> documented during the measurement year or the year prior to the measurement year (as identified by appropriate BMI).	26.42%	26.56%	0.14
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had <u>counseling for nutrition</u> documented during the measurement year or the year prior to the measurement year.	17.52%	21.99%	4.47

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change from RY 2013 to RY 2014
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had <u>counseling for physical activity</u> documented during the measurement year or the year prior to the measurement year.	15.19%	15.51%	0.32
Preventive Care	Adult	A	Cholesterol Screening	The percentage of male enrollees age \geq 35 years and female enrollees age \geq 45 years who had an outpatient visit and had <u>LDL-C/cholesterol screening</u> in the measurement year or during the four years prior.	73.89%	77.56%	3.67
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–11 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of <u>both a height and weight</u> on the same date of service during the measurement year.	67.15%	62.29%	-4.86
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 12–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of <u>both a height and weight</u> on the same date of service during the measurement year.	68.39%	57.04%	-11.35
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of <u>both a height and weight</u> on the same date of service during the measurement year.	67.59%	60.65%	-6.94
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–11 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a <u>healthy weight for height</u> during the measurement year.	10.70%	17.84%	7.14
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 12–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a <u>healthy weight for height</u> during the measurement year.	15.09%	20.25%	5.16
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a <u>healthy weight for height</u> during the measurement year.	12.29%	18.56%	6.27
Preventive Care	Child	H	Adolescent Screening/ Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and who had <u>screening/counseling for tobacco</u> .	36.36%	30.37%	-5.99

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change from RY 2013 to RY 2014
Preventive Care	Child	H	Adolescent Screening/ Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and who had <u>screening/counseling for alcohol/substances.</u>	28.57%	17.04%	-11.53
Preventive Care	Child	H	Adolescent Screening/ Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and had <u>screening/counseling for sexual activity.</u>	18.83%	14.07%	-4.76
Preventive Care	Child	H	Adolescent Screening/ Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and who had <u>screening for depression</u> documented.	NR	11.85%	N/A
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for tobacco use</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	25.06%	26.48%	1.42
				The percentage of pregnant members who had a screening for tobacco use and were found <u>positive for tobacco use.</u>	NR	54.26%	N/A
				The percentage of pregnant members who were found positive for tobacco use and received <u>intervention for tobacco use.</u>	NR	43.14%	N/A
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for alcohol use</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	20.76%	22.54%	1.78
				The percentage of pregnant members who had a screening for alcohol use and were found <u>positive for alcohol use.</u>	NR	33.75%	N/A
				The percentage of pregnant members who were found positive for alcohol use and <u>received intervention for alcohol use.</u>	NR	3.70%	N/A
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for substance/drug use</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	21.77%	21.97%	0.20
				The percentage of pregnant members who had a screening for substance/drug use and were found <u>positive for substance/drug use.</u>	NR	34.62%	N/A
				The percentage of pregnant members who were found positive for substance/drug use and were provided <u>intervention for drug/substance use.</u>	NR	7.41%	N/A

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change from RY 2013 to RY 2014
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>assessment of and/or counseling for nutrition</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	9.87%	10.99%	1.12
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>assessment of and/or counseling for OTC/ prescription medication</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	12.41%	12.11%	-0.30
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for domestic violence</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	10.13%	9.30%	-0.83
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for depression</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	14.18%	11.27%	-2.91
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for depression during a postpartum visit</u> .	0.00%	40.81%	40.81
Children with Special Health Needs: Access to Care and Preventive Care Services							
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Annual Dental Visit	The percentage of members 2–21 years of age who had <u>at least one dental visit</u> during the measurement year.			
				SSI Total(B, BP, D, DP, K, M)	54.32%	55.33%	1.01
				SSI Blind (B, BP, K)	66.67%	40.00%	-26.67
				SSI Disabled (D, DP, M)	54.25%	55.37%	1.12
				Foster (P,S, X)	73.10%	68.98%	-4.12
				CSCN (provider type 22 and 23)	67.27%	66.67%	-0.60
Total ADV 2–21 years)					60.76%	63.48%	2.72
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Well Child Visits in the First 15 Months of Life (6+ visits)	The percentage of members who turned 15 months old during the measurement year and who <u>6 or more well-child visits</u> with a PCP during their first 15 months of life.			
				SSI Total(B, BP, D, DP, K, M)	N/A	N/A	N/A
				SSI Blind (B, BP, K)	N/A	N/A	N/A
				SSI Disabled (D, DP, M)	N/A	N/A	N/A
				Foster (P,S, X)	N/A	N/A	N/A

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change from RY 2013 to RY 2014
				CCSHCN (provider type 22 and 23)	N/A	N/A	N/A
				Total WC15mo	N/A	N/A	N/A
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Well Child Visits in the 3 rd , 4 th , 5 th & 6 th Years of Life	The percentage of members 3–6 years of age who received <u>one or more well-child visits with a PCP</u> during the measurement year.			
				SSI Total(B, BP, D, DP, K, M)	57.01%	55.25%	-1.76
				SSI Blind (B, BP, K)	N/A	0.00%	N/A
				SSI Disabled (D, DP, M)	57.10%	55.25%	-1.85
				Foster (P,S, X)	69.69%	67.51%	-2.18
				CCSHCN (provider type 22 and 23)	75.00%	82.61%	7.61
				Total WC34	63.18%	65.88%	2.70
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Adolescent Well Care Visits	The percentage of enrolled members 12–21 years of age who had <u>at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner</u> during the measurement year.			
				SSI Total(B, BP, D, DP, K, M)	35.46%	28.28%	-7.18
				SSI Blind (B, BP, K)	N/A	33.33%	N/A
				SSI Disabled (D, DP, M)	35.45%	28.26%	-7.19
				Foster (P,S, X)	54.20%	48.76%	-5.44
				CCSHCN (provider type 22 and 23)	44.36%	43.75%	-0.61
				Total AWC	41.17%	38.81%	-2.36
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 12 months – 19 years of age who had <u>a visit with a primary care practitioner (PCP)</u> .			
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 12–24 months of age who had <u>a visit with a primary care practitioner (PCP)</u> during the measurement year.			
				SSI Total(B, BP, D, DP, K, M)	96.67%	89.74%	-6.93%
				SSI Blind (B, BP, K)	N/A	0.00%	N/A
				SSI Disabled (D, DP, M)	96.63%	89.74%	-6.89%
				Foster (P,S, X)	99.13%	98.31%	-0.82%
				CCSHCN (provider type 22 and 23)	100.00%	100.00%	0.00%
				Total CAP 12–24 months	98.26%	95.76%	-2.50%
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 25 months–6 years of age who had <u>a visit with a primary care practitioner (PCP)</u> during the measurement year.			
				SSI Total(B, BP, D, DP, K, M)	95.60%	27.94%	-67.66%

