MAC Binder Section 6 – Audits

Table of Contents with Document Summary

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

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1 - FY 16 Year 4 Evaluation Summary Report_Final_6.9.16:

This comprehensive evaluation summary presents an in-depth review of the accountability strategy, monitoring mechanisms and compliance assessment system described in the Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services.

2 - KY Provider Network Report July 2016 FINAL:

In March 2016, Island Peer review Organization (IPRO), on behalf of the Kentucky Department for Medicaid Services (DMS), conducted its sixth audit of the plans' provider directory data files to validate their accuracy. This is the second provider network validation for FY 2016.

3 - KY_Prenatal_Smoking_Study_EXEC_SUM_Final 7.12.16:

Smoking has been reported to be among the most prevalent, modifiable causes of adverse pregnancy outcomes.

The aims of the proposed focused study are: 1. assess smoking prevalence, member characteristics, and receipt of prenatal smoking cessation services among the Kentucky MMC population who delivered a singleton live or non-live birth; 2. for the identified smoker subpopulation, evaluate the relationships between smoking cessation benefit utilization and demographic, clinical and health care access characteristics; 3. identify clinical, demographic and smoking-related factors that impact selected adverse perinatal outcomes; and 4. profile provider prenatal and postpartum interventions relative to guidelines, including the 5 A's, managed care organization (MCO) care coordination and case management of prenatal and postpartum interventions, whether or not smoking abstinence was achieved and, if it was achieved, whether it was achieved during the prenatal period or the postpartum period.

This is the executive summary for this study.

4 - KY_Prenatal_Smoking_Study_Final 7.12.16:

This is the full report for the study – see description in #3 above.

5 - KY Web Provider Directory Report FINAL 7.12.2016:

The Web-Based Provider Directory Validation Study is one of a variety of activities performed to ensure enrollees are being provided accurate information regarding the providers comprising the health plans' provider networks. It is essential that enrollees have up-to-date and accurate information to enable them to contact their providers and schedule appointments that are timely and within easy access to their homes.

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Table of Contents with Document Summary

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6 - KY_2016_Tech_Report_Final Revised 7.21.16:

To meet federal requirements, the Department for Medicaid Services (DMS) has contracted with Island Peer Review Organization (IPRO), an EQRO, to conduct the annual EQR of Kentucky's Medicaid managed care (MMC) plans. This EQR technical report focuses on the three federally mandated EQR activities that were conducted. As set forth in 42 CFR 438.358.

7 - Managed Care Program Progress Report_FY16_FINAL_8.17.16:

The Commonwealth of Kentucky's report, Strategy for Assessing and Improving the Quality of Managed Care Services, outlines a strategy for quality oversight. The purpose of this Progress Report is to summarize information from the external quality review activities that describe the status and progress that has occurred in Kentucky's MMC Program during the contract period of July 1, 2015 through June 30, 2016.

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

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

FINAL REPORT
June 2016

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Table of Contents

Introduction 3

Core Program Goals and Results 7

Quality Monitoring and Assessment 11

- EQRO Activities Overview 11
- Data Reporting Systems Review 11
- Annual Compliance Reviews 15
- State Review Activities Overview 17
- State-MCO-EQRO Communication 21

Strategies and Interventions to Promote Quality Improvement 23

- Performance Improvement Projects 23
- Focused Studies of Health Care Quality 25
- Financial Incentives 28

Strengths, Opportunities for Improvement and Recommendations 29

- Strengths 29
- Opportunities for Improvement 30
- Recommendations 32

Attachment A: Selected Quality Improvement Initiatives from Other States 33

References 39

List of Tables

Table 1: List of Current Medicaid MCOs by Service Area and Enrollment 4
Table 2: Goal 1 – Improve Preventive Care for Adults 8
Table 3: Goal 2 – Improve Preventive Care for Chronic Illness 8
Table 4: Goal 3 – Improve Behavioral Health Care for Adults and Children 9
Table 5: Goal 4 –Improve Access to a Medical Home 9
Table 6: Growth in Encounters 2015–2016 12
Table 7: Enrollment in Case and Disease Management, July–September 2015 19
Table 8: EPSDT Screening and Participation Rates – RY 2014 and 2015 20
Table 9: PIP Project Status 2013–2016 24

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Introduction

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

Authorizing legislation and regulation for state Medicaid managed care (MMC) programs include the Social Security Act (Part 1915[2] and Part 1932(a))[3], the Balanced Budget Act of 1997 and Title 42[4], Part 438 of the Code of Federal Regulations (CFR)[5]. On April 25, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and CHIP Managed Care Final Rule[6] in the Federal Register. This final rule, which is the first major update to Medicaid and CHIP managed care regulations in more than a decade, aligns Medicaid rules with those of other health insurance coverage programs, modernizes how states purchase managed care for beneficiaries, and strengthens the consumer experience and consumer protections.

Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services (also referred to as Kentucky's Quality Strategy) was approved by CMS in September 2012, and includes the following:

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

The intent of this Comprehensive Evaluation Summary is to continue the evaluation of Kentucky's Quality Strategy using updated information, reports and interviews conducted during the period July 1, 2015 through June 30, 2016. As part of the introduction, recent developments in Kentucky's MMC Program are discussed including a description of program monitoring responsibilities and evaluation methodology.

Medicaid Managed Care in Kentucky – Recent Progress

In December 1995, the Commonwealth of Kentucky received approval from CMS under Section 1115 waiver authority[7] to establish a statewide MMC program that would be phased into eight different regions of the state over time. The waiver initially established two health care partnerships of medical providers in both public and private sectors providing comprehensive medical services to Medicaid beneficiaries living in two designated regions Region 3 (Jefferson County and 15 surrounding counties) and Region 5 (Fayette County and 20 surrounding counties). In 1999, the Region 5 partnership withdrew from the managed care program and by the fall of 2000, Kentucky stopped plans to implement a statewide risk-based managed care program. The partnership with University Health Care (doing business as Passport Health Plan) continued service in Region 3 and the rest of Kentucky's Medicaid members were enrolled in the fee-for-service (FFS) system.

With increasing Medicaid health care expenditures and a growing eligible population, Kentucky once again turned to risk-based managed care as a solution and in 2011, initiated a procurement process to contract with MCOs to provide services statewide. Three additional MCOs were awarded contracts by July 2011: Coventry Health and Life Insurance Company (doing business as CoventryCares of Kentucky), Kentucky Spirit Health Plan, Inc., and WellCare of Kentucky, Inc. On November 1, 2011, risk-based managed care was implemented.

After a little more than a year, Kentucky Spirit Health Plan notified the Kentucky Department of Medicaid Services (DMS) that they would be withdrawing from the managed care program as of July 2013. The state successfully procured a new contract with Humana-CareSource and the transition of enrollees was underway before the end of 2013. The Patient Protection and Affordable Care Act (ACA) allowed DMS to further expand Medicaid eligibility in 2014 and Kentucky contracted with Anthem Blue Cross and Blue Shield (BCBS) Medicaid to first serve Medicaid expansion members in all regions of the state excluding Region 3 and then included Region 3 in 2015. On May 7, 2013, Aetna acquired Coventry Health Care Inc. resulting in the transition of CoventryCares of Kentucky to Aetna Better Health of Kentucky by February 1, 2016.

Program enrollment grew by 4.8% from 1,174,716, in April 2015 to 1,231,505 in April 2016. Anthem BCBS Medicaid almost doubled its enrollment over the last year, followed by increases in enrollment for Passport Health Plan (14.1%), Humana-CareSource (11.2%) and WellCare of Kentucky (1.0%). Enrollment in Aetna Better Health of Kentucky decreased by 9.1% from April 2015 to April 2016 (Table 1).

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

MCO	Enrollment 4/2015	Enrollment 4/2016	Percent Change	Service Area
Anthem BCBS Medicaid	69,031	100,849	+46.1%	Statewide
Aetna Better Health of Kentucky	303,686	276,052	-9.1%	Statewide
Humana-CareSource	113,039	125,658	+11.2%	Statewide
Passport Health Plan	251,855	287,255	+14.1%	Statewide
WellCare of Kentucky	437,105	441,691	+1.0%	Statewide
Total	1,174,716	1,231,505	+4.8%	N/A

MCO: managed care organization; BCBS: Blue Cross and Blue Shield; N/A: not applicable

Responsibility for Program Monitoring

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

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

During 2015, several changes in leadership occurred. Newly elected Governor Matt Bevin appointed a new cabinet secretary, Vickie Yates Brown Glisson, and a new commissioner to DMS, Stephen Miller. One of the deputy commissioners retired and Veronica Cecil was named deputy commissioner. The medical director position is currently vacant. At the division level, Director Patricia Biggs left DPQ&O, and Cindy Arflack, who was previously deputy director, became the new director. The assistant director position is vacant. A number of staff vacancies also exist including a nurse/consultant inspector position in the Disease and Case Management Branch as well as one internal policy analyst III position in the Contract Compliance Branch.

The Managed Care Oversight – Quality Branch of DPQ&O monitors EQRO progress and reviews findings from all EQRO documents, encounter data summaries, the Healthcare Effectiveness Data and Information Set (HEDIS®) and other quality reports with an eye toward quality improvement. Branch staff updates DPQ&O's web pages with current documents and information; reviews and modifies all MCO reports; creates spreadsheets, reports and dashboards to display and analyze the data; and monitors the EQRO contract for compliance and correct invoicing. With the aid of the

EQRO, the Quality Branch is recently working on performing more in-depth reviews of access and availability issues and performing more case reviews as they relate to access and availability. The Quality Branch is currently participating in several collaborative initiatives including the CMS Tobacco Cessation Affinity Group, the Substance Abuse and Mental Health Services Administration (SAMHSA) Tobacco Policy Group for Kentucky (focusing on provider education) and the CMS Antipsychotic Use in Children Affinity Group. Their efforts with the two smoking groups are aimed at helping to raise quit attempts and to lower the smoking rate in Kentucky. They also continue to work at developing HEDIS-like quality measures for the Kentucky FFS population with Hewlett Packard (HP).

The Managed Care Oversight – Contract Management Branch of DPQ&O is responsible for monitoring contract compliance for the five Kentucky MCOs and reviewing required reports submitted by the MCOs. They continue to intensify their contract compliance efforts and have initiated penalties/withholds for non-compliance and failure to correct after being issued corrective action plans (CAPS) and letters of concern (LOCs).

The Disease and Case Management Branch of DPQ&O responsibilities cover a broad range of monitoring and coordinating functions working closely with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), Department for Aging and Independent Living (DAIL) and the Department of Community-Based Services (DCBS). The Disease and Case management Branch has focused on care coordination and case management referrals for special populations such as medically fragile children, foster care children and adults in guardianship and during this past year have been working more on provider issues related to both grievances and appeals and disenrollment for cause requests. They are also leading the Kentucky group for the CMS Oral Health Affinity Group.

With several leadership changes and increasing branch responsibilities for monitoring and quality improvement, Kentucky continues to vigorously apply staff resources and expertise in the development of their expanding MMC Program, thus providing needed direction and cohesiveness for it moving forward. Although staff continually faces the challenge of achieving more with less, they have enthusiastically applied for and received acceptance to participate in several CMS Affinity Group collaboratives which offer an opportunity to expand state resources through collaboration with other state and national participants. CMS's Medicaid Prevention Learning Network offers state Medicaid programs an opportunity to receive technical assistance and state-to-state learning to promote best practices in preventive health care in Medicaid and Children's Health Insurance Program (CHIP). The Tobacco Cessation Affinity Group focuses on strategies to increase utilization and quality of smoking cessation benefits for Medicaid and CHIP enrollees and aims to reduce tobacco use, improve health, and reduce costs attributable to smoking-related health conditions. The Antipsychotic Drug Use in Children Group supports state efforts to improve quality of care for children prescribed antipsychotic drugs, while the Oral Health Affinity Group provides a forum to share quality improvement practices in oral health care.[8]

All five Kentucky MCOs participate in the CMS Affinity Groups and the SAMHSA Tobacco Policy Group, and all agree that they are valuable learning collaboratives.

Evaluation Methodology

The methodology for this report included a review of documents from external review activities, MCO reports and interviews with staff from IPRO, DMS and each of the five MCOs. Managed care activities and experience from other states' external quality reviews and quality improvement initiatives were researched to provide valuable insight into promising practices for DMS consideration.

This report includes an overview of Kentucky's MMC data reporting systems obtained from MCO and EQRO reports. Quality strategies, obtained from state websites, provided information regarding EQRO activities, performance improvement projects (PIPs) and quality improvement (QI) initiatives from other states. Core program goals from Kentucky's Quality Strategy were quantified and statewide aggregate baseline data were obtained from HEDIS and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 2015 results.

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

- 2016 External Quality Review Technical Report (April 2016 Draft), Review of MCO Contract Year(s) 2013–2015
- A Member's Guide to Choosing a Medicaid Health Plan, 2016

- Kentucky Monthly Encounter Validation Report, February 2016
- EPSDT Encounter Data Validation 2015, October 2015
- Kentucky Medicaid Managed Care Early Periodic Screening, Diagnostic and Treatment Services (EPSDT) Review of 2014, Final June 2015
- Access and Availability PCP Survey, August 2015
- Access and Availability Dental Survey, February 2016
- FY16 Validation of Managed Care Provider Network Submissions: Audit Report, January 2016
- Web-Based Provider Directory Validation Study Summary Report Final, January 2016
- Kentucky Medically Fragile Children Focused Study, Final Report August 2015
- Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity among the Kentucky Medicaid Managed Care Population, Clinical Focused Study 2015, Final Report September 2015
- Kentucky MCO Performance Improvement Project Progress Tracking Sheet, SFY 2016
- Quarterly Desk Audit Reports, 3rd Quarter 2015

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

Core Program Goals and Results

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

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

To measure improvement and evaluate program success, benchmarks from the National Committee for Quality Assurance (NCQA) Quality Compass Medicaid[9] were included for each quality objective listed in the strategy. NCQA's Quality Compass Medicaid is derived from HEDIS data submitted to NCQA by Medicaid plans throughout the nation. Using these standardized measures as benchmarks allows states to make meaningful comparisons of their rates to rates for all reporting MMC plans nationwide and thus allows state policy makers to better identify program strengths and weaknesses and target areas most in need of improvement. In the Kentucky strategy, improvement is measured by a comparison of the state's rate to the 50th or 75th percentile of the 2012 national Medicaid benchmark or as an improvement of 10 percent of the difference between the state's baseline rate and the re-measurement rate. The use of national HEDIS performance is a reasonable approach to setting benchmarks particularly when the bar is set at a conservative 50th percentile rate for the majority of the measures, such as those regarding colorectal cancer screening, breast cancer screening, cervical cancer screening, cholesterol management, antidepressant medication management and outpatient visits. The 75th percentile benchmark was selected for measures of behavioral health care and access to care for adults and children.