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change from RY 2013 to RY 2014
				SSI Blind (B, BP, K)	N/A	0.00%	N/A
				SSI Disabled (D, DP, M)	95.58%	27.94%	-67.64%
				Foster (P,S, X)	94.28%	91.54%	-2.74%
				CCSHCN (provider type 22 and 23)	100.00%	100.00%	0.00%
				Total CAP 25 months–6 years	95.45%	76.78%	-18.67%
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 7–11 years of age who had a visit with a primary care practitioner (PCP) during the measurement year, or the year prior.			
				SSI Total(B, BP, D, DP, K, M)	N/A	51.14%	N/A
				SSI Blind (B, BP, K)	N/A	50.00%	N/A
				SSI Disabled (D, DP, M)	N/A	51.15%	N/A
				Foster (P,S, X)	N/A	95.83%	N/A
				CCSHCN (provider type 22 and 23)	N/A	100.00%	N/A
				Total CAP 7 -11 years	N/A	84.42%	N/A
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 12–19 years of age who had a visit with a primary care practitioner (PCP) during the measurement year, or the year prior.			
				SSI Total(B, BP, D, DP, K, M)	N/A	95.18%	N/A
				SSI Blind (B, BP, K)	N/A	96.02%	N/A
				SSI Disabled (D, DP, M)	N/A	94.79%	N/A
				Foster (P,S, X)	N/A	94.39%	N/A
				CCSHCN (provider type 22 and 23)	N/A	100.00%	N/A
				Total CAP 12 -19 years	N/A	94.85%	N/A

N/A: not applicable (plan did not have any eligible members for this rate); NR: not reportable (plan did not produce a valid rate); H: hybrid measure; A: administrative measure; RY: reporting year.

Appendix B – Validation Findings for Humana-CareSource

Medical Record Tools, Instructions and Processes

Key findings from the review of Humana-CareSource's medical record review tools and instructions revealed that:

All tools included general documentation requirements, i.e., review date, reviewer, member name, member plan identification number and member date of birth

§ All tools included exclusion criteria where appropriate.

Adolescent Preventive Screening/Counseling: Depression Screening

§ The type of practitioner (PCP or OB/GYN) is not specified in the abstraction tool.

§ Humana-CareSource might consider pre-loading the member's age as of December 31 of the measurement year on the tool as a cue for the reviewers. The tool currently shows the date on which the member's 16th birthday either has occurred or will occur in the future.

§ Humana's training instructions identify members who "had a well-care/preventive outpatient visit during 2013." Per the specifications, the preventive visit is a denominator criterion, any type of visit and multiple visits may be used to obtain documentation for these numerators. The specifications also state that services rendered during sick visits dated within the measurement year may be used to identify numerator positive events. Humana-CareSource should revise the language in the training materials to reflect that both well-care/preventive visits, sick visits and multiple visits can be used to abstract numerator data.

Prenatal and Postpartum Risk Assessment and Education/Counseling

§ The tools and instructions should specify "tobacco use" and not "smoking" as all types of tobacco use are included in the measure (i.e., cigarettes, cigars, chew, smokeless tobacco, etc.).

§ In the vendor presentation slide, a positive prenatal screening for tobacco is defined as a finding that the member is a positive smoker during the first two prenatal visits or one of the first two prenatal visits following enrollment. The definition of a member positive for tobacco use should be expanded to include all forms of tobacco use (i.e., cigarettes, cigars, chew, smokeless tobacco, etc.).

§ In the vendor presentation slide, interventions are defined as being for a member identified as a smoker during the member's first prenatal visits or one of the first two prenatal visits following enrollment. The specifications state that interventions are warranted members with a positive tobacco use in any form (i.e., cigarettes, cigars, chew, smokeless tobacco, etc.).

§ The vendor training materials indicate that providing an information packet or viewing a video are acceptable to meet the numerator requirements. This is only acceptable if the specific date and relevant topic(s) are documented for each member.

§ The vendor training materials indicate that education on depression/domestic violence meets the measure requirements. There must be a specific notation regarding screening for depression/domestic violence to meet numerator requirements.

MRR Validation

The results were as follows:

Adolescent Preventive Screening/Counseling: Depression Screening – PASSED VALIDATION

15 of 15 records passed validation.

Prenatal and Postpartum Risk Assessment and Education/Counseling: Screening/Intervention for Alcohol Use (Prenatal) – PASSED VALIDATION

14 of 14 records passed validation.

Prenatal and Postpartum Risk Assessment and Education/Counseling: Screening for Nutrition (Prenatal) – PASSED VALIDATION

10 of 10 records passed validation.

Performance Trends RY 2013 to RY 2014

Humana-CareSource's performance for RY 2014 is presented in Table B-1. Since this was the first year that Humana-CareSource reported the performance measures, no discussion of rate trends is possible.

Table B1: Humana-CareSource – RY 2014 Performance Measure Rates

Performance Measure Domain	Age Group	Admin/Hybrid	Category	Measure Definition	RY 2014 Rate
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had their <u>height and weight</u> documented during the measurement year or the year prior to the measurement year.	N/A
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had a <u>healthy weight for height</u> documented during the measurement year or the year prior to the measurement year (as identified by appropriate BMI).	N/A
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had <u>counseling for nutrition</u> documented during the measurement year or the year prior to the measurement year.	N/A
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had <u>counseling for physical activity</u> documented during the measurement year or the year prior to the measurement year.	N/A
Preventive Care	Adult	A	Cholesterol Screening	The percentage of male enrollees age \geq 35 years and female enrollees age \geq 45 years who had an outpatient visit and had <u>LDL-C/cholesterol screening</u> in the measurement year or during the four years prior.	76.90%
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–11 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of <u>both a height and weight</u> on the same date of service during the measurement year.	70.23%

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2014 Rate
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 12–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of <u>both a height and weight</u> on the same date of service during the measurement year.	68.75%
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of <u>both a height and weight</u> on the same date of service during the measurement year.	69.83%
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–11 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a <u>healthy weight for height</u> during the measurement year.	29.28%
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 12–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a <u>healthy weight for height</u> during the measurement year.	32.56%
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a <u>healthy weight for height</u> during the measurement year.	30.19%
Preventive Care	Child	H	Adolescent Screening/ Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and who had <u>screening/counseling for tobacco</u> .	58.04%
Preventive Care	Child	H	Adolescent Screening/ Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and who had <u>screening/counseling for alcohol/substances</u> .	47.32%
Preventive Care	Child	H	Adolescent Screening/ Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and had <u>screening/counseling for sexual activity</u> .	41.07%
Preventive Care	Child	H	Adolescent Screening/ Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and who had <u>screening for depression</u> documented.	31.25%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for tobacco use</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	8.50%
				The percentage of pregnant members who had <u>positive screening for tobacco use</u> .	42.31%
				The percentage of pregnant members who had positive screening for tobacco use and <u>received intervention for tobacco use</u> .	36.36%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for alcohol use</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	4.58%
				The percentage of pregnant members who had <u>positive screening for alcohol use</u> .	0.00%

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2014 Rate
				The percentage of pregnant members who were found positive for alcohol use and received <u>intervention for alcohol use</u> .	N/A
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for substance/drug use</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	4.90%
				The percentage of pregnant members who had <u>positive screening for substance/drug use</u> .	0.00%
				The percentage of pregnant members who were found positive for substance/ <u>drug use</u> and were provided <u>intervention for drug/substance use</u> .	N/A
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>assessment of and/or education/ counseling for nutrition</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	4.90%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>assessment of and/or education/ counseling for OTC/ prescription medication</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	3.27%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for domestic violence</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	4.25%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for depression</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	2.61%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for depression</u> during a <u>postpartum visit</u> .	14.10%
Children with Special Health Care Needs					
Preventive Care	Child - CSHCN Cohort	A	HEDIS® Annual Dental Visit	The percentage of members 2–21 years of age who had <u>at least one dental visit</u> during the measurement year.	
				SSI Total(B, BP, D, DP, K, M)	40.03%
				SSI Blind (B, BP, K)	N/A
				SSI Disabled (D, DP, M)	40.20%
				Foster (P,S, X)	44.33%
				CCHCN (provider type 22 and 23)	43.11%
				Total ADV 2–21 years)	41.29%

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2014 Rate
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Well Child Visits in the First 15 Months of Life (6 or More Visits)	The percentage of members who turned 15 months old during the measurement year and who had <u>at least 6 well-child visits with a PCP during their first 15 months of life.</u>	
				SSI Total(B, BP, D, DP, K, M)	N/A
				SSI Blind (B, BP, K)	N/A
				SSI Disabled (D, DP, M)	N/A
				Foster (P,S, X)	N/A
				CCSHCN (provider type 22 and 23)	N/A
				Total WC15mo	N/A
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Well Child Visits in the 3 rd , 4 th , 5 th & 6 th Years of Life	The percentage of members 3–6 years of age who received <u>one or more well-child visits with a PCP during the measurement year.</u>	
				SSI Total(B, BP, D, DP, K, M)	53.85%
				SSI Blind (B, BP, K)	N/A
				SSI Disabled (D, DP, M)	53.33%
				Foster (P,S, X)	67.74%
				CCSHCN (provider type 22 and 23)	66.67%
				Total WC34	59.76%
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Adolescent Well Care Visits	The percentage of enrolled members 12–21 years of age who had <u>at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.</u>	
				SSI Total(B, BP, D, DP, K, M)	32.55%
				SSI Blind (B, BP, K)	N/A
				SSI Disabled (D, DP, M)	32.72%
				Foster (P,S, X)	32.41%
				CCSHCN (provider type 22 and 23)	40.68%
				Total AWC	33.39%
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 12 months – 19 years of age who had <u>a visit with a primary care practitioner (PCP).</u>	
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 12–24 months of age who had <u>a visit with a primary care practitioner (PCP) during the measurement year.</u>	
				SSI Total(B, BP, D, DP, K, M)	N/A
				SSI Blind (B, BP, K)	N/A
				SSI Disabled (D, DP, M)	N/A
				Foster (P,S, X)	N/A
				CCSHCN (provider type 22 and 23)	N/A
				Total CAP 12–24 months	93.33%
Preventive Care	Child -	A	HEDIS®	The percentage of members 25 months–6 years of age who had <u>a visit with a primary care</u>	

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2014 Rate
	CSCHN Cohort		Children's Access to PCPs	practitioner (PCP) during the measurement year.	
				SSI Total(B, BP, D, DP, K, M)	79.59%
				SSI Blind (B, BP, K)	N/A
				SSI Disabled (D, DP, M)	79.38%
				Foster (P,S, X)	77.50%
				CCSHCN (provider type 22 and 23)	91.80%
				Total CAP 25 months–6 years	82.91%
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 7–11 years of age who had a visit with a primary care practitioner (PCP) during the measurement year, or the year prior.	
				SSI Total(B, BP, D, DP, K, M)	N/A
				SSI Blind (B, BP, K)	N/A
				SSI Disabled (D, DP, M)	N/A
				Foster (P,S, X)	N/A
				CCSHCN (provider type 22 and 23)	N/A
				Total CAP 7 -11 years	N/A
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 12–19 years of age who had a visit with a primary care practitioner (PCP) during the measurement year, or the year prior.	
				SSI Total(B, BP, D, DP, K, M)	N/A
				SSI Blind (B, BP, K)	N/A
				SSI Disabled (D, DP, M)	N/A
				Foster (P,S, X)	N/A
				CCSHCN (provider type 22 and 23)	N/A
				Total CAP 12 -19 years	N/A

N/A: not applicable (plan did not have any eligible members for this rate); NR: not reportable (plan did not produce a valid rate); H: hybrid measure; A: administrative measure; RY: reporting year.