In this evaluation summary report, results from Kentucky's HEDIS 2013 serve as baseline rates, and are compared to results from HEDIS 2015 for each measure in order to evaluate improvement from baseline to re-measurement. Kentucky's HEDIS 2013 and HEDIS 2015 state weighted average rates are shown in Tables 2, 3, 4, and 5 for the objectives listed in the Quality Strategy. Two methods were used to evaluate improvement.

First, the HEDIS 2015 weighted average rate for each objective was compared to the 2012 NCQA Quality Compass national Medicaid percentile rate for that measure, and a target rate was set to meet or exceed the selected Quality Compass percentile. For example, Kentucky's HEDIS 2015 weighted average statewide rate for the Breast Cancer Screening measure was 52.86% which was above the 2012 national Medicaid 50th percentile rate of 50.46%, thus exceeding the target rate for this measure.

Second, the level of improvement from baseline to re-measurement was calculated as a percent for comparison with a targeted percent improvement, i.e., 10%. None of the measures showed a 10% (or greater) improvement over the baseline. It should be noted that while a measure could reach the target rate using both methods, it is only necessary to meet or exceed one of the designated target rates for the objective to be met (Tables 2, 3, 4, and 5).[10] While the Quality Strategy includes the Colorectal Cancer Screening measure as an adult preventive care objective, this measure has not yet been specified for HEDIS Medicaid and thus no data were reported. Also included in the Quality Strategy, but not reported in HEDIS 2015, were two measures from the Comprehensive Diabetes Care (CDC) measure (CDC: LDL-C Screening, and CDC: LDL-C Control [< 100 mg/dL]) and two rates for the Cholesterol Management for Patients with Cardiovascular Conditions measure (CMC: LDL-C Screening and CMC: LDL-C Control [< 100 mg/dL]).

Table 2: Goal 1 – Improve Preventive Care for Adults

Objectives[1]	2012 Medicaid 50th Percentile	HEDIS 2013 Baseline Rate (%)	HEDIS 2015 Re-measure Rate (%)	Difference HEDIS 2013–2015	% Improved 2013–2015	Met Objective? (Yes/No)
HEDIS Colorectal Cancer Screening[2]	NR	NR	NR	N/A	N/A	N/A
HEDIS Breast Cancer Screening	50.46	51.67	52.86	1.19	2.30%	Yes
HEDIS Cervical Cancer Screening	69.10	49.61	46.95	-2.66	-5.36%	No

[1]Improvement in preventive care for adults is defined as "all measures meet/exceed 2012 Medicaid 50th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate."
[2]HEDIS rates for Colorectal Cancer Screening were not reported for Kentucky's Medicaid population.
[3]NR: not reported; N/A: not applicable.

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

Objectives[1]	2012 Medicaid 50th Percentile	HEDIS 2013 Baseline Rate (%)	HEDIS 2015 Re-measure Rate (%)	Difference HEDIS 2013–2015	% Improved 2013–2015	Met Objective? (Yes/No)
HEDIS Comprehensive Diabetes Care Measure						
Hemoglobin A1c Testing	82.38	83.38	88.78	5.40	6.48%	Yes
HbA1c Poor Control (> 9.0%)[2]	41.68	47.42	43.01	-4.41	-9.30%	No
HbA1c Control (< 8.0%)	48.72	44.51	48.22	3.71	8.34%	No
HbA1c Control (< 7.0%)	36.72	35	35.33	0.33	0.94%	No
Eye Exam Performed	52.88	41.91	41.61	-0.30	-0.72%	No
LDL-C Screening[3]	76.16	75.27	NR	N/A	N/A	N/A
LDL-C Control (< 100 mg/dL)	35.86	32.8	NR	N/A	N/A	N/A
Medical Attention for Nephropathy	78.71	76.67	82.31	5.64	7.36%	Yes
Blood Pressure Control (< 140/90 mmHg)	63.5	56.67	59.39	2.72	4.80%	No
HEDIS Cholesterol Management Measure						
LDL-C Screening[3]	82.48	79.91	NR	N/A	N/A	N/A
LDL-C Control (< 100 mg/dL)[3]	42.39	44.59	NR	N/A	N/A	N/A

[1]Improvement in preventive care for chronic illness is defined as "all measures meet/exceed 2012 Medicaid 50th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate."
[2]For this measure, a lower rate is better.
[3]This measure was retired for HEDIS 2015.
LDL-C: low-density lipoprotein cholesterol; NR: not reported; N/A: not applicable.

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

Objectives	2012 Medicaid 50th Percentile	HEDIS 2013 Baseline Rate (%)	HEDIS 2015 Re-measure Rate (%)	Difference HEDIS 2013–2015	% Improved 2013–2015	Met Objective? (Yes/No)
HEDIS Antidepressant Medication Management[1]						
Effective Acute Phase	49.42	58.36	58.28	-0.08	-0.14%	Yes
Effective Continuation Phase	32.42	42.98	43.95	0.97	2.26%	Yes
HEDIS Follow-up After Hospitalization for Mental Illness[2]						
Within 30 Days of Discharge	77.47	62.55	53.53	-9.02	-14.42%	No
Within 7 Days of Discharge	57.68	36.60	30.85	-5.75	-15.71%	No

[1]Improvement in behavioral health care for adults and children for these measures is defined as "measures meet/exceed 2012 Medicaid 50th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate."
[2]Improvement in behavioral health care for adults and children for these measures is defined as "measures meet/exceed 2012 Medicaid 75th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate."

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

Objectives	2012 Medicaid 75th Percentile	HEDIS 2013 Baseline Rate (%)	HEDIS 2015 Re-measure Rate (%)	Difference HEDIS 2013–2015	% Improved 2013–2015	Met Objective? (Yes/No)
HEDIS Adult Access to Preventive/Ambulatory Health Services[1]						
Ages 20–44 Years	85.43	86.22	81.33	-4.89	-5.67%	No
Ages 45–64 Years	89.94	91.32	88.45	-2.87	-3.14%	No
Ages 65+ Years	91.11	91.31	84.24	-7.07	-7.74%	No
Total	86.67	88.75	83.99	-4.76	-5.36%	No
HEDIS Children and Adolescents Access to Primary Care[1]						
12–24 Months	97.88	97.65	97.49	-0.16	-0.16%	No
25 Months–6 Years	91.40	92.07	90.91	-1.16	-1.26%	No
7–11 Years	92.88	91.95	95.63	3.68	4.00%	Yes
12–19 Years	91.59	91.64	94.39	2.75	3.00%	Yes
Objectives	**2012 Medicaid 50th Percentile (Visits/1,000 MM)[3]**	**HEDIS 2013 Baseline (Visits/1,000 MM)**	**HEDIS 2015 Re-measure (Visits/1,000 MM)**	**Difference HEDIS 2013–2015**	**% Change 2013–2015**	**Met Objective? (Yes/No)**
HEDIS Outpatient and Emergency Department (ED) Visits for All Age Groups[2]						
Outpatient Visits	347.76	645.76	501.16	-144.60	-22.39%	Yes
ED Visits	N/A	84.45	83.92	-0.53	-0.63%	No

[1]Improvement in access to a medical home is defined as "all measures meet/exceed 2012 Medicaid 75th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate."
[2]Improvement in access to a medical home with regards to state aggregate HEDIS Ambulatory measures are defined as "outpatient visits meet/exceed 2012 Medicaid 50th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate" for the Outpatient Visits for all Age Groups measure, and as "emergency department (ED) visits decrease rate of utilization by 10% between the baseline rate and the re-measurement rate" for the ED Visits for all Age Groups measurement.
MM: member months; N/A: not applicable.

Eleven of Kentucky's HEDIS 2013 baseline rates met or exceeded the selected 2012 Medicaid national benchmark rates and, historically, 17 (60.7%) of Kentucky's re-measurement HEDIS 2014 rates met or exceeded the Medicaid national benchmark (see prior year Evaluation Summary Report). The latest HEDIS 2015 re-measurement results, however, did not compare favorably to the previous years, with only eight measures (38.1%) meeting or exceeding the selected 2012 national benchmark, while another 8 measures were within five percentage points of the national benchmark.

The eight measures that met objectives for the Quality Strategy included the following measures:

- Breast Cancer Screening
- CDC: Hemoglobin A1c Testing
- CDC: Medical Attention for Nephropathy
- Antidepressant Medication Management: Effective Acute Phase
- Antidepressant Medication Management: Effective Continuation Phase
- Children and Adolescents Access to Primary Care for ages 7–11 years and ages 12–19 years
- Outpatient Visits for all Age Groups

Opportunities for improvement are evident for the following measures with declining rates of performance from baseline to HEDIS 2015 re-measurement:

- Cervical Cancer Screening
- CDC: Eye Exam Performed
- Follow-up After Hospitalization for Mental Illness Within 30 Days of Discharge and Within 7 Days of Discharge
- Adult Access to Preventive/Ambulatory Health Services, all age groups
- Children and Adolescents Access to Primary Care, ages 12–24 months and ages 25 months to 6 years.

HEDIS 2015 measures for Follow-up After Hospitalization for Mental Illness Within 7 and 30 Days of Discharge were markedly below the HEDIS 2012 national benchmark by as much as 26.8 and 23.9 percentage points, respectively.

Using the updated CMS Quality Strategy Tool Kit for States,[11] the Managed Care Oversight – Quality Branch is currently rewriting the Quality Strategy and aim to have it completed by the end of 2016. Previous comprehensive evaluation summary reports have recommended that the state consider re-evaluating their benchmark targets and also expanding the goals to address the large enrollment of women and children in the MMC Program by including goals and objectives for prenatal/postpartum care and preventive measures for children, such as childhood obesity, dental care, counseling for nutrition and physical activity, and adolescent risk screening. Measures of member satisfaction should be considered. Additional measures related to kyhealthnow 2019 goals[12] would reflect the following objectives:

- Reduce Kentucky's rate of uninsured individuals to less than 5%
- Reduce Kentucky's smoking rate by 10%
- Reduce the rate of obesity among Kentuckians by 10%
- Reduce Kentucky cancer deaths by 10%
- Reduce cardiovascular deaths by 10%
- Reduce the percentage of children with untreated dental decay by 25% and increase adult dental visits by 10%
- Reduce deaths from drug overdose by 25% and reduce by 25% the average number of poor mental health days of Kentuckians

Unbridled Health, A Plan for Coordinated Chronic Disease Prevention and Health Promotion 2012–2016[13] is another approach that outlines quality indicators and strategies focusing on improving chronic disease outcomes in Kentucky. In December 2015, the Commonwealth submitted a state health system innovation plan (SHSIP) as part of the State Innovation Model (SIM) Design Grant.[14] Each of these documents incorporates a wealth of information on the health care system in Kentucky and goals for the future and should more than adequately serve as a basis for the state's updated Quality Strategy.

Quality Monitoring and Assessment

Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services outlines a strategy for quality oversight that is aligned with federal regulations. The Social Security Act (Part 1932(a))[15] requires states that contract with Medicaid MCOs to provide for an external independent review. The Balanced Budget Act of 1997 further described mechanisms states should use in monitoring Medicaid MCO quality. In early 2003, CMS issued a final rule defining the requirements for external quality review and state quality monitoring[16] and more recently a draft update of the final rule was released for comment.[17] This two-part section describes and assesses the activities of Kentucky's EQRO and the review and monitoring activities of DMS.

EQRO Activities Overview

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

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

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

Data Reporting Systems Review

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

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

Encounter Data

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

In early 2013, the EQRO conducted a review of the state's encounter data systems and processes that are used to load MCO encounter files. This review covered state requirements for collection and submission; confirmation of the data submission format; description of the information flow from the MCO to the state; list of edit checks built into the state's system; process for voids and adjustments; error reports; state uses of loaded data; process for quality checks to

ensure that all data from the MCO's system and from vendors are loaded completely and accurately into the data warehouse; and key reasons for encounter record rejections. There was also a section on claims processing.

The EQRO receives a final extracted file from DMS each month and prepares a monthly data validation report for DMS summarizing each MCO's submission. The format of this report has two parts: a file validation report and an intake report. In both reports, data are presented for all MCOs and for each MCO separately. The most recent validation report reviewed for this evaluation was the Monthly Encounter Data Validation Report, for January 1, 2016 through January 31, 2016.

The intake report presents the number of encounters submitted to Kentucky Medicaid Management Information System (MMIS) and includes encounter volume reports by place of service. Between January 2015 and January 2016, the number of MMC encounters increased by 0.30% while enrollment increased by 3.12% (Table 6). The ratio of encounters per enrollee dropped from 7.89 in January 2015 to 7.68 in January 2016.

Table 6: Growth in Encounters 2015–2016

Events	January 2015	January 2016	Percent Change
Total Encounters	9,437,918	9,465,825	0.30%
Enrollment	1,195,439	1,232,789	3.12%
Encounters/enrollee	7.89	7.68	-2.90%

The validation report presents the number and percent of missing data and the number and percent of invalid data for each encounter variable. A separate validation table is created by encounter type including inpatient, outpatient, professional, home health, long-term care, dental care and pharmacy.

A review of missing data elements by place of service indicated a number of variables with a consistently high percent missing. Inpatient encounters are frequently missing procedure codes, performing provider key, procedure modifier codes, referring provider key and inpatient surgical International Classification of Diseases, Revision 9 (ICD-9) codes. Outpatient encounters are frequently missing diagnosis codes above diagnosis 3, performing provider key, procedure modifier, referring provider key and surgical ICD-9 codes. Professional encounters have a high percent of missing diagnosis codes above diagnosis 2, performing provider key, procedure modifier and referring provider key.

DMS continues to work with the MCOs, the EQRO and other branches of DMS to correct errors in encounter data submissions and to more closely align the edits used by MCOs with those used by DMS. Encounter Data Workgroup conference calls are held regularly for all plans together as well as one-on-one calls with each MCO. The MCOs actively attend the Encounter Data Workgroup conference calls and their participation on these calls has improved with MCOs suggesting agenda items and participating more in the discussions. DMS has made an effort to design conference call agendas that address issues identified by the MCOs and most importantly, have staff on the call who can answer specific questions or address specific issues on the agenda. Penalties and withholds are in place when an MCO is out of compliance. Once compliance is met, withholds, but not penalties, are released. DMS staff has invoked both penalties and withholds in an attempt to improve encounter data. DMS noted that the Managed Care Assignment Processing System (MCAPS, Kentucky's database for collecting provider panel information) is being phased out and thus no changes to rectify some of the missing data elements are planned. DMS staff is reviewing the edits required for submission to see if any other edits should be activated.

MCOs interviewed commented that their communication with DMS regarding encounter data submissions continues to be positive and the monthly conference calls with DMS continue to be helpful. The MCOs have increased staffing for encounter data monitoring and have developed internal structures, such as a cross-disciplinary encounter workgroup and an encounter monitoring dashboard for weekly analysis and validation. MCO technical expertise has been increasing, which has allowed each of the plans to better problem-solve issues prior to submission. All MCOs are actively focusing efforts on improving submission acceptance rates in order to avoid withholds/penalties for acceptance rates

below 95%. To further assist MCOs in tracking and improving their encounter data completeness, DMS should consider sharing the monthly EQRO encounter data validation reports with the MCOs.

EPSDT Encounter Data Validation 2015, Final Report, October 2015

This study was conducted to validate EPSDT-related visits and service codes by comparing medical record documentation to submitted encounter data for children enrolled in Kentucky MMC and to describe age-appropriate EPSDT services provided during the EPSDT visits. Medical record documentation of well-child visits identified by encounter data submission were reviewed for age-appropriate EPSDT screening components for a complete physical examination including a comprehensive health and developmental history; psycho-social and behavioral health assessment; dental assessment; developmental assessment; hearing and vision assessment; and health education including anticipatory guidance for child development, healthy lifestyles and accident and injury prevention. A sample of 120 enrollees for each of the five MCOs was randomly selected from the eligible population. Sixteen of the 552 records received were excluded for a final study sample of 536.

Study findings demonstrated that evaluation and management codes for comprehensive preventive visits reflected a well-child or preventive visit as indicated in medical record documentation in nearly all (99.6%) cases. Immunization status was documented in over 87% of preschool children, for whom many immunizations are required, but only 63% of adolescents had immunization status documented. Physical examination components continued to be well documented. Between 2013 and 2014, improvement was evidenced in the rates of oral health assessment, developmental screening, mental health assessments and adolescent substance use screening. Over 90% of records that indicated a developmental concern also included documentation of follow-up actions.

Opportunities for improvement were identified in rates of prevention and identification of overweight and obesity, vision and hearing screening, adolescent depression screening and oral health screening for adolescents. More than one third (35%) of the study sample, and 44% of adolescents, had neither assessment of oral health needs during their EPSDT visit nor referral for dental care. These study findings should be examined in more detail in future studies in order to support Kentucky's ongoing focus on oral health care in the Healthy Smiles Kentucky Program and the kyhealthnow 2019 goal to reduce the percentage of children with untreated dental decay by 25%. MCOs were encouraged to continue to focus on persistent opportunities for improvement in receipt of EPSDT services identified in this study and to access CMS and other resources, such as the National Academy for State Health Policy's "EPSDT Resources to Improve Medicaid for Children and Adolescents."[18]

Provider Network Data

MCO provider networks must include a sufficient number of providers and provider types to deliver contracted services to their target Medicaid populations and meet state accessibility standards. DMS requires the EQRO to verify the provider information submitted by Kentucky MCOs to MCAPS. 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 MCOs' networks, assess capacity, create performance measures related to the MCOs' provider networks, and conduct access and availability studies; hence, the accuracy of the source data is essential. In January 2016, the EQRO completed two audits of Kentucky's provider network submissions: one audit to validate provider network submissions and a second one to validate web-based provider directories.

Validation of Managed Care Provider Network Submissions, Audit Report, January 2016

This provider network validation used a sample of providers randomly selected from MCAPS. A two-phase mailing was conducted to validate the accuracy of the provider directory data submissions for primary care providers (PCPs) and specialists participating with any of the five MMC MCOs: Aetna Better Health of Kentucky, Anthem BCBS Medicaid, Humana-CareSource, Passport Health Plan and WellCare of Kentucky. Surveys were sent to 100 PCPs and 100 specialists from each MCO. The overall response rate was 58.1%. Returned responses validated information that was correct in the MCAPS data system and reported revisions that should be made to incorrect data. A total of 206 (45.2%) providers who returned the survey noted at least one revision. Four survey items had a substantial percentage of providers with missing data in the provider directory file: provider license number, secondary specialty, Spanish and other languages spoken. There was an average of 1.83 revisions per provider for the 206 providers who submitted surveys with changes. A comparison of the statewide rates of accuracy, between the last audit conducted in April 2015 and this more recent audit, revealed an improvement from 49.1% to 54.8%, although the difference was not statistically significant.

Plan-specific reports including a list of changes and a list of incorrect addresses were sent to the MCOs and requested that the MCOs update their provider directory file with this information. Based on the findings from the provider network validation studies, the EQRO also recommended that DMS consider expanding the MCAPS data dictionary to include more specificity in the definitions of the data elements and that they consider adding several data elements to MCAPS to collect information about wheelchair access, hours at site, interpreter services/translation services available, provider usage of health information technology (HIT) and providers' Patient-Centered Medical Home Certification status and level. Other recommendations called for clarifications or relocation for the field "Spanish" and secondary specialty. The reviewer suggested that DMS may want to contact MMC programs of other states to learn how other states have augmented their data collection of provider network information.

Web-Based Provider Directory Validation

The web-based provider directory validation was performed to ensure that enrollees are receiving accurate information regarding providers when they access the plan's web-based directory. The objectives of this study were two-fold: 1) to determine if all providers included in the MCAPS submission for each MCO were listed in the web-based provider directory, and 2) to ensure that provider information published in the MCOs' web directories is consistent with the information reported in the MCAPS and/or the provider network audit responses. The January 2016 study used provider network data submitted in September 2015 to the EQRO for the five MCOs: Aetna Better Health of Kentucky, Anthem BCBS Medicaid, Humana-CareSource, Passport Health Plan and WellCare of Kentucky. A random sample of 50% of providers who responded to the provider network validation study was drawn, but no more than 50 providers from each MCO (25 PCPs and 25 specialists) were audited. For each survey that was included in the web validation sample, the reported provider information was validated against the corresponding MCO's web directory within one week of receiving the survey response.

Results of the survey indicated that 97% of the PCPs and 77% of the specialists were found in the MCO web directories. Overall accuracy was measured as the percentage of providers in the web validation sample that had accurate provider network information when checked against the web-based directory. The resulting overall accuracy rate of the provider information published in the web directories was 80% for PCPs and 88% for specialists.

It was suggested that DMS follow up with MCOs to ensure that inaccuracies in provider information from this validation study and the provider network survey are corrected and are accurately reflected in both the MCO's MCAPS submissions and their web directories.

Quality Performance Data

Quality performance data are the basis for quality review and improvement activities. MCOs are responsible for contracting with a certified HEDIS auditor to conduct an NCQA-approved audit prior to submitting their HEDIS and CAHPS[19] data to DMS. The Healthy Kentuckians data, submitted annually to DMS, are validated by the EQRO based on the CMS protocol, "Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities (updated 2012)."[20] All audit findings are compiled as part of the EQRO's validation of quality performance data, and audit reports including reportable rates are prepared for each MCO. The performance validation methodology includes an information systems capabilities assessment; denominator validation; data collection validation; and numerator validation. For HEDIS 2015, all effectiveness of care, access and availability, dental access and utilization measures were required to be submitted. DMS elected not to rotate any of the measures that were selected for rotation by the NCQA.

Quality performance data results were presented in the following EQRO documents:[21]

- A Member's Guide to Choosing a Medicaid Health Plan, 2016 (a.k.a. the Annual Health Plan Report Card);
- Kentucky MCO Dashboard HEDIS 2015 (for internal DMS use only); and
- the 2015 External Quality Review Technical Report.

Annual Health Plan Report Card

An annual health plan report card is developed by the EQRO in collaboration with DMS to provide quality performance information as a guide for individuals when choosing a MMC health plan. Entitled "A Member's Guide to Choosing a Medicaid Health Plan," the 2015 edition is available in a printed version and electronically on the DMS website.[22]

The format for 2016 is a tri-fold brochure with an MCO comparison of performance in the center and MCO contact information and questions members should ask their MCO on the back. This tool is a consumer-friendly document that allows an enrollee to compare each MCO's performance in the areas of preventive care, access and satisfaction by the number of stars shown, i.e., 5 stars representing excellent, 4 stars for above average, 3 stars for average, 2 stars for below average and 1 star for much below average performance. Public presentation of MCO quality data is being used by many state MMC programs to encourage MCO quality improvement. With each new version, DMS, in collaboration with the EQRO, has revised the content and format of the report. Input from the MCOs has also been helpful. Going forward, DMS may want to research various other options for content and format to determine what their members would prefer. Conducting member focus groups is one way to obtain their input and perspectives. Researching what other states present in an annual report should also be pursued.

Quality Performance Dashboards

Two types of MCO dashboards are used for monitoring. A monthly MCO dashboard is prepared by DMS using data obtained from MCO monthly reports submitted to DMS. This dashboard presents information regarding claims, encounter data submissions, prior authorizations, as well as information about member, provider and behavioral call-center calls. Financial metrics, provider credentialing, terminations from MCO, program lock-ins and the number of new members in the foster care and adult guardianship programs are also included. Data cells that are in contract compliance are highlighted in green while cells shaded red indicate lack of compliance.

Using HEDIS 2015 data, the EQRO designed a dashboard to pictorially describe national, statewide and MCO-specific performance on selected quality and satisfaction measures using graphs and charts. This version of a dashboard is posted on the EQRO website for DMS internal monitoring purposes only. The dashboard's content is comprehensive and clearly displayed. It is easy to navigate the site and quickly obtain information, making it a more useful tool for consumers/enrollees rather than for internal monitoring.

Technical Report

The Balanced Budget Act of 1997 requires state agencies that contract with Medicaid MCOs to prepare an annual external, independent review of quality outcomes, timeliness and access to health care services. A draft version of the 2016 External Quality Review Technical Report, completed in April 2016 for the MCO contract years 2013–2015 includes results for all five Kentucky Medicaid MCOs: Aetna Better Health of Kentucky (formerly CoventryCares of Kentucky), Anthem BCBS Medicaid, Humana-CareSource, Passport Health Plan and WellCare of Kentucky. The report provides quality performance data, CAHPS satisfaction data, results of compliance reviews, validation results of Kentucky performance measures and validation of PIPs. MCO strengths and opportunities for improvement are also outlined for each MCO. The MCOs are required to submit a response for each opportunity for improvement, which are then published in the next annual technical report. While the federal regulations require an annual review of access, timeliness and quality of care, a full review is only necessary every three years.

Annual Compliance Reviews

Federal regulations require that every state with an MMC program conduct a full review of MCO compliance with state and federal regulations at least once every three years. The reviews can be done by the state or the EQRO. In Kentucky, the EQRO conducts the annual reviews for compliance with contract requirements and state and federal regulatory standards. In reporting year (RY) 2015, four MCOs (CoventryCares of Kentucky [now Aetna Better Health of Kentucky], Humana-CareSource, Passport Health Plan and WellCare of Kentucky) underwent a partial review, based on findings of the previous review. Anthem BCBS Medicaid received a full review since 2014 was its first year participating in the Kentucky Medicaid Program.

According to 42 CFR§ 438.360, states can use information obtained from a national accrediting organization's review for the mandatory external quality review activities conducted by either the state or its EQRO. With this authority, states can deem NCQA standards equivalent to state requirements and thus use the information obtained through

accreditation surveys to streamline their oversight process.[23] Since Kentucky has specific measures that are not included in the accreditation reviews, the state prefers to use a policy for deeming based on previous plan performance rather than deeming based on accreditation.

DMS remains committed to conducting compliance reviews on an annual basis. In 2016, the compliance reviews were conducted in January instead of March for an earlier turnaround time in order to complete the technical report on schedule. Also, over the past two years, all MCOs have been reviewed during the same one week period. DMS tracks the non-compliant and minimal scores for multiple years and issues withholds/penalties for issues remaining in this status for two or more years. They are also tracking substantial findings over multiple years to identify whether the same reasons are resulting in less than full compliance and if so, instead of another substantial finding, the finding will be scored minimal until it is fixed.

In an effort to streamline the compliance review requirements, beginning in 2014, the EQRO received selected MCO quarterly reports as they were submitted and created desk audit tables by plan and by quarter for the following review areas:

- Availability and Access (Reports 12A and 13)
- Continuity and Coordination (Reports 79, 65, 66 and 20)
- Coverage and Authorization of Services (Report 59)
- Enrollee Rights (Report 11)
- Grievance System (Reports 27, 28 and 29)

DMS commented that reviewing the quarterly reports as they are submitted has made the annual compliance review easier as some of the documents have already been reviewed and acted upon by the MCOs. At the annual review, the EQRO only has to recheck elements found non-compliant in the quarterly reviews. DMS has been training the MCOs to use this tool throughout the year to bring non-compliant elements into compliance prior to the annual review. DMS continues to work with the EQRO to further improve the process.