Appendix C – Validation Findings for Passport Health Plan

Medical Record Tools, Instructions and Processes

Key findings from the review of Passport Health Plan's medical record review tools and instructions revealed that:

- § All tools included general documentation requirements, i.e., review date, reviewer, member name, member plan identification number and member date of birth
- § All tools included exclusion criteria where appropriate.

It is important to note that, since Passport Health Plan passed the medical record validation for both performance measures, the findings below did not impact the validity and reliability of the abstracted data.

IPRO findings included:

Adolescent Preventive Screening/Counseling: All Numerators

- § The abstraction tool states members “who had a well-care visit in 2013.” Per the specifications, although a preventive visit in the measurement year is a denominator criterion, any type of visit and multiple visits may be used to obtain documentation for these numerators. The specifications also state that services rendered during sick visits dated within the measurement year may be used to identify numerator positive events. Passport Health Plan should ensure that reviewers are directed that both well-care and sick visits can be used to abstract numerator data.

Prenatal and Postpartum Risk Assessment and Education/Counseling: All Numerators

- § Passport Health Plan's tool does not specify the provider type. The servicing provider should be a midwife, OB/GYN, Family Practitioner or other PCP. However, it is understood that the MCO medical record retrieval process will direct the reviewer to only provider type(s) that meet numerator requirements. In addition, the specific practitioner is listed on the tool.
- § Passport should add fields to collect the dates for all numerator services (i.e., tobacco use; alcohol use; substance use; OTC/prescription medication counseling; nutrition counseling; depression screening; and domestic violence screening).
- § In order to be consistent with the Healthy Kentuckians Performance Measure, Passport should revise the abstraction tool for the tobacco use, alcohol use, and substance use numerator sets to include fields that capture each of the following: screening/assessment, positive findings and interventions documented by the provider with the dates of service.
- § Passport should direct the reviewer to complete the intervention field only when there is a positive screening finding.
- § PHP should ensure that reviewers are instructed that screening for tobacco use includes all types of tobacco – cigarettes, cigars, chew, smokeless tobacco and e-cigarettes.
- § PHP should ensure that reviewers are instructed that intervention for positive use (tobacco, alcohol, substances) includes counseling, education, referrals and other interventions.

MRR Validation

The results were as follows:

Adolescent Preventive Screening/Counseling: Depression Screening– PASSED VALIDATION

14 of 15 records passed validation.

The reasons that one (1) record failed validation were:

- § The assessment was for mental health in general or another behavioral health condition, e.g., anxiety.
- § Screening was done by a specialist, not a PCP.
- § Documentation addressed general statements regarding mental status with no specific mention of depression: normal mood, normal judgment/insight, orientation to person/place/time, mood and affect, coordination, attention span and concentration.

Prenatal and Postpartum Risk Assessment and Education/Counseling: Screening for Alcohol Use (Prenatal) – PASSED VALIDATION

15 of 15 records passed validation.

Prenatal and Postpartum Risk Assessment and Education/Counseling: Screening for Nutrition (Prenatal) – PASSED VALIDATION

14 of 15 records passed validation.

The reason one (1) record failed validation was:

- § Nutrition education handouts were provided to the member but the provider did not specifically document the date and that nutrition education materials were provided.

Performance Trends RY 2013 to RY 2014

Passport Health Plan's performance for RYs 2013 and 2014 is presented in Table C-1, along with the change in rate (increase or decrease) from year to year.

Overall observations regarding Passport Health Plan's performance include:

- § Performance improved for all numerators of the adult healthy weight for height measure. Increases ranged from a low of 0.96 percentage points for healthy weight for height to a high of almost 6 percentage points for documentation of height and weight.
- § While the rate for documentation of height and weight is strong at 89.85%, the rates for the other three (3) numerators are quite low – healthy weight for height (23.59%), documentation of counseling for nutrition (43.05%) and for physical activity (40.40%). It is important to note that the healthy weight for height measure is currently for reporting purposes only; MCOs are not held accountable for improvement.
- § For children and adolescents 3 – 17 years of age, documentation of height and weight rose slightly more than 3 percentage points, to 92.05%, while those with a healthy weight for height remained stable at 55.64%.
- § The rate for cholesterol screening for adults was very good, at 87.79%, up from 84.23% in RY 2013.

- § Related to adolescent screening and counseling, all two of three (2 of 3) rates that were reportable in both RY 2013 and RY 2104 declined; for alcohol/substances from 63.70% to 59.51% and for sexual activity from 55.48% to 53.99%. Screening for tobacco use improved from 71.92% to 74.85%, an increase of almost 3 percentage points. Screening for depression was not reportable in RY 2013; as a result no comparison can be made. The RY 2014 rate is 28.83%.
- § Rates declined substantially for measures of screening and counseling during the perinatal period, by approximately 20 to 30 percentage points.
- § Screening for tobacco use, alcohol use and substance use were most often found (all three rates 64.10%) while screening for domestic violence was infrequently noted (20.72%). Rates for the other numerators in RY 2014 ranged from 63.86% (assessment/counseling for OTC/prescription medication) to a low of approximately 40%(screening for depression both prenatally and postpartum).
- § Positive screening for tobacco use was most common (28.57%) while positive alcohol and substance use were seen less frequently (4.14% and 5.64%, respectively). Intervention for positive findings occurred most often for tobacco use (60.53%) than for alcohol (36.36%) or substance use (40%).
- As noted prior, depression screening rates were quite low, prenatally (39.04%) and postpartum (39.02%).
- § Regarding access to care for CSHCN, performance ranged from a high of 97.94% (*Children's Access to PCPs (CAP), ages 12 – 24 months*) to 49.69% (*Well-Child Visits in the First 15 Months of Life (WC15)*). Rates for all measures in the Children with Special Health Care Needs (CSHCNs) domain improved from RY 2013 to RY 2014. Improvements ranged from 1.42 to 6.24 percentage points.
- § Rates for the CAP set of measures were very strong, all above 90%. While the highest rate of well-child visits was seen for the ages 3 – 6 years group, at 75.19%.

Table C1: Passport Health Plan – RY 2013 and 2014 Performance Measure Rates

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change from RY 2013 to RY 2014
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had their <u>height and weight</u> documented during the measurement year or the year prior to the measurement year.	83.89%	89.85%	5.96
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had a <u>healthy weight for height</u> documented during the measurement year or the year prior to the measurement year (as identified by appropriate BMI).	22.63%	23.59%	0.96
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had <u>counseling for nutrition</u> documented during the measurement year or the year prior to the measurement year.	38.85%	43.05%	4.20
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had <u>counseling for physical activity</u> documented during the measurement year or the year prior to the measurement year.	30.68%	40.40%	9.72

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change from RY 2013 to RY 2014
Preventive Care	Adult	A	Cholesterol Screening	The percentage of male enrollees age \geq 35 years and female enrollees age \geq 45 years who had an outpatient visit and had <u>LDL-C/cholesterol screening</u> in the measurement year or during the four years prior.	84.23%	87.79%	3.56
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–11 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of <u>both a height and weight</u> on the same date of service during the measurement year.	87.95%	92.03%	4.08
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 12–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of <u>both a height and weight</u> on the same date of service during the measurement year.	91.10%	92.11%	1.01
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of <u>both a height and weight</u> on the same date of service during the measurement year.	88.96%	92.05%	3.09
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–11 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a <u>healthy weight for height</u> during the measurement year.	59.63%	59.21%	-0.42
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 12–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a <u>healthy weight for height</u> during the measurement year.	48.12%	48.57%	0.45
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a <u>healthy weight for height</u> during the measurement year.	55.83%	55.64%	-0.19
Preventive Care	Child	H	Adolescent Screening/ Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and who had <u>screening/counseling for tobacco</u> .	71.92%	74.85%	2.93
Preventive Care	Child	H	Adolescent Screening/ Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and who had <u>screening/counseling for alcohol/substances</u> .	63.70%	59.51%	-4.19
Preventive Care	Child	H	Adolescent Screening/ Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and had <u>screening/counseling for sexual activity</u> .	55.48%	53.99%	-1.49

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change from RY 2013 to RY 2014
Preventive Care	Child	H	Adolescent Screening/ Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and who had <u>screening for depression</u> documented.	NR	28.83%	N/A
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for tobacco use</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	87.76%	64.10%	-23.66
				The percentage of pregnant members who had <u>positive screening for tobacco use</u> .	31.75%	28.57%	-3.18
				The percentage of pregnant members who had positive screening for tobacco use and received <u>intervention for tobacco use</u> .	65.42%	60.53%	-4.89
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for alcohol use</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	86.46%	64.10%	-22.36
				The percentage of pregnant members who had <u>positive screening for alcohol use</u> .	3.92%	4.14%	0.22
				The percentage of pregnant members who were found positive for alcohol use and received <u>intervention for alcohol use</u> .	< 30	36.36%	N/A
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for substance/drug use</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	85.94%	64.10%	-21.84
				The percentage of pregnant members who had <u>positive screening for substance/drug use</u> .	5.76%	5.64%	-0.12
				The percentage of pregnant members who were found positive for substance/drug use and were provided <u>intervention for drug/substance use</u> .	< 30	40.00%	N/A
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>assessment of and/or counseling for nutrition</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	50.00%	30.12%	-19.88

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change from RY 2013 to RY 2014
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>assessment of and/or counseling for OTC/prescription medication</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	84.11%	63.86%	-20.25
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for domestic violence</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	45.05%	20.72%	-24.33
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members year who had evidence of <u>screening for depression</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	70.83%	39.04%	-31.79
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for depression during a postpartum visit</u> .	58.39%	39.02%	-19.37
Children with Special Health Needs: Access to Care and Preventive Care Services							
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Annual Dental Visit	The percentage of members 2–21 years of age who had <u>at least one dental visit</u> during the measurement year.			
				SSI Total(B, BP, D, DP, K, M)	52.94%	57.02%	4.08
				SSI Blind (B, BP, K)	52.94%	60.00%	7.06
				SSI Disabled (D, DP, M)	52.94%	57.01%	4.07
				Foster (P,S, X)	67.60%	76.71%	9.11
				CCSHCN (provider type 22 and 23)	71.43%	64.86%	-6.57
			Total ADV 2–21 years)	56.76%	63.00%	6.24	
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Well Child Visits in the First 15 Months of Life (6+ visits)	The percentage of members who turned 15 months old during the measurement year and who had <u>at least 6 well-child visits with a PCP</u> during their first 15 months of life.			
				SSI Total(B, BP, D, DP, K, M)	35.47%	37.37%	1.90
				SSI Blind (B, BP, K)	100.00%	0.00%	-100.00
				SSI Disabled (D, DP, M)	34.32%	37.37%	3.05
				Foster (P,S, X)	61.47%	68.75%	7.28
				CCSHCN (provider type 22 and 23)	0.00%	0.00%	0.00
			Total WC15mo	45.55%	49.69%	4.14	
Preventive Care	Child - CSCHN	A	HEDIS® Well Child	The percentage of members 3–6 years of age who received <u>one or more well-child visits with a PCP</u> during the measurement year.			