MCOs commented that they appreciate these summaries and find the comments from the EQRO helpful, particularly on the narrative reports. Having the EQRO's findings during the year does allow the MCO to address issues during the year rather than during or after the compliance review is completed. The timeliness of these audits was mentioned as an issue, especially in light of this year's schedule for conducting the compliance reviews in January, rather than March. Only reports through the second quarter of 2015 were completed prior to the review. MCOs further commented that the process of summarizing the selected quarterly report information across plans highlighted the variability in the data reported and raises questions about how each of the MCOs are interpreting the questions. It was generally agreed that more data specification and interpretive guidance is needed so that all MCOs are reporting consistently and that a fair comparison can be made across plans.

Changing the month in which the compliance reviews were conducted also presented problems for some of the MCOs. With end-of-year activities requiring attention, MCOs were challenged to find enough time and staff available to pull together the supporting documentation and medical records for the review. Receiving more advance notice regarding necessary supporting documentation and medical record lists would give the MCOs more time to prepare. Conducting the reviews during the same week, for all five MCOs, also means that each MCO may have different reviewers this year than in previous years. MCOs commented that this can be problematic as the reviewers may not be as familiar with the plan and/or the managed care contract and thus time has to be spent providing background information to better inform the reviewers. The EQRO should try to have at least one consistent reviewer from year to year for each MCO, preferably the lead reviewer.

State Review Activities Overview

As described earlier, the Kentucky MMC quality review and oversight activities are the responsibility of DPQ&O composed of three branches:

- Managed Care Oversight – Contract Management Branch has oversight responsibility for MCO contract compliance including review and analysis of monthly encounter data reports from the EQRO and review of quarterly reports submitted directly to DMS from the MCOs. They actively initiate penalties/withholds for MCO non-compliance.
- Disease and Case Management Branch has oversight responsibility for Medicaid enrollee care coordination including resolving provider issues identified in grievances and appeals and disenrollment for cause.
- Managed Care Oversight – Quality Branch oversees the EQRO contract and works with the EQRO to develop quality measurement and improvement initiatives.

State review activities are described on the DMS website where consumers can also access many quality-related materials including DMS branch responsibilities, MCO contact information, HEDIS and CAHPS results and all EQRO reports. Public posting of the quality review reports is a critical part of the state's effort to provide data transparency regarding its MMC program. It also acts as an incentive for MCOs to improve performance when each MCO's data are compared to the data of other MCOs, and to state and national benchmarks.

MCO Reporting Requirements

The state's current Medicaid MCO Model Contract incorporates established standards for access to care, structure and operations and quality measurement and improvement. To monitor MCOs' compliance with these standards, Appendix K of the model contract includes a list of monitoring reports MCOs are required to submit on a monthly, quarterly and annual basis. All three branches have staff reviewing specific reports to assure that they are all adequately reviewed and information is tracked and evaluated. The Managed Care Oversight – Quality Branch prepares a monthly MCO dashboard summary of data from several key monthly reports.

Originally created in September 2011, Appendix K contained 152 required reports and 11 exhibits with crosswalks, definitions and codes. While monitoring MCO compliance in the early phases of Kentucky's MMC Program was critical, the reporting burden on MCOs and the report review burden on DMS continued to grow as program enrollment increased along with the number of MCOs. In response, the Managed Care Oversight – Quality Branch initiated a workgroup that included members from DMS, DBHDID and the MCOs to review all required MCO reports. DMS requested MCO input and meetings were held to discuss ways to modify, combine, reduce or eliminate some of the required reports in order to reduce the burden and to assure that all MCOs were reporting data in the same way to allow for valid plan-to-plan comparisons. As a result, a revised Appendix K was drafted and lists 68 (or 45%) of the originally listed reports as "inactive." The behavioral health reports were modified to get the data that DBHDID needed in a correct and consistent format. Some reports have been changed from monthly to quarterly and some reports were revised to provide better and more accurate data. DMS has also been working with the EQRO to revise and clarify the reports used in the quarterly desk audits.

One common theme in the MCOs' comments regarding the reporting requirements was that they do not receive feedback from DMS. Feedback would help clarify and improve their responses. Providing interpretive guidance for each report and more data specification, including data sources to be used, would help improve the consistency in MCO reporting. The MCOs agreed that the reporting requirement changes were helpful and appreciated the opportunity to provide input and suggestions to DMS in the process. They all further agree, however, that more needs to be done and that the meetings to discuss the reports should continue as a work-in-progress. Several MCOs interviewed gave specific suggestions of reports that could be changed, combined or eliminated. One MCO also commented that since changes in the reporting requirements are made throughout the year, it would be helpful when DMS distributes a revised Appendix K that they include a list of specific report changes and include any new report templates that the MCOs will be required to use going forward.

Monitoring Access to Care

MCOs are required to meet contract standards for access to providers geographically by county and by average distance (in miles) to a choice of providers for all members. MCOs monitor compliance with these network standards through geo-access analysis of providers, including PCPs, primary care centers, dental care providers, specialty care providers,

non-physician providers, hospitals, urgent care centers, local health departments, federally qualified health centers, pharmacies, significant traditional providers, maternity care providers, vision care providers and family planning clinics. MCOs also monitor access to high-volume specialists, such as those specializing in cardiology, obstetrics/gynecology and surgery. Analyses are provided for enrollees in urban and rural areas. The EQRO's Quarterly Desk Audit of Availability and Access of Services for the compliance reviews identified gaps in access that could be addressed by the MCO prior to the annual review. The EQRO commented that the MCO geo-access reports were inconsistent in content; for example, some reports did not cover access to all required provider types and some provider types were not submitted by urban/rural region.

Each MCO regularly conducts surveys to determine appointment availability for urgent or non-urgent care in accordance with contract availability standards. Because these surveys use various methods for data gathering, it is difficult to summarize and aggregate results on a state-program level. DMS reports that the Managed Care Oversight – Contract Compliance Branch conducts secret shopper calls monthly to random providers in the MCOs' networks to assess compliance with the contract standards.

Access and Availability PCP Survey

During 2015, DMS and the EQRO collaborated on a design to conduct an access and availability survey for PCPs using the "secret shopper" methodology. Primary care providers included PCPs, pediatricians and obstetricians/gynecologists (ob/gyns). The objective of the survey was to measure compliance with the contract standard stating that routine services must be provided within 30 days and non-urgent care must be provided within 48 hours. Providers must also be accessible to member phone calls 24 hours a day, 7 days a week. MCOs participating in the Kentucky MMC Program must maintain a compliance rate of at least 80% to satisfy applicable appointment standards. All five MCOs participated in the survey: Anthem BCBS Medicaid, CoventryCares of Kentucky (now Aetna Better Health of Kentucky), Humana-CareSource, Passport Health Plan and WellCare of Kentucky.

From provider network data electronically submitted by each of the MCOs, a random sample of 250 providers per MCO was selected for a total of 1,250 providers. The methodology used several different scenarios for requesting an appointment for routine care, non-urgent care or after-hours care. Surveyors made up to four attempts to contact a live person at each provider office to complete the survey.

Among the 525 providers called for a routine visit, 453 (86.3%) were able to be contacted and among the 525 called for a non-urgent visit, 459 (87.4%) were contacted. Overall compliance rates were 31.8% for routine calls, 24.8% for non-urgent calls and 52.0% for after-hours calls, all substantially below the standard of 80%. For routine calls, compliance rates were highest for ob/gyns, while for non-urgent and after-hours calls, compliance rates were highest for pediatricians. In contrast, PCPs had the lowest compliance rates for routine calls and ob/gyns had the lowest compliance rates for non-urgent and after-hours calls.

Access and Availability Dental Survey

A survey of dental providers was completed in February 2016. A total of 1,100 dentists were randomly selected from provider network data files submitted by the five participating MCOS: Aetna Better Health of Kentucky, Anthem BCBS Medicaid, Humana-CareSource, Passport Health Plan and WellCare of Kentucky. A "secret shopper" methodology was used to test provider compliance for two types of appointments: routine appointments (within 21 days) and urgent appointments (within 48 hours).

Overall, 92.4% of the dentists who were called for routine appointments were able to be contacted and 88.2% of the dentists called for an urgent appointment were able to be contacted. Routine appointments were made with 59.4% of the dentists contacted and urgent appointments were made with 62.5% of those contacted. After allowable exclusions, only 35.2% of the dentists called for a routine appointment were able to be contacted and an appointment made within the timeliness standards of the contract. For urgent appointments, only 31.6% of the dentists were compliant. For both routine and urgent calls, the most common reasons for not making an appointment included: the provider was not in the plan; the provider practice was restricted to specialty care; the provider was not accepting new patients; the provider was not at the site and no alternative provider was available; and the staff was not scheduling any appointments at this time.

DMS expressed concern over the results of both of these surveys and began an in-depth root cause analysis (RCA). They are following up on the call disposition summary reports from the EQRO and conducting on-site audits with the MCOs. They are also surveying a random sample of providers that the EQRO could not get an appointment with to see if these providers are still accepting new patients and/or are still participating with the MCOs. Standing agenda items for network adequacy and access/availability have been added to all operations meetings for continued discussion. CAPs will be issued when compliance problems are identified.

For both access and availability surveys, each MCO received a listing of providers in their plan who could not be contacted, who could not make an appointment, and those who offered an appointment that was not within the correct time frame. MCOs were given 30 days to review the files and submit explanations regarding the contacts and appointments that could not be made. Each MCO followed up with their providers to gain information regarding the practice and to re-educate the provider (and the office manager) on contract requirements including standards for providing access. MCOs also resurveyed these providers and reported improved results. The EQRO will prepare a summary report categorizing the MCO responses. MCOs were also instructed to update their provider systems to ensure that these providers are correctly reported in their provider network files.

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

- The small sample size may not have been large enough to represent the network for the MCOs with larger enrollment.
- A process should be added to allow a call-back number to be provided for practices using an electronic voice messaging system.
- Calls should not be failed when the caller is referred to another provider.
- The definition of urgency should be better clarified in the scenarios.

Care Coordination

With the implementation of the ACA, case management has become increasingly important in improving the quality and efficiency of health care. MCOs have traditionally embraced this concept and many have developed sophisticated systems to identify enrollees at risk, provide disease and case management services and monitor and track outcomes. As of September 2015, less than 1% of Kentucky's MMC enrollees were enrolled in case management and another 8.26% were enrolled in disease management (Table 7).

Table 7: Enrollment in Case and Disease Management, July–September 2015

Members	Enrolled at End of Period	% of Members
Total members	1,193,510	-
Enrolled in case management	5,141	0.43%
Enrolled in disease management	98,578	8.26%

To identify new enrollees with care coordination needs, MCOs are required to request that all members complete an initial health risk assessment (HRA). MCOs also identify enrollees in need of care coordination by using encounter data algorithms or predictive modeling to track high-risk diagnosis codes, high utilization, repeat use of emergency rooms, frequent inpatient stays and hospital readmissions as markers. DMS's Disease and Case Management Branch plays an active role in working with MCOs to enhance care coordination and case management referrals for special populations, such as medically fragile children, foster children and adults in guardianship. The disenrollment for cause data help DMS identify member problems with their MCOs, to analyze trends and to refer members directly to case management.

Compliance reviews conducted in 2015 and in 2016 continue to note coordination challenges between the MCOs and Kentucky's DCBS and DAIL agencies. It is critical that the MCOs have access to baseline information about individuals identified by DCBS and DAIL to enable timely and appropriate referrals and for MCO case managers to assure access to needed services. DMS reported that the MCOs continue to have monthly meetings with DCBS and DMS to address

service plans. They are working collaboratively to ensure the care coordination of these members. DMS and the EQRO conducted a care coordination case study on one of the MCOs and shared findings from the study with all Kentucky Medicaid MCOs to improve care coordination in these medically fragile populations. In addition, DMS and the EQRO conducted a focused study to evaluate health care utilization and coordination of care among medically fragile children. Results from this study were shared at a CMS conference in Washington D.C.[24]

Several Kentucky MCOs have found that an aggressive, proactive approach has helped them to better coordinate case information with DCBS. One MCO developed a tracking mechanism to identify service plans requested, received and those still pending. Another MCO established an electronic portal between the MCO and DCBS to share service plans and case records. In addition to conference calls, some MCOs are scheduling monthly, face-to-face meetings with DCBS, at DCBS offices. An all-plan meeting with DCBS was held in May 2016 to discuss improved communication through workshops and training.

EPSDT Compliance

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

Data submitted on form CMS-416[25] indicated an increase in the number of individuals eligible for EPSDT between RY 2014 and RY 2015 but a slight decline in the screening rate during this period from 83% in RY 2014 to 82% in RY 2015 (Table 8). Total eligible members receiving at least one initial or periodic screen (referred to as the participation rate) increased slightly from 57% in RY 2014 to 58% in RY 2015. CMS has historically set a goal of 80% for EPSDT screening and participation. National EPSDT rates, as of June 16, 2015, with four states not reporting, were 86% for screening and 61% for participation in 2014. Kentucky's reported screening and participation rates were thus slightly lower than the national average rates in 2014.

Table 8: EPSDT Screening and Participation Rates – RY 2014 and 2015

Indicator[1]	RY 2014	RY 2015
Total individuals eligible for EPSDT	576,542	591,453
Screening rate	83%	82%
Participation rate	57%	58%

[1]Rates were reported by Kentucky MCOs on Form CMS-416 for the reporting year (RY) from October 1, 2013 through September 30, 2014 (RY 2014) and from October 1, 2014 through September 30, 2015 (RY 2015).
EPSDT: Early Periodic Screening, Diagnostic and Treatment

Kentucky Medicaid Managed Care Early Periodic Screening, Diagnostic and Treatment Services (EPSDT) Review of 2014, Final June 2015

The purpose of this report was to validate whether the MCOs' administration of EPSDT benefits was consistent with federal and state requirements and expectations. All five Kentucky Medicaid MCOs were evaluated, including Anthem BCBS Medicaid, CoventryCares of Kentucky (now Aetna Better Health of Kentucky), Humana-CareSource, Passport Health Plan and WellCare of Kentucky. Data for Anthem BCBS Medicaid were limited since the MCO had just begun enrollment in 2014.