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change from RY 2013 to RY 2014
	Cohort		Visits in the 3rd, 4th, 5th and 6th Years of Life	SSI Total(B, BP, D, DP, K, M)	70.42%	73.18%	2.76
				SSI Blind (B, BP, K)	100.00%	80.00%	-20.00
				SSI Disabled (D, DP, M)	70.35%	73.13%	2.78
				Foster (P,S, X)	77.08%	78.27%	1.19
				CCSHCN (provider type 22 and 23)	0.00%	0.00%	0.00
				Total WC34	72.61%	75.19%	2.58
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Adolescent Well Care Visits	The percentage of enrolled members 12–21 years of age who had <u>at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.</u>			
				SSI Total(B, BP, D, DP, K, M)	48.86%	52.16%	3.30
				SSI Blind (B, BP, K)	42.86%	45.45%	2.59
				SSI Disabled (D, DP, M)	48.88%	52.19%	3.31
				Foster (P,S, X)	59.34%	62.56%	3.22
				CCSHCN (provider type 22 and 23)	59.65%	56.67%	-2.98
Total AWC	51.38%	54.96%	3.58				
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 12 months – 19 years of age who had <u>a visit with a primary care practitioner (PCP).</u>			
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 12–24 months of age who had <u>a visit with a primary care practitioner (PCP) during the measurement year.</u>			
				SSI Total(B, BP, D, DP, K, M)	93.49%	97.25%	3.76
				SSI Blind (B, BP, K)	100.00%	0.00%	-100.00
				SSI Disabled (D, DP, M)	93.37%	97.25%	3.88
				Foster (P,S, X)	100.00%	98.82%	-1.18
				CCSHCN (provider type 22 and 23)	0.00%	0.00%	0.00
Total CAP 12–24 months	96.19%	97.94%	1.75				
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 25 months–6 years of age who had <u>a visit with a primary care practitioner (PCP) during the measurement year.</u>			
				SSI Total(B, BP, D, DP, K, M)	90.95%	92.58%	1.63
				SSI Blind (B, BP, K)	100.00%	80.00%	-20.00
				SSI Disabled (D, DP, M)	90.92%	92.66%	1.74
				Foster (P,S, X)	91.03%	92.15%	1.12
				CCSHCN (provider type 22 and 23)	0.00%	0.00%	0.00
Total CAP 25 months–6 years	90.98%	92.40%	1.42				

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change from RY 2013 to RY 2014
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 7–11 years of age who had a visit with a primary care practitioner (PCP) during the measurement year.			
				SSI Total(B, BP, D, DP, K, M)	90.97%	94.62%	3.65
				SSI Blind (B, BP, K)	100.00%	100.00%	0.00
				SSI Disabled (D, DP, M)	90.95%	94.60%	3.65
				Foster (P,S, X)	89.06%	96.05%	6.99
				CCSHCN (provider type 22 and 23)	100.00%	100.00%	0.00
				Total CAP 7 -11 years	90.56%	94.90%	4.34
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 12–19 years of age who had a visit with a primary care practitioner (PCP) during the measurement year, or the year prior.			
				SSI Total(B, BP, D, DP, K, M)	88.76%	92.38%	3.62
				SSI Blind (B, BP, K)	83.33%	100.00%	16.67
				SSI Disabled (D, DP, M)	88.78%	92.35%	3.57
				Foster (P,S, X)	86.58%	94.06%	7.48
				CCSHCN (provider type 22 and 23)	94.44%	96.43%	1.99
				Total CAP 12 -19 years	88.33%	92.68%	4.35

N/A: not applicable (plan did not have any eligible members for this rate); NR: not reportable (plan did not produce a valid rate); H: hybrid measure; A: administrative measure; RY: reporting year.

Appendix D – Validation Findings for WellCare of Kentucky

Medical Record Tools, Instructions and Processes

Key findings from the review of WellCare’s medical record review tools and instructions revealed that:

- § All tools included general documentation requirements, i.e., review date, reviewer, member name, member plan identification number and member date of birth
- § All tools included exclusion criteria where appropriate.

It is important to note that, since WellCare passed the medical record validation for both performance measures, the findings below did not impact the validity and reliability of the abstracted data.

Adolescent Preventive Screening/Counseling: All Numerators

- § The type of practitioner (PCP or OB/GYN) is not specified in the abstraction tool.
- § WellCare should consider pre-loading the member’s age as of December 31 of the measurement year on the tool as a cue for the reviewers. The tool currently shows the date on which the member’s 16th birthday either has occurred or will occur in the future.
- § WellCare’s training instructions indicate members who “had a well-care/preventive outpatient visit during 2013.” Per the specifications, the preventive visit is a denominator criterion; any type of visit and multiple visits may be used to obtain documentation for the numerators. The specifications also state that services rendered during sick visits dated within the measurement year may be used to identify numerator positive events. WellCare should consider revising the language in the training materials to reflect that both well-care/preventive out patient, sick visits and multiple visits can be used to abstract numerator data.

Prenatal and Postpartum Risk Assessment and Education/Counseling: All Numerators

- § The tools and instructions should specify “tobacco use” and not “smoking” as all types of tobacco use are included in the measure (i.e., cigarettes, cigars, chew, smokeless tobacco, etc.).
- § In the vendor presentation slide, a positive prenatal screening for tobacco is defined as an assessment of being a positive smoker during the first two prenatal visits or one of the first two prenatal visits following enrollment. The specifications indicate that the criteria for “positive tobacco use” include all forms of tobacco (i.e., cigarettes, cigars, chew, smokeless tobacco, etc.).
- § In the vendor presentation slide, interventions are indicated for a member positively identified as a smoker during the member's first prenatal visits or one of the first two prenatal visits following enrollment. The specifications indicate that interventions are warranted for members with a positive screening for tobacco use in any form (i.e., cigarettes, cigars, chew, smokeless tobacco, etc.).
- § The vendor training materials indicate that providing an information packet or viewing a video are acceptable to meet the numerator requirements. This is only acceptable if the specific date and relevant topic(s) are documented for each member.
- § The vendor training materials indicate that education on depression/domestic violence meets the measure requirements. For these numerators, there must be a specific notation regarding screening. Education or counseling does not meet the numerator requirements.

MRR Validation

The results were as follows:

Adolescent Preventive Screening/Counseling: Depression Screening – PASSED VALIDATION

14 of 15 records passed validation.

The reasons that one (1) record failed validation were:

- § The record did not contain documentation of screening for depression.
- § The PCP documentation addressed general statements regarding mental status with no specific mention of depression, i.e., psychiatric/behavior (negative).

Prenatal and Postpartum Risk Assessment and Education/Counseling: Screening/Intervention for Alcohol Use (Prenatal) – PASSED VALIDATION

15 of 15 records passed validation.

Prenatal and Postpartum Risk Assessment and Education/Counseling: Screening for Nutrition (Prenatal) – PASSED VALIDATION

15 of 15 records passed validation.

Performance Trends RY 2013 to RY 2014

WellCare of Kentucky's performance for RYs 2013 and 2014 is presented in Table D-1, along with the change in rate (increase or decrease) from year to year.