Data sources for this study included:

- 2015 Annual Compliance Review findings,
- 2013 EPSDT Encounter Data Validation Study,
- HEDIS 2014 and Healthy Kentuckians performance measure rates,
- Kentucky statutory reports relevant to EPSDT services, including the following:
  - Quarterly Report #24 – Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death,

- Annual Report #93 – EPSDT Annual Participation Report (as reported on CMS-416),
- Quarterly Report #17 – Quality Assessment and Performance Improvement Work Plan,
- Quarterly Report #85 – Quality Improvement Program Evaluation,
- Annual Report #94 – CAHPS Medicaid Child Survey,
- Annual Report #86 – Annual Outreach Plan,
- Quarterly Report #18 – Monitoring Indicators, Benchmarks and Outcomes, and
- Quarterly Report #19 – Performance Improvement Projects.

The 2015 Annual Compliance Review revealed that all five MCOs were fully or substantially compliant with most review elements related to EPSDT services. Expected EPSDT screenings among eligible children and adolescents were below 80% for four of the five MCOs, with the exception of Passport Health Plan. All five MCOs had participation rates for EPSDT services considerably below the 80% benchmark goal. Older age groups had especially low participation rates for all MCOs. Reported HEDIS 2014 measures further revealed opportunity for improvement in the percentage of children who received expected well-child visits, which would be equivalent to EPSDT screening visits.

All five MCOs showed evidence of providing a sufficient network of EPSDT providers and they all implemented numerous initiatives to educate and outreach to physicians and members to help 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 for effectiveness. All MCOs engage providers in outreaching to members in need of services and all actively track receipt of services, but with participation rates far below the 80% goal, the effectiveness of some of these approaches needs to be further studied. Case management outreach and service coordination for members needing services was documented by all MCOs, with the exception of DCBS clients.

The report noted that efforts to monitor providers' delivery of EPSDT services had improved from the previous year, but results of the EPSDT validation study and HEDIS and Kentucky performance measures revealed opportunities for improvement in mental health, vision, hearing, and developmental screening; depression and behavioral risk screening for adolescents; body mass index (BMI) screening and nutrition/physical activity counseling; immunizations and lead screening. Oral health assessment was also found lacking in the validation study.

As a limitation, it was noted that the MCOs' statutory reports did not appear to follow a standardized format, thus resulting in variation in the report contents which made MCO comparisons difficult to interpret.

State-MCO-EQRO Communication

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

- regular quarterly meetings with MCO quality directors; operations staff; EPSDT coordinators; behavioral health staff and information technology (IT) staff;
- monthly encounter data meetings;
- continuing meetings to discuss MCO reporting requirements;
- MCO medical directors' meetings led by DMS's medical director;
- Coordination and facilitation of numerous meetings and workgroups by the Disease and Case Management Branch, including MCOs and DBHDID, DCBS and DAIL;
- EQRO-initiated periodic conference calls with all MCOs and with each MCO to discuss PIP progress and problems;
- technical assistance provided by the EQRO and DMS to MCOs both by phone and in scheduled training sessions; and
- DMS website postings, which include reports and data generated by all three branches of the Division of Program Quality and Outcomes and the EQRO.

All MCOs reported good working relationships between the state, MCOs and the EQRO. Input and feedback from the MCOs is often sought and both DMS and the EQRO are responsive to phone calls and questions. MCOs commented that there was not a lot of communication around the quarterly reports. In terms of the meetings, it was mentioned that

most meetings had written agendas, but meeting notes were not always prepared and distributed, especially for the encounter data meetings. Several MCOs also commented on the value of face-to-face meetings over conference calls.

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

- prepare and distribute meeting notes for all meetings;
- continue to meet to discuss reporting requirements, report formats and data specifications; and
- have more face-to-face meetings and meetings with more clinical interaction.

Strategies and Interventions to Promote Quality Improvement

Kentucky's Quality Strategy includes several activities focused on quality improvement including PIPs and focused clinical studies. While not in the Quality Strategy, DMS has further enhanced their quality improvement activities through public reporting and financial incentives. This section discusses the current projects completed or ongoing by the MCOs, DMS and the EQRO.

A review of other states' quality strategies further provides an opportunity to examine a range of different approaches to monitoring MMC quality and conducting quality improvement. Experience from other states and innovative improvement initiatives are presented for consideration in Attachment A for New York State,[26] California,[27] Florida,[28] Maryland[29] and New Jersey.[30]

Performance Improvement Projects

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

The PIP protocol is based on a problem solving approach to achieve improvement known as a Plan-Do-Study-Act (PDSA) cycle.[31] Each state's MMC program determines the number of PIPs required to be conducted each year. In Kentucky, two new PIP topics are proposed each year and are generally completed in two to three years. Each MCO is likely to have two to six PIPs at various stages of activity: initiation, baseline measurement, implementation, and up to two years of re-measurement (Table 9). Initially, Kentucky MCOs selected their own PIP topics, usually based on HEDIS results that needed improvement. More recently, DMS has designated two topic categories: physical health and behavioral health.

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

Statewide Collaborative PIPs

In 2014, Kentucky initiated its first statewide collaborative PIP, entitled "Safe and Judicious Antipsychotic Medication Use in Children and Adolescents," to satisfy the behavioral health category requirement. In 2015, the statewide topic selected was "The Effectiveness of Coordinated Care Management on Physical Health Risk Screenings in the Seriously Mentally Ill Population." MCOs are required to actively participate in the collaborative PIP efforts and attend all scheduled conference calls including all-plan calls and individual plan calls. DMS commented that the MCOs are very active in trying to make their PIPs successful and collect solid results. The EQRO outlined key strengths of the first statewide PIP which included strong rationale supported by references; thorough barrier analyses; and robust interventions that address members, providers and health plan processes. Of specific note, Aetna Better Health of Kentucky developed a "Pediatric Antipsychotic Look-up Tool" that has the potential to inform targeted provider and member interventions and Passport Health Plan is conducting a pilot program to address access to psychiatric services in rural areas via tele-health and placing behavioral health practitioners in rural primary care settings.

Areas identified for improvement were data collection and measure reporting, alignment of interventions with performance measures, and correction of the study timeline. Anthem BCBS Medicaid faced enrollment limitations for the child and adolescent age groups resulting in eligible population size less than 30 members. Aetna Better Health of Kentucky experienced a late start after several revisions in the study design and needed to develop alternate strategies and/or work-arounds to address the reported delays due to the transition of CoventryCares of Kentucky systems and processes to Aetna Better Health of Kentucky systems.

Table 9: PIP Project Status 2013–2016

Plan	PIP Topic	Proposal Submitted	PIP Period
All-plans	Safe and Judicious Antipsychotic Medication Use in Children and Adolescents	2014	2015–2017
	The Effectiveness of Coordinated Care Management on Physical Health Risk Screenings in the Seriously Mentally Ill Population	2015	2016–2018
Anthem BCBS Medicaid	Reducing Avoidable Emergency Department Utilization	2014	2015–2017
	Increasing Annual Dental Visits	2015	2016–2018
Aetna Better Health of Kentucky (CoventryCares of Kentucky)	Major Depression: Anti-Depressant Medication Management and Compliance	2012	2013–2015
	Decreasing Non-Emergent Inappropriate Emergency Department Use	2012	2013–2015
	Secondary Prevention by Supporting Families of Children with Attention Deficit Hyperactivity Disorder (ADHD)	2013	2014–2016
	Decreasing Avoidable Hospital Re-admissions	2013	2014–2016
	Increasing Comprehensive Diabetes Testing and Screening	2014	2015–2017
	Improving Postpartum Care	2015	2016-2018
Humana-CareSource	Untreated Depression	2013	2014–2016
	Emergency Department Use Management	2013	2014–2016
	Increasing Postpartum Visits	2014	2015–2017
	HbA1c Control	2015	2016–2018
Passport Health Plan	Reduction of Emergency Room Care Rates	2012	2013–2015[1]
	Reduction of Inappropriately Prescribed Antibiotics for Pharyngitis and Upper Respiratory Infections (URI)	2012	2013–2015[1]
	You Can Control Your Asthma! Development and Implementation of an Asthma Action Plan	2013	2014–2016
	Psychotropic Drug Intervention Program	2013	2014–2016
	Reducing Readmission Rates of Postpartum Members	2014	2015–2017
	Healthy Smiles	2015	2016–2018
WellCare of Kentucky	Utilization of Behavioral Health Medication in Children	2012	2013–2015
	Decreasing Inappropriate Emergency Department Utilization	2012	2013–2015
	Follow-up After Hospitalization for Mental Illness	2013	2014–2016
	Management of Chronic Obstructive Pulmonary Disease (COPD)	2013	2014–2016
	Postpartum Care	2014	2015–2017
	Pediatric Oral Health	2015	2016–2018

[1]Final EQRO review of second re-measurement was sent to MCO 2/24/2015.

The EQRO validation team approach is a key tool used in validating the PIP results, but more importantly, it helps the MCO refine the measurement indicators and study methodology prior to implementation. The MCO benefits from a shared perspective of more than one reviewer. Periodic calls with each MCO to discuss ongoing activities helps the MCO identify problems early and allows for possible revisions. For the collaborative statewide PIPs, the MCOs, DMS and the EQRO also participate in all-plan calls to review study progress collaboratively. DMS intends to produce a report on lessons learned and outcomes from each of the collaborative PIPs as they are finished. They will also post the finished PIPs on the DMS website.

The statewide collaborative PIP offers an opportunity for shared learning and an avenue to address the same message to all MMC providers and members. The CMS Affinity Groups, which Kentucky MCOs are participating in, use a learning collaborative model led by the Center for Health Care Strategies (CHCS). Kentucky MCOs benefit from an opportunity to learn from other states and share promising practices in the areas of antipsychotic medication use, tobacco cessation

and oral health care. Through regular conference call meetings and communication with CMS, Kentucky is establishing a network of partners to improve quality of care in these topic areas.

MCOs interviewed for this evaluation had high praise for the CMS collaborative experience and all commented that this model of shared learning is missing in the Kentucky statewide collaborative PIPs. There have been very few all-plan calls and their content and discussions have not led to any collaboration on the part of the plans. The CMS Oral Health Initiative PIP template was also recognized as a more useful PIP template tool than the EQRO's current PIP tool. Several MCOs also commented on the required six measures for the Safe and Judicious Antipsychotic Medication Use in Children and Adolescents PIP. Three of these measures are not HEDIS-approved measures, and therefore, software for calculating the measures was not available to the MCOs. In addition, five of the six measures are hybrid measures, putting larger burden on providers for medical record requests.

The number of PIPs performed and the duration of a PIP is determined by the state and not mandated by CMS. Kentucky's requirement for MCOs to initiate two new PIPs annually, one of which is the statewide collaborative PIP, was acknowledged as a burden by all MCOs.

Focused Studies of Health Care Quality

Described in federal regulation as an optional quality review activity, the Commonwealth of Kentucky has chosen to include focused studies of health care quality in their Quality Strategy. A focused study examines a particular aspect of clinical or non-clinical service. The EQRO initiates new topic selections by annually developing several proposals that are reviewed and discussed with DMS. DMS chooses two topics annually. All final reports are shared electronically with MCO chief executive officers (CEOs), medical directors, compliance officers and quality managers. The reports are sent with a letter explaining the study and request that the MCO address the recommendations. Final reports are posted on the DMS website and discussed at the MCO quality meetings.

The two study topics for 2015 were medically fragile children and child and adolescent overweight and obesity. Two new topics selected for focused clinical studies in fiscal year (FY) 2016 are emergency department (ED) visits for non-traumatic dental problems and prenatal smoking.

Medically Fragile Children Focused Study, August 2015

This focused clinical study conducted in 2014–2015, had two aims: 1) to profile health care utilization among children in foster care for whom approval for a medically fragile designation has been obtained from DCBS Medical Support Section, and 2) to identify gaps in care coordination and opportunities to improve the performance of the care coordination team (MCO care/case managers, DCBS social workers and nurse consultants with the Kentucky Commission for Children with Special Health Care Needs [CCSHCN]).

The health care utilization profile linked 223 children in foster care who were identified by DCBS as medically fragile with their administrative claims/encounter data records for the study period of 7/1/2013–6/30/2014. Utilization overall and by MCO was profiled for hospitalizations, ED visits, outpatient visits by PCP and specialists and dental visits for medically fragile children compared to all other children. Medically fragile children in the study population identified by DCBS were enrolled in one of the four MCOs: CoventryCares of Kentucky (now Aetna Better Health of Kentucky), Humana-CareSource, Passport Health Plan and WellCare of Kentucky. Qualitative findings were derived from a validated survey instrument, "Relational Coordination Survey for Patient Care"[32] which was modified and used to survey 26 MCO care/case managers, 168 DCBS social workers and 18 CCSHCN nurse consultants. Response rates ranged from 94% for CCSHCN, 69% for MCOs and 53% for DCBS. A review of 105 medically fragile children's case management charts was also conducted and a review of service denials for 21 medically fragile children was performed.

Key findings included:

- Very young children, adolescents and infants comprised the majority of medically fragile children, and most were diagnosed with a complex chronic condition.
- Medically fragile children utilized a disproportionate amount of hospital inpatient and ED services.
- The low relational coordination ranking of PCP and specialist physician providers by all workgroups indicates the need to engage physicians as part of the medically fragile care coordination team.

- Access to and availability of physicians is a barrier to medically fragile child health care coordination.
- Lack of MCO care/case manager access to the foster parent is a barrier to MCO provision of care coordination for medically fragile children.
- There is a lack of MCO engagement as part of the medically fragile child health care coordination team.
- Excessive medically fragile child health care caseload is a prime concern for DCBS, but not MCOs.