Overall observations regarding WellCare of Kentucky's performance include:

- § Performance could not be trended for the adult healthy weight for height numerators as WellCare did not have a sufficient sample to report this measure in RY 2013.
- § While the RY 2014 rate for documentation of height and weight was strong at 84.72%, the rates for the other three (3) numerators were lower - healthy weight for height (25.53%), documentation of counseling for nutrition (27.78%) and for physical activity (33.33%). It is important to note that the healthy weight for height measure is currently for reporting purposes only; MCOs are not held accountable for improvement.
- § For children and adolescents 3 – 17 years of age, documentation of height and weight rose over 10 percentage points, to 79.86%, while those with a healthy weight for height increased over 6 percentage points to 19.48%.
- § The rate for cholesterol screening for adults was very good, at 80.86%, up from 72.94% in RY 2013, an increase of almost 8 percentage points.
- § Related to adolescent screening and counseling, each of the four rates improved, from almost 4 percentage points for tobacco use screening/counseling to just over 7 percentage points for alcohol/substance screening/counseling. Screening/counseling for tobacco use was seen most often, at 54.90%, followed by screening/counseling for alcohol/substances (37.91%), for sexual activity (24.18%), and lastly, screening for depression (21.57%).
- § Rates for measures of screening and counseling during the perinatal period generally improved, from nearly 5 percentage points (screening for domestic violence) to over 12 percentage points (assessment/counseling for OTC/prescription medications).

- § Screening for tobacco use was most often found (40.96%) while assessment/counseling for nutrition was infrequently noted (17.82%). Rates for the other numerators in RY 2014 ranged from 40.16% (screening for alcohol use) to a low of 20.48% (screening for domestic violence).
- § Depression screening rates were 27.93% (prenatally) and 44.16% (postpartum). Prenatal screening increased by 7.10 percentage points, while postpartum screening dropped by 2.56 percentage points.
- § Positive screening for tobacco use was most common (36.31%), while positive substance and alcohol use were seen less frequently (9.29% and 2.63%, respectively). Intervention for positive findings occurred more often for tobacco use (59.65%) and substance use (53.85%) than for alcohol use (25%).
- § Regarding access to care for CSHCN, performance ranged from a high of 97.09% (Children’s Access to PCPs (CAP), ages 7 – 11 years) to 36.97% Adolescent Well-Care Visits (AWC)).
- § Rates for the CAP set of measures were very strong, all above 90%. While the highest rate of well-child visits was seen for the ages 3 – 6 years group, at 62.77%.
- § Rates for the majority of measures in the Children with Special Health Care Needs (CSHCNs) domain declined slightly from RY 2013 to RY 2014 (between 0.51 to 1.77 percentage points); however, the rate for *Well-Child Visits in the First 15 Months of Life* (WC15) improved substantially (+35.60 percentage points). Performance could not be trended for CAP, ages 7–11 and 12–19 years, since WellCare did not report these rates in RY 2013 due to lack of an eligible population.

Table D1: WellCare of Kentucky – RY 2013 and 2014 Performance Measure Rates

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change RY 2013 to RY 2014
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had their <u>height and weight</u> documented during the measurement year or the year prior to the measurement year.	< 30	84.72%	N/A
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had a <u>healthy weight for height</u> documented during the measurement year or the year prior to the measurement year (as identified by appropriate BMI).	< 30	25.53%	N/A
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had <u>counseling for nutrition</u> documented during the measurement year or the year prior to the measurement year.	< 30	27.78%	N/A
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had <u>counseling for physical activity</u> documented during the measurement year or the year prior to the measurement year.	< 30	33.33%	N/A

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change RY 2013 to RY 2014
Preventive Care	Adult	A	Cholesterol Screening	The percentage of male enrollees age \geq 35 years and female enrollees age \geq 45 years who had an outpatient visit and had <u>LDL-C/cholesterol screening</u> in the measurement year or during the four years prior.	72.94%	80.86%	7.92
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–11 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of <u>both a height and weight</u> on the same date of service during the measurement year.	68.42%	78.49%	10.07
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 12–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of <u>both a height and weight</u> on the same date of service during the measurement year.	72.11%	82.35%	10.24
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of <u>both a height and weight</u> on the same date of service during the measurement year.	69.68%	79.86%	10.18
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–11 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a <u>healthy weight for height</u> during the measurement year.	10.71%	21.62%	10.91
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 12–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a <u>healthy weight for height</u> during the measurement year.	17.76%	15.75%	-2.01
Preventive Care	Child	H	BMI	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a <u>healthy weight for height</u> during the measurement year.	13.20%	19.48%	6.28
Preventive Care	Child	H	Adolescent Screening/ Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and who had <u>screening/counseling for tobacco</u> .	51.02%	54.90%	3.88
Preventive Care	Child	H	Adolescent Screening/ Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and who had <u>screening/counseling for alcohol/substances</u> .	30.61%	37.91%	7.30

Performance Measure Domain	Age Group	Admin/Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change RY 2013 to RY 2014
Preventive Care	Child	H	Adolescent Screening/Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and had <u>screening/counseling for sexual activity</u> .	18.37%	24.18%	5.81
Preventive Care	Child	H	Adolescent Screening/Counseling	The percentage of adolescents 12–17 years of age who had a well care/preventive visit in measurement year with a PCP or OB/GYN and who had <u>screening for depression</u> documented.	15.65%	21.57%	5.92
Perinatal Care	N/A	H	Prenatal Screening/Counseling	The percentage of pregnant members who had evidence of <u>screening for tobacco use</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	32.81%	40.96%	8.15
				The percentage of pregnant members who had a screening for tobacco use who were found <u>positive for tobacco use</u> .	43.65%	36.31%	-7.34
				The percentage of pregnant members who were found positive for tobacco use and received <u>intervention for tobacco use</u> .	56.36%	59.65%	3.29
Perinatal Care	N/A	H	Prenatal Screening/Counseling	The percentage of pregnant members who had evidence of <u>screening for alcohol use</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	29.43%	40.16%	10.73
				The percentage of pregnant members who had a screening for alcohol use and who were found <u>positive for alcohol use</u> .	4.42%	2.63%	-1.79
				The percentage of pregnant members who were found positive for alcohol use and received <u>intervention for alcohol use</u> .	< 30	25.00%	N/A
Perinatal Care	N/A	H	Prenatal Screening/Counseling	The percentage of pregnant members who had evidence of <u>screening for substance/drug use</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	29.17%	36.97%	7.80
				The percentage of pregnant members who had <u>positive screening for substance/drug use</u> .	8.93%	9.29%	0.36
				The percentage of pregnant members who were found positive for substance/drug use and received <u>intervention for drug/substance use</u> .	< 30	53.85%	N/A
Perinatal Care	N/A	H	Prenatal Screening/Counseling	The percentage of pregnant members who had evidence of <u>assessment of and/or counseling for nutrition</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	11.72%	17.82%	6.10