As a result of these findings, several recommendations were proposed. DMS was encouraged to continue to work with the MCOs to improve access and availability for medically fragile children to both physical and behavioral health providers. It was suggested that DMS convene a collaborative workgroup of lead MCO, DCBS and CCSHCN care/case managers to further identify the specific provider specialties with barriers to access for medically fragile children. The workgroup could also develop associated communication tools for ongoing monitoring of case management and coordinate collaborative quality improvement activities.

DMS actions regarding the recommendations have been thorough. DMS has conducted additional access and availability studies including behavioral health and dental providers, and is performing a more in-depth review of call dispositions that were not able to schedule any appointment or an appointment in the time required by the standards. DMS is also starting to analyze full-time-equivalents for physicians who have more than one office and are considering the feasibility of applying street-level rather than direct distance ("as the crow flies") parameters for access and availability reviews.

Also in response to recommendations, the Disease and Case Management Branch formed a workgroup to improve access and availability for medically fragile children (referred to here as the Medically Complex Children Workgroup) which met for the first time in December 2015 and is intended to meet quarterly going forward. The workgroup included staff members from the MCOs, DMS, DCBS, CCSHCN, and the EQRO. Discussion at this first meeting led to the following agreements and actions:

- DMS compiled a list of MCO contacts regarding medically complex children and shared them with DCBS and the CCSHCN.
- When DCBS staff identifies a medically complex child, DMS staff is advised and DMS forwards that information to the MCO. DCBS also agrees to notify DMS when a medically complex child is discharged, which is also forwarded by DMS to the MCO.
- A monthly list of medically complex children will be sent from DCBS to DMS, who will separate the members by MCO and share with the respective MCO contact for the workgroup on medically complex child health care.
- All medically complex children will be referred to MCO case management.
- The service plans for medically complex children will be closely monitored and either manually or electronically signed by an MCO representative.
- Monthly DCBS/MCO meetings will include medically complex children as an agenda item.

MCOs commented that they continue to have monthly meetings with DCBS and that the first meeting of the Medically Complex Children Workgroup was quite productive, but there has not been a follow-up meeting.

Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity Among the Kentucky Medicaid Managed Care Population, Clinical Focus Study 2015, September 2015

This focused study was a retrospective review of medical records of children and adolescents enrolled in Kentucky MMC. The purpose of the study was to assess the implementation of the Expert Committee guideline recommendations[33] for the prevention, identification, assessment and treatment of overweight and obesity among children. A random sample of eligible enrollees who turned 2–18 years old during the measurement year, November 1, 2013 to October 31, 2014, was selected from the five MMC plans: Anthem BCBS Medicaid, CoventryCares of Kentucky (now Aetna Better Health of Kentucky), Humana-CareSource, Passport Health Plan and WellCare of Kentucky. The final study sample of 668 was fairly evenly distributed by age group with 217 preschool children, 225 school-age children and 226 adolescents.

Key findings included:

- While BMI value or percentile was appropriately documented for older adolescents, BMI percentile documentation was present for only 49% of younger children.

- Risk assessment was lacking in medical record documentation, with only 57% of records including family history and 29% including plotting of BMI on a growth chart.
- Less than half of the members in the study sample had nutritional counseling (47%) or physical activity counseling (41%), and most counseling was not specific to risk behaviors.
- Obesity was noted to be particularly prevalent in the adolescent age group (30%), but 17% of preschool children were also noted to be obese.
- Most records of overweight and obese children did not include appropriate laboratory testing for obesity-related conditions, and risk behavior assessment was not universally documented.
- Most records of at-risk overweight and obese children and adolescents did not include assessment of risk behaviors or behavioral or weight goals; only 5% included a scheduled follow-up of weight status, and only 2% included any structured, higher intensity interventions.

The study recommendations encouraged MCOs to promote BMI percentile screening and universal prevention interventions for all MMC-enrolled children beginning in early childhood; to improve provider risk assessment, management and monitoring of overweight and obese enrollees; to ensure that resources for nutrition, physical activity and weight management are disseminated to network providers; and to educate members and families regarding cardiovascular and other health risks associated with overweight and obesity. It was further recommended that improvement efforts address obesity with a chronic care model that includes motivational interviewing, family involvement and engagement of all office staff in the care of at-risk children and adolescents.

In response to these study findings, DMS intends to use their HEDIS Measures Incentive Program to encourage follow-up by the MCOs. As part of the incentive program, all of the HEDIS measures for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents will earn performance and improvement incentives.

Since this focused study required medical record reviews, MCOs again expressed their concern in terms of the medical record request burden they are placing on their providers. It was suggested that DMS and the EQRO plan the timing of focused studies that require medical record reviews so that they are not added to the provider's burden for medical records during HEDIS and PIP measurement periods.

Emergency Department Visits for Non-traumatic Dental Problems among the Adult Kentucky Medicaid Managed Care Behavioral Health Subpopulation

This study utilized administrative encounter data to identify risk factors for ED visits for non-traumatic dental problems (NTDV), an indicator of unmet dental need, among the adult Kentucky MMC behavioral health (BH) subpopulation. The report was submitted to DMS on May 19, 2016. Novel findings shed light on the potential for health system and provider interventions to improve access to and quality of dental care. Members who had an outpatient dental visit for pain/palliative care, but who did not receive treatment, had more than three times greater odds for a subsequent NTDV event compared to the members who received outpatient dental treatment. The study concluded that unmet dental need is a substantial problem for the Kentucky MMC BH subpopulation, and a driver of costs attributable to NTDVs. Improving access to preventive and treatment-based outpatient dental care holds the potential to reduce unnecessary ED visits and improve the health of this vulnerable subpopulation, as well as generate considerable cost savings. Recommendations emphasized that enhanced care coordination that facilitates access to PCPs, BH providers, as well as dentists, is merited. MCOs should consider the risk factors identified in this study for targeting care management interventions, as well as investigate patterns of multiple hospital ED use. Specific recommendations were made for plans to develop partnerships with academic medical centers for implementation of ED dental diversion programs in urban areas, as well as evaluate dental networks in rural and Appalachian counties, and undertake initiatives to improve access and availability of dental providers.

Prenatal Smoking

This study profiled smoking prevalence, member characteristics, receipt of prenatal smoking cessation services and perinatal outcomes among the Kentucky MMC population who delivered a singleton live or non-live birth. Provider prenatal and postpartum interventions and case management interventions were also profiled, including whether smoking abstinence was achieved. Data for the study were derived from two sources: 1) administrative encounter data to define the eligible population; and 2) medical chart and case management record reviews of a random sample of 400 members. The report was submitted to DMS on June 9, 2016. Findings showed that many prenatal smokers enrolled in

Kentucky MMC did not receive American College of Obstetricians and Gynecologists (ACOG)-recommended smoking cessation interventions from providers. With few exceptions, neither prenatal care providers nor MCO care managers referred prenatal smokers to the Kentucky quit line. What's more, there were considerable missed opportunities for care managers to identify, contact and engage prenatal smokers in smoking cessation programs early in the pregnancy, as well as missed opportunities to contact prenatal care providers for coordination of smoking cessation interventions. Consequently, only a handful of pregnant smokers achieved smoking abstinence during the critical prenatal period. Recommendations emphasized that DMS can provide guidance to the plans by initiating a statewide collaborative PIP for prenatal smoking cessation and by working with the plans to address prenatal access and availability issues, in accordance with the specific MCO recommendations outlined in the report.

Financial Incentives

Many state MMC programs across the country use some form of incentive or sanction to encourage quality performance. In the states reviewed for this summary, New York, Maryland and New Jersey have a Pay for Performance (P4P) incentive. Florida's Quality Strategy, on the other hand, describes a Performance Measure Sanction Strategy to financially penalize MCOs for failing to reach benchmarks. California selects priority focus areas and sets performance targets for its MMC plans and will impose sanctions, including financial penalties, to plans under a CAP that do not meet established milestones.

Kentucky recently revised the MMC Contract to include language describing their newly proposed HEDIS Measures Incentive Program. Funded from a pool created by withholding a percent of the capitation payments, this incentive program seeks to improve statewide quality performance for all HEDIS measures. In the initial incentive period, from July 1, 2015 through December 31, 2015, the incentive pool will be funded with 1% of the capitation payments; and thereafter, by calendar year, the pool will increase by 0.25%, not to exceed a maximum of 2%. There are two types of awards: 1) a performance incentive and 2) an improvement incentive. To be eligible to receive a performance incentive, the MCO is required to have submitted HEDIS data for the calendar year for the incentive period. To be eligible for the improvement incentive, the MCO must have submitted HEDIS data for the calendar year of the incentive period and the preceding year.

MCOs will earn shares based on the number of HEDIS measures (at or greater than the 50th, 75th or 90th percentile) plus for each 2 percentage increase in a measure between the incentive period and the preceding year. The incentive pools will be divided between the MCOs based on the proportion of shares received. The contract language for the incentive program provides a series of examples to demonstrate how the incentive and payout amounts will be calculated.

In addition to the withholds/penalties DMS has in place for encounter data submissions and for failure to correct CAPs, DMS is pleased to initiate this incentive program as a positive re-enforcement of the importance of quality performance in the Kentucky MMC Program. MCOs commented that conceptually, being rewarded for good performance is a good idea, but there was some uncertainty about how the incentive would be operationalized. The MCOs understand that it will be their responsibility to determine which measures they need to improve and how they will mobilize resources to achieve the targets.

MCOs commented that they were anticipating more specific information on the incentive program, but conceptually they expressed optimism that P4P programs were positive methods of driving improved performance. With all HEDIS measures included in the program, several MCOs acknowledged that in order to maximize their share of the payout pools, deciding where to invest their quality improvement resources would be critical.

Strengths, Opportunities for Improvement and Recommendations

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

Strengths

Program Administration

- The Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services was approved by CMS in September 2012 and included all required elements, which were adequately described.
- Kentucky continues to have a contract in place for external quality review, including work plan activities for the annual technical report, the three mandatory quality review activities and several optional activities, such as conducting focused quality studies and validation of MCO submitted data files.
- With several leadership changes and increasing branch responsibilities for monitoring and quality improvement, DMS continues to vigorously apply staff resources and expertise in the development of their expanding MMC Program.
- DMS applied for and received acceptance to participate in several CMS Affinity Group collaboratives and a SAMHSA Tobacco Policy Group collaborative, which offer opportunities to expand state resources through collaboration with other state and national participants.
- All required data collection systems are in place and data submissions are occurring according to schedule.
- MCOs commented that their communication with DMS regarding encounter data submissions continues to be positive and the monthly conference calls with DMS continue to be helpful.
- DMS continues to update their internet website to include MCO data reports and external quality review reports.

Goals and Benchmarks

- For HEDIS 2015, the following measures met or exceeded the 2012 national benchmark:
  - Breast Cancer Screening
  - CDC: Hemoglobin A1c Testing
  - CDC: Medical Attention for Nephropathy
  - Antidepressant Medication Management: Effective Acute Phase
  - Antidepressant Medication Management: Effective Continuation Phase
  - Children and Adolescents Access to Primary Care for ages 7–11 years and ages 12–19 years
  - Outpatient Visits for all age groups.

Quality Monitoring and Assessment

- Kentucky's MMC Program is composed of five MCOs. Program enrollment grew by 4.8% from 1,174,716, in April 2015 to 1,231,505 in April 2016.
- In an effort to streamline reporting requirements, DMS convened a workgroup to review and make changes to the reports MCOs are required to submit monthly, quarterly and annually. As a result, a revised Appendix K was drafted and lists 68 (or 45%) of the originally listed reports as "inactive." Some reports have been changed from monthly to quarterly and some reports were revised to provide better and more accurate data.
- An annual health plan report card entitled "A Member's Guide to Choosing a Medicaid Health Plan" was prepared for 2015 open enrollment. It was also posted on the DMS website.
- Using HEDIS 2015 data, the EQRO prepared a quality performance dashboard as an internal monitoring tool for DMS.
- DMS continues to prepare a monthly MCO dashboard using data submitted in MCO monthly reports.
- EQRO monitoring continues to provide annual MCO compliance reviews, monthly encounter data validation reports, provider network validations, MCO web-based provider directory validations, access and availability surveys and Kentucky performance measurement validations.
- The EQRO's quarterly desk audits allow the MCO to address issues during the year rather than during or after the compliance review is completed.

- According to the EQRO review of Kentucky EPSDT for 2014, all five MCOs showed evidence of a sufficient network of EPSDT providers. MCOs continue to implement a variety of initiatives to improve EPSDT screening, including educating and outreaching to members, educating providers and facilitating EPSDT service through several innovative member outreach efforts.
- The annual technical report continues to meet federal regulations and provides a useful summary of external quality review findings related to access, timeliness and quality of care.
- There is a good working relationship between the state, EQRO and the MCOs. DMS and the EQRO continue to facilitate numerous workgroups and regularly scheduled meetings to discuss program progress and resolve issues.

Quality Improvement

- The EQRO continues to effectively validate MCO PIPs using an established process that includes proposal review, ongoing progress, re-measurement and final report.
- Two statewide, collaborative PIPs are ongoing. Initiated in 2014, "Safe and Judicious Antipsychotic Medication Use in Children and Adolescents" is in its second year and the 2015 PIP "The Effectiveness of Coordinated Care Management on Physical Health Risk Screenings in the Seriously Mentally Ill Population" is in development.
- Two focused clinical studies were completed in 2015: the Kentucky Medically Fragile Children Focused Study and Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity among the Kentucky Medicaid Managed Care Population.
- Additional two focused studies were completed in 2016: Emergency Department (ED) Visits for Non-traumatic Dental Problems Among the Adult Kentucky Medicaid Managed Care Behavioral Health Subpopulation and Prenatal Smoking.
- A HEDIS Measures Incentive Program was drafted.

Opportunities for Improvement

Program Administration

- Kentucky's Quality Strategy is due to be updated. DMS plans to update the Quality Strategy to reflect the kyhealthnow 2019 goals. The update is expected to be completed by the end of 2016.
- DMS's medical director position is currently vacant. In DPQ&O, the assistant director position is vacant. A number of staff vacancies also exist including a nurse/consultant inspector position in the Disease and Case Management Branch and one internal policy analyst III position in the Contract Compliance Branch.
- Coordination opportunities still exist between DMS, the MCOs and other state agencies, including DCBS, DAIL and DBHDID, to address and improve care coordination for foster children, aged members and individuals with behavioral health, developmental and intellectual disabilities.
- To further assist MCOs in tracking and improving their encounter data completeness, DMS should consider sharing the monthly EQRO encounter data validation reports with the MCOs.
- DMS, in collaboration with the EQRO and with input from the MCOs, revised the content and format of the annual report card. Going forward, DMS may want to research various other options for content and format to determine what their members would prefer. Conducting member focus groups is one way to obtain their input and perspectives. Researching what other states present in an annual report could also be pursued.

Goals and Benchmarks

- Over the past two years, the number of Quality Strategy measures that met or exceeded the 2012 Medicaid national benchmark rates fell from 17 (60.7%) in HEDIS 2014 to only 8 measures (38.1%) in HEDIS 2015.
- Opportunities for improvement are evident for the following measures with declining rates of performance from baseline to HEDIS 2015 re-measurement:
  - Cervical Cancer Screening
  - CDC: Eye Exam Performed
  - Follow-up After Hospitalization for Mental Illness Within 30 Days of Discharge and Within 7 Days of Discharge
  - Adult Access to Preventive/Ambulatory Health Services, all age groups
  - Children and Adolescents Access to Primary Care, ages 12–24 months and ages 25 months to 6 years.
- HEDIS 2015 measures for Follow-up After Hospitalization for Mental Illness Within 7 and 30 Days of Discharge were markedly below the HEDIS 2012 national benchmark by as much as 26.8 and 23.9 percentage points, respectively.

- Kentucky's Quality Strategy could be strengthened by adding goals for prenatal/postpartum care and childhood preventive health. Additional measures related to kyhealthnow 2019 goals would include enrollment growth, smoking cessation, cardiovascular care, overweight and obesity for children and adults, substance abuse, poor mental health and dental care for children and adults.
- For an updated Quality Strategy, the benchmark rates should be revised to reflect the kyhealthnow 2019 goals.

Quality Monitoring and Assessment

- The process of summarizing selected quarterly report information across plans in the form of quarterly desk audits highlights the variability in the data reported and raises questions about how each of the MCOs are interpreting the questions. More data specification and interpretive guidance is needed, so that all MCOs are reporting consistently and a fair comparison can be made across plans.
- Providing interpretive guidance and more data specification for all required monthly, quarterly and annual reports, including data sources to be used, would help improve the consistency in MCO reporting. DMS feedback and comments regarding MCO quarterly report information would also be helpful.
- Results of the PCP Access and Availability Survey indicated that only 31.8% of the calls for routine visits received an appointment within the standard time frame; 24.8% of the calls for non-urgent care received an appointment within the standard time frame and 52.0% of the after-hours calls were compliant. All rates are substantially below the standard of 80%.
- Results of the Dental Access and Availability Survey indicated that only 35.2% of the dentists called for a routine appointment were able to be contacted and an appointment made within the timeliness standards of the contract. For urgent appointments, only 31.6% of the dentists were compliant. Both rates are substantially below what would be expected.
- As of September 2015, less than 1% of Kentucky MMC enrollees were enrolled in an MCO case management program and another 8.26% were enrolled in an MCO disease management program.
- Reported EPSDT screening rates dropped from 83% in RY 2015 to 82% in RY 2015. The reported participation rate for EPSDT services in RY 2015 was 58%, well below the 80% standard set by CMS. Results of the EPSDT validation study and HEDIS and Healthy Kentuckians measures indicated opportunities for improvement in mental health, vision, hearing, and developmental screening; depression and behavioral risk screening for adolescents; BMI screening and nutrition/physical activity counseling; immunizations and lead screening. Oral health assessment was also found lacking in the validation study.
- Meeting notes are not always prepared and distributed, especially for the encounter data meetings. Several MCOs also commented on the value of face-to-face meetings over conference calls whenever possible.

Quality Improvement

- MCOs continue to express concern about the quantity of PIPs that are ongoing at any one time (as many as four to six), which places a burden on MCO resources and may result in fewer or less aggressive interventions.
- The CMS collaborative experiences offer a model of shared learning that is missing in the Kentucky statewide collaborative PIPs. There have been very few all-plan calls and their content and discussions have not led to any collaboration on the part of the plans.
- The CMS Oral Health Initiative PIP template was recognized by the MCOs as a more useful PIP template tool than the EQRO's current PIP tool.
- As a result of the Medically Fragile Children Focused Clinical Study, DMS was encouraged to continue to work with the MCOs to improve access and availability for medically fragile children to both physical and behavioral health providers.
- As a result of the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity Clinical Focused Study, MCOs were encouraged to promote BMI percentile screening and universal prevention interventions for all MMC-enrolled children beginning in early childhood; to improve provider risk assessment, management and monitoring of overweight and obese enrollees; to ensure that resources for nutrition, physical activity and weight management are disseminated to network providers; and to educate members and families regarding cardiovascular and other health risks associated with overweight and obesity. It was further recommended that improvement efforts address obesity with a chronic care model that includes motivational interviewing, family involvement and engagement of all office staff in the care of at-risk children and adolescents.

- In consideration of the medical record request burden placed on MCOs during HEDIS and PIP studies, it is suggested that DMS and the EQRO plan the timing of focused studies requiring medical record reviews so that they do not add to the provider's burden for responding to medical record requests during HEDIS and PIP measurement periods.
- With Kentucky's HEDIS Measures Incentive still to be implemented, there remains some uncertainty among the MCOs about how the incentive will be operationalized. Good communication and data transparency are important in rolling out the incentive program.

Recommendations

- The Kentucky Quality Strategy should be updated. DMS should consider adding goals and objectives for childhood preventive health, prenatal/postpartum care and other measures identified in kyhealthnow 2019 goals. DMS should re-evaluate how benchmarks or other targets for improvement can be applied.
- DMS should consider enhancing the statewide collaborative PIP process by adopting a learning collaborative model to include more all-plan conference calls and learning sessions with experts in the field of behavioral health, coordinated care management and antipsychotic medication use by children and adolescents. MCOs should be encouraged to engage partners in conducting their interventions, including other MCOs, community-based organizations or national organizations that focus on child and adolescent behavioral health.
- DMS should continue to collaborate with MCOs in the review of program monitoring and reporting requirements.
- Learning from the experience in other states, DMS may want to further augment their focus on quality improvement by offering more technical assistance and feedback to the MCOs regarding HEDIS rate improvement, including face-to-face conferences and trainings based on lessons learned from focused quality studies and PIPs. Data transparency and communication through the state website and other social media forums can also be useful educational tools.

Attachment A: Selected Quality Improvement Initiatives from Other States

Extracted from State Quality Strategies:

State (Program Name)	Quality Improvement Initiatives
New York State[34] Year of Strategy: July 2014 Administered by: Office of Quality and Patient Safety, NYS Department of Health (NYS DOH) Medicaid and CHIP Enrollment* Jan. 2016 (Prelim): 6,431,583	Prevention Quality Indicators The PQIs are a set of measures developed by the Agency for Healthcare Research and Quality (AHRQ) to identify ambulatory care sensitive conditions. These are conditions for which good outpatient care can potentially prevent the need for hospitalizations, or for which early intervention and treatment would prevent complications or severe disease. While the hospital admission is used to identify the PQI, the PQIs can be used to flag problems in the health care system outside the hospital. Each year, the NYS DOH calculates plan-specific adult and pediatric PQI reports which are sent to the health plans. These reports also include enrollee characteristics and PQI rates by hospital. Health plans with a PQI rate higher than the statewide average are required to respond to NYS DOH with a root-cause analysis and action plan. Quality Improvement plan managers at the Office of Quality and Patient Safety (OQPS) oversee the response process and offer guidance on best practices to improve PQI measured performance. Collaborative PIPs Medicaid managed care plans are required to conduct one PIP annually using a report template that reflects CMS requirements for a PIP. In the past, each plan chose a topic, and with the technical assistance from the EQRO, developed a study methodology and conducted interventions to reach their improvement goals. More recently, the NYS DOH has encouraged plans to participate in collaborative PIP studies. From 2009-2010, 18 plans worked with NYS DOH and the EQRO to improve the prevention of childhood obesity. From 2011-2012, ten plans worked on addressing potentially preventable hospital readmissions, and six plans worked to reduce disparities in asthma care by partnering with health care practices in Central Brooklyn. The 2013-2014 PIP addresses diabetes management and prevention, hypertension, and smoking cessation. One component of this PIP is the Medicaid Incentives for the Prevention of Chronic Disease (MIPCD) grant, in which New York is participating alongside ten other states to determine the effect of offering financial incentives as a means of engaging recipients in preventive health services. Pay for Performance – Quality Incentive In 2002, the NYS DOH began rewarding plans for superior performance by adding up to three percent to the plan's per-member, per-month premium. This Quality Incentive (QI) program uses a standardized algorithm to award points to health plans for high quality in the categories of: Effectiveness of Care, Access and Availability, and Use of Services. Points are deducted for any Statements of Deficiency (SOD) issued for lack of compliance with managed care requirements. Assessments of quality and satisfaction are derived from HEDIS measures, CAHPS satisfaction data, and PQIs. Quality Performance Matrix In order to monitor health plan performance on quality measures, a quality performance matrix was developed and

State (Program Name)	Quality Improvement Initiatives
	implemented in 1998. The matrix approach provides a framework for benchmarking performance and helps plans prioritize quality improvement planning. The matrix gives a multi-dimensional view of plan performance by comparing rates for selected measures in two ways: 1) to the statewide average and 2) a trend over two years. The result is a 3x3 table where measures are displayed in cells corresponding to a letter grade ranging from A (best performance) to F (worst performance). Plans are instructed to conduct a root-cause analysis and action plan for any measure where there is poor performance based on the barriers identified. The action plans are reviewed and approved by DOH staff and are monitored throughout the year to assure that they are being conducted and evaluated for effectiveness in improving performance. Publication of Quality Performance Reports Reports on Medicaid quality performance, patient satisfaction, health plan comparisons, enrollment, quality improvement initiatives, and research results are made available online at: http://www.health.state.ny.us/health_care/managed_care/reports/index.htm. These easy-to-read reports are designed to help members choose a health plan that meets their needs and the needs of their families, and to inform stakeholders. Data is provided for commercial and government-sponsored managed care. Published reports also include results from External Quality Review of the MMC program. Journal articles are submitted to peer review journals publishing health plan quality performance. Quality Improvement Conferences and Trainings NYS DOH is committed to providing MMC plans with tools to conduct successful quality improvement initiatives. One successful approach has been the sharing of other plan experiences in best practice forums. NYS DOH, in collaboration with its EQRO, has conducted conferences on immunization strategies, partnering for quality improvement, understanding CAHPS (consumer survey) results, adolescent preventive care, physician profiling, ADHD, childhood obesity, asthma, diabetes, and prenatal care. Conferences are also held upon completion of collaborative PIPs. Evaluation feedback is always sought and comments are used in planning future events. Plan Manager Technical Assistance Each plan is assigned a DOH plan manager. They provide technical assistance to plan staff as they develop their root-cause analyses and action plans in response to the Quality Performance Matrix and PQI measures. They prepare a plan's Quality Profile for the area office staff prior to their conducting an on-site Compliance Review survey. They also consult with plans concerning their PIPs.
California[35] Annual Assessment of Strategy: Nov 2015; Revised: Feb 2016 Administered by: Dept. of Health Care Services (DHCS)	QI training Many forms of QI education and training are implemented throughout the Department to equip staff with the skills they need to advance quality system-wide. For example, the Office of Workforce Planning and Development coordinates a full-day training on Lean methodologies to improve business processes in government. The Medi-Cal Adult Quality Care Improvement Initiative is providing training on the core principles of QI and a longitudinal course in the application of QI methodology among a cross-section of DHCS clinicians and staff, who are working to improve diabetes and maternal care for Medi-Cal recipients. DHCS hosts a monthly learning series, journal club, and book club to foster scientific and policy dialogue and to inspire innovation in health care quality.