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change RY 2013 to RY 2014
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>assessment of and/or counseling for OTC/ prescription medication</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	18.23%	30.59%	12.36
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for domestic violence</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	15.63%	20.48%	4.85
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of <u>screening for depression</u> during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	20.83%	27.93%	7.10
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who delivered a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year who had evidence of <u>screening for depression during a postpartum visit</u> .	46.72%	44.16%	-2.56
Children with Special Health Care Needs – Access to Care and Preventive Care Services							
Preventive Care	Child – CSCHN Cohort	A	HEDIS® Annual Dental Visit	The percentage of members 2–21 years of age who had <u>at least one dental visit</u> during the measurement year.			
				SSI Total(B, BP, D, DP, K, M)	52.72%	55.60%	2.88
				SSI Blind (B, BP, K)	58.33%	58.50%	0.17
				SSI Disabled (D, DP, M)	52.70%	55.60%	2.90
				Foster (P,S, X)	70.85%	74.20%	3.35
				CCSHCN (provider type 22 and 23)	65.96%	70.40%	4.44
				Total ADV 2–21 years)	58.48%	61.81%	3.33
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Well Child Visits in the First 15 months of Life (6 or More Visits)	The percentage of members who turned 15 months old during the measurement year and who had <u>6 or more well-child visits with a PCP</u> during their first 15 months of life.			
				SSI Total(B, BP, D, DP, K, M)	0.09%	40.00%	39.91
				SSI Blind (B, BP, K)	0.00%	100.00%	100.00
				SSI Disabled (D, DP, M)	0.09%	39.20%	39.11
				Foster (P,S, X)	23.07%	59.10%	36.03
				CCSHCN (provider type 22 and 23)	16.66%	54.20%	37.54
				Total WC15mo	16.67%	52.27%	35.60

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change RY 2013 to RY 2014
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Well Child Visits in the 3 rd , 4 th , 5 th & 6 th Years of Life	The percentage of members 3, 4, 5, and 6 years of age who had <u>one or more well-child visits with a PCP</u> during the measurement year.			
				SSI Total(B, BP, D, DP, K, M)	60.41%	58.00%	-2.41
				SSI Blind (B, BP, K)	50.00%	60.00%	10.00
				SSI Disabled (D, DP, M)	60.46%	58.00%	-2.46
				Foster (P,S, X)	67.07%	67.60%	0.53
				CCSHCN (provider type 22 and 23)	65.96%	67.50%	1.54
				Total WC34	63.45%	62.77%	-0.68
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Adolescent Well Care Visits	The percentage of enrolled members 12–21 years of age who had <u>at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner</u> during the measurement year.			
				SSI Total(B, BP, D, DP, K, M)	32.33%	31.70%	-0.63
				SSI Blind (B, BP, K)	11.76%	25.90%	14.14
				SSI Disabled (D, DP, M)	32.43%	31.70%	-0.73
				Foster (P,S, X)	54.30%	52.70%	-1.60
				CCSHCN (provider type 22 and 23)	41.08%	41.70%	0.62
				Total AWC	37.48%	36.97%	-0.51
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 12 months – 19 years of age who had a visit with a primary care practitioner (PCP).			
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 12–24 months of age who had <u>a visit with a primary care practitioner (PCP)</u> during the measurement year.			
				SSI Total(B, BP, D, DP, K, M)	96.15%	96.80%	0.65
				SSI Blind (B, BP, K)	100.00%	100.00%	0.00
				SSI Disabled (D, DP, M)	96.12%	96.70%	0.58
				Foster (P,S, X)	97.53%	95.70%	-1.83
				CCSHCN (provider type 22 and 23)	99.17%	95.60%	-3.57
				Total CAP 12–24 months	97.71%	95.94%	-1.77
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 25 months–6 years of age who had <u>a visit with a primary care practitioner (PCP)</u> during the reporting year.			
				SSI Total(B, BP, D, DP, K, M)	95.45%	94.50%	-0.95
				SSI Blind (B, BP, K)	75.00%	83.30%	8.30
				SSI Disabled (D, DP, M)	95.53%	94.50%	-1.03
				Foster (P,S, X)	91.39%	90.50%	-0.89

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	Change RY 2013 to RY 2014
				CCSHCN (provider type 22 and 23)	96.36%	94.30%	-2.06
				Total CAP 25 months-6 years	94.61%	93.36%	-1.25
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 7-11 years of age who had <u>a visit with a primary care practitioner (PCP)</u> during the measurement year, or the year prior.			
				SSI Total(B, BP, D, DP, K, M)	N/A	97.90%	N/A
				SSI Blind (B, BP, K)	N/A	100.00%	N/A
				SSI Disabled (D, DP, M)	N/A	97.90%	N/A
				Foster (P,S, X)	N/A	94.40%	N/A
				CCSHCN (provider type 22 and 23)	N/A	98.60%	N/A
				Total CAP 7 -11 years	N/A	97.09%	N/A
Preventive Care	Child - CSCHN Cohort	A	HEDIS® Children's Access to PCPs	The percentage of members 12-19 years of age who had <u>a visit with a primary care practitioner (PCP)</u> during the measurement year, or the year prior.			
				SSI Total(B, BP, D, DP, K, M)	N/A	95.50%	N/A
				SSI Blind (B, BP, K)	N/A	100.00%	N/A
				SSI Disabled (D, DP, M)	N/A	95.50%	N/A
				Foster (P,S, X)	N/A	94.00%	N/A
				CCSHCN (provider type 22 and 23)	N/A	97.60%	N/A
				Total CAP 12 -19 years	N/A	95.29%	N/A

N/A: not applicable (plan did not have any eligible members for this rate); H: hybrid measure; A: administrative measure; RY: reporting year.