State (Program Name)	Quality Improvement Initiatives
Medicaid and CHIP Enrollment* Jan. 2016 (Prelim): 12,259,866	Focus on Priority Areas Quality Strategy focuses on the following: two chronic disease areas (diabetes and hypertension), two services within maternal/child health (postpartum care and immunization of two year olds) and tobacco cessation. Objectives are set for each measure for a 5 percentage point improvement over the baseline year of measurement year 2013. DHCS closely monitors Medi-Cal Managed Care plan interventions throughout the year and requires managed care plans to use rapid-cycle improvement initiatives (PDSA). DHCS staff provides in-depth technical assistance to help plans identify barriers, develop root cause analyses and implement quality improvement initiatives. New PIP Process Beginning in September 2015, managed care plans will be required to use rapid-cycle improvement methods to pilot small changes. The EQRO developed a series of five modules which follow a framework based on a modified version of The Institute for Healthcare Improvement's (IHI) Model for Improvement. The EQRO will provide technical assistance throughout the process with frequent contact and feedback. PIPs will last 18 months with the first topic being one of four preselected DHCS topics that align with the state's priority focus areas. The second PIP topic will be selected by the managed care plan. The following four Quality Improvement Collaboratives were established: Diabetes Quality Improvement Collaborative; Hypertension Quality Improvement Collaborative; Postpartum Quality Improvement Collaborative and the Quality Improvement Learning Collaborative. Public Reporting of Performance Results Publically reports audited performance results for each plan on its website and in frequent presentations to stakeholders. The Medi-Cal Managed Care Performance Dashboard displays data on enrollment and demographics, financial strength of plans, health care service utilization, grievances and state Fair Hearings, continuity of care and medical exemption requests and HEDIS and CAHPS rates. In March 2015, DHCS and the California Health and Human Services (DHHS) implemented an Open Data Portal which facilitates public access to non-confidential health and human services data.
Florida[36] Year of Strategy: 2014 Administered by: Agency for Health Care Administration (AHCA) Medicaid and CHIP Enrollment* Jan. 2016 (Prelim): 3,576,943	Use of Social Media The Agency for Health Care Administration uses profiles on Facebook, Twitter, YouTube and SlideShare to engage with stakeholders at all levels. Hosting these sites allows the Agency to share news and events with legislators, state and federal agencies and healthcare providers as well as respond to questions and concerns from both providers and recipients. These platforms have resulted in over 193,000 views of Agency slideshow presentations, nearly 14,000 views of the Agency's instructional videos, and dozens of direct interactions with Medicaid providers and recipients. The Agency will continue to foster relationships using social media as part of its ongoing pursuit of its mission, "Better Health Care for All Floridians." Quality Performance Measure Sanction Strategy Written into the 2012-2015 HMO and Provider Service Network (PSN) contracts, the Performance Measure Sanction Strategy applies sanctions based on managed care plans' performance measure submissions. The key provisions of the sanction strategy are as follows: • For the 2012 measurement year, each performance measure (PM) was assessed a score based on its ranking relative to the

State (Program Name)	Quality Improvement Initiatives
	national 50th percentile. A seven point scoring system is used (0-6). • The PMs were combined into groups of similar PMs. The PM groups receive an average PM group score. The PM groups are: Mental Health and Substance Abuse; Well-Child; Prenatal/Postpartum; Chronic Care; Diabetes; and Other Preventive Care. • Managed care plans were required to develop and submit Performance Measure Action Plans (PMAPs) for any HEDIS measure where the plan's score falls below the 50th national percentile. The managed care plans submit quarterly reports describing their progress with details on the interventions being used to improve care and their performance. Common intervention strategies include enrollee and provider outreach and education, enhanced disease management programs, incentives for compliance with preventive and routine care, and strengthening the role of quality staff. PMs were included in determinations of sanctions after the health plan developed and implemented a PMAP. • For the 2013 performance measure submission, PM group sanctions were assessed for PM group scores that fell below the equivalent of the 50th national percentile. Managed care plans were sanctioned up to $10,000 per PM group score that fell below the threshold national percentile. • Individual measure sanctions for measures in the Mental Health and Substance Abuse, Chronic Care, and Diabetes groups may be applied if the health plan's rate falls below the equivalent of the 10th national percentile. PIPs With the implementation of the Statewide Medicaid Managed Care program, the Managed Medical Assistance plans are required to perform 4 Agency-approved performance improvement projects. Two PIP topics are state-mandated: one PIP combines a focus on improving prenatal care and well-child visits in the first fifteen months, while the other PIP focuses on preventive dental care for children. A third PIPs is an administrative/non-clinical PIP and the fourth PIP is selected from one of the following topic areas: population health issues (such as diabetes, hypertension and asthma) within a specific geographic area that is identified as in need of improvement; integrating primary care and behavioral health; or reducing preventable readmissions. NCQA Accreditation As a condition of participation in the Statewide Medicaid Managed Care program, all managed care plans are required to be accredited by the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), or another nationally recognized accrediting body, or have initiated the accreditation process within one year after their contract with the Agency is executed. For any health plan not accredited within 18 months after contract execution, the Agency will suspend automatic assignment of recipients to those managed care plans. Achieved Savings Rebate In order to ensure that capitated payments made to plans participating in the Statewide Medicaid Managed Care (SMMC) program are appropriate, the Agency implemented a statutorily defined program called the Achieved Savings Rebate program. This program includes enhanced financial monitoring of plans and plan expenditures through submission of detailed financial reporting by plans and an annual audit of that documentation conducted by an independent certified public accountant. The independent auditor will determine the achieved savings of each plan. This program includes the incentive that a plan which exceeds Agency-defined quality measure benchmarks in the reporting period may retain an additional one percent of revenue.

State (Program Name)	Quality Improvement Initiatives
	In order to retain the one percent incentive, plans must achieve a group score of four or higher for each of the six performance measure groups in the first year of reporting performance measures. Consumer Report Card Florida is developing a consumer report card for the plans that will be participating in the Statewide Medicaid Managed Care program. This new initiative will provide valuable feedback to the plans and the public on the performance of all Medicaid managed care plans. Medical Schools Quality Network The Statewide Medicaid Managed Care statute required that the Florida Medicaid program contract with a single organization representing medical schools and graduate medical education programs in the state for the purpose of establishing an active and ongoing program to improve clinical outcomes in all managed care plans. Contracted activities must support greater clinical integration for Medicaid enrollees through interdependent and cooperative efforts of all providers participating in managed care plans.
Maryland[37] (Maryland HealthChoice) Year of Strategy: June 2015 Administered by: Dept. of Health and Mental Hygiene Medicaid and CHIP Enrollment* Jan. 2016 (Prelim): 1,159,510	Value Based Purchasing (VBP) The HealthChoice Value Based Purchasing Initiative improves quality by awarding financial incentives to MCOs based on their performance. Maryland's VBP strategy aims to better coordinate a variety of quality improvement efforts toward a shared set of priorities that focus on the core populations served by HealthChoice. The Department and its stakeholders identify legislative priorities in selecting the performance measures. The performance measures are from HEDIS measures and encounter data. Measures may be added or removed, based upon evolving priorities and participant health care needs. The Department uses a standard methodology to calculate the incentive, neutral, and disincentive ranges, based on previous MCO performance in HEDIS and encounter data measures. Consumer Report Card The Consumer Report Card assists Medicaid participants in selecting one of the participating HealthChoice MCOs. Information in the Report Card includes performance measures from HEDIS, the CAHPS survey, and the Value Based Purchasing Initiative. There are six reporting categories, with one level of summary scores for each reporting category. Three stars represent performance that is above the Maryland HealthChoice average; two stars for the same as the Maryland HealthChoice average; or one star for below the Maryland HealthChoice average. Patient Centered Medical Home In 2011, Maryland began a three-year pilot program to test the use of a patient-centered medical home (PCMH), called the Maryland Multi-Payer Patient-Centered Medical Home Program (MMPP). The MMPP provides Maryland patients with many services, such as integrated care plans, chronic disease management, medication reconciliation at every visit, and same-day appointments for urgent matters. Across Maryland, 52 primary practices, multispecialty practices, and federally qualified health centers participate in MMPP. These practices are paid through HealthChoice MCOs and private insurance carriers, depending on their patient population.

State (Program Name)	Quality Improvement Initiatives
	Chronic Health Home Demonstration In the FY 2013 budget, the Maryland General Assembly set aside funds for the development of a chronic health home demonstration; The Department partnered with the Center for Chronic Disease Prevention and Control (CCDPC) in their Million Hearts effort. Million Hearts in Maryland set out to improve clinical and community linkages through the use of community health workers and community referrals. CMS's State Innovation Models (SIM) Initiative With the help of the SIM planning grant, Maryland developed the capacity to use its data resources for community health assessment and planning. Maryland's health information exchange (HIE), known as the Chesapeake Regional Information System for our Patients (CRISP), accesses data in real time from all of Maryland's acute care hospitals and emergency departments. It provides real-time admission data to primary care clinicians thousands of times a day via secure email, in order to improve communication between hospitals and PCPs. Maryland was awarded up to $2.3 million in the first round of the model design program of the SIM Initiative. The Department sought to expand Maryland's community integrated medical homes (CIMH) model by partnering with healthcare providers and community health organizations. The CIMH model focuses on preventive health care and management rather than urgent intervention of serious medical issues.
New Jersey[38] Year of Strategy: June 2014 Administered by: Div. of Medical Assistance and Health Services Medicaid and CHIP Enrollment* Jan. 2016 (Prelim): 1,703,107	Lead Poisoning Surveillance System Medicaid information is matched with the NJ DOH Childhood Lead Poisoning Surveillance System and identification of children who are lead-burdened or in need of lead screening is shared with MCOs for appropriate outreach or follow-up. As a result of this program blood lead screening rates have improved and there is more timely case management of lead burdened children. Care Management Tool The state monitors MCO care management through Focused Chart Audits conducted annually by the EQRO. The records are evaluated for timely outreach, early identification of special needs populations, completion of an initial health screening and a needs assessment and care plan (if necessary), level of care management, preventive services, care of lead-burdened children, adherence to lead screening protocols, appropriate linkages, continuity and coordination of services and discharge planning following hospitalization. Findings are compared to desired performance standards. Performance-Based Contracting (PBC) The performance based contracting program began in July, 2013 to motivate MCOs to improve and sustain improvement in clinical priority areas chosen by the state: birth outcomes, diabetes and obesity. Funding for the incentive is derived by setting aside a portion of the capitation rate and a revision of the associated efficiency expectations in SFY 2015. MCOs earn PBC amounts based on improved performance measure results from baseline (CY2013) to measurement year.

*Source: Centers for Medicare and Medicaid Services, accessed 4/26/2016. https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/january-2016-enrollment-report.pdf

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

FY 16 Validation of Managed Care Provider Network Submissions: Audit Report

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Final Report
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Table of Contents

EXECUTIVE SUMMARY **3**
INTRODUCTION **4**
OBJECTIVES **4**
METHODOLOGY **5**
SAMPLING 5
SURVEY 5
MAILING 6
DATA ANALYSES 6
METHODOLOGICAL CONSIDERATIONS 6
SURVEY RESULTS **8**
RESPONSE RATE CALCULATIONS 8
ACCURACY RATE CALCULATIONS 8
COMPARISON BETWEEN SEPTEMBER 2015 AND MARCH 2016 RESULTS 9
FINDINGS 9
RECOMMENDATIONS **14**
APPENDIX A – RESPONSE RATE BY PLAN **15**
APPENDIX B – OVERALL ACCURACY BY PLAN **16**
APPENDIX C **17**
SAMPLE OF SPECIALIST SURVEY SENT TO PROVIDERS 17
SAMPLE OF PCP SURVEY SENT TO PROVIDERS 18

List of Tables

Table 1: Fields for Validation by Provider Type 5
Table 2: Missing Provider Directory Data 7
Table 3: Survey Responses by PCP/Specialist 8
Table 4: Status of Surveys by Provider Type 9
Table 5: Statewide Rates of Accuracy for September 2015 and March 2016 9
Table 6: Provider Identification Elements – Statewide 10
Table 7: Specialty – Statewide and by Provider Group 11
Table 8: Reporting of Languages – Statewide 12
Table 9: Provider Group Summary on Survey Items 13
Table A1: Response Rate by Plan 15
Table B1: Overall Accuracy by Plan 16

EXECUTIVE SUMMARY

In March 2016, Island Peer review Organization (IPRO), on behalf of the Kentucky Department for Medicaid Services (DMS), conducted its sixth audit of the plans' provider directory data files to validate their accuracy. This is the second provider network validation for FY 2016. There are five managed care organizations (MCOs) operating in Kentucky: Aetna Better Health, Anthem Blue Cross and Blue Shield Medicaid, Humana-CareSource, Passport Health Plan, and WellCare of Kentucky.

Data validation surveys (**Appendix C**) were sent to 100 primary care providers (PCPs) and 100 specialists from each of the five MCOs. The overall response rate was 60.6% (**Appendix A**). PCPs responded at a significantly higher rate than specialists, at 67.9% and 52.7%, respectively. The response rates also varied by MCO: ranging from 51.4% for Aetna Better Health to 71.2% for Passport Health Plan. After removing exclusions, 467 providers were available for analysis.

Highlights of the Audit Findings

- A total of 219 (46.9%) providers who returned surveys included at least one revision. A higher percentage of PCP records had revisions than specialist records.
- Four survey items had a substantial percentage of providers with missing data in the provider directory 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 64.5% rate of accuracy, most of the revisions were additions, because the original provider directory data were blank. As such, this finding should be interpreted with caution.
- The fields with the most accurate rates were "State" with a 100.0% rate, "National Provider ID (NPI)" with a 100.0% rate, "First Name" with a 99.6% rate, whether the provider has a contract to accept Medicaid patients with a 98.3% rate, "Last Name" with a 98.1% rate, "Provider Type" with a 97.0% rate, "Primary Specialty" with a 95.7% rate, "PCP Panel Size" with a 95.5% rate, "Secondary Specialty" with a 95.3% rate, "City" with a 95.1% rate, "PCP, Specialist, or Both" with a 94.9% rate, and "Zip Code" with a 92.1% rate.
- There was an average of 2.00 revisions per provider for the 219 providers that submitted surveys with changes.
- The "Street Address" element had an accuracy rate of 87.2%. The "Phone Number" element had an accuracy rate of 85.0%, although more than half the revisions coincided with a change in address. The accuracy rate for "PCP Open or Closed Panel" was 86.8%.
- The "License Number" field was reported correctly in 81.7% of records among the 394 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 85.0%. At least one language was added by 68 providers.
- A comparison of the statewide rates of overall accuracy, between the last audit conducted in September 2015 and the current audit, revealed a slight decrease from 54.8% to 53.1%, although the difference was not statistically significant. Among the individual items, none of the accuracy rates differed significantly 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 Managed Care Assignment Processing System (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 provider directory 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 provider directory data and an error rate is computed for each data element that is validated.

This report is a summary of the sixth audit of the accuracy of provider directory data, conducted by IPRO for the DMS. Note that for the first three audits, the MCAPS data were utilized for validation purposes. This is the third audit where the source data utilized electronic provider directory data submitted by MCOs. IPRO requested MCOs to submit the same data fields and same data definitions that are included in the MCAPS template, and the data sources should contain the same data.

The last audit, conducted in September 2015, 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 five surveys in which PCPs and specialists who participate in Medicaid were audited.

OBJECTIVES

The objectives of this study were to:

- Validate the accuracy of MCO provider directory data 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 September 2015 and March 2016 survey studies.

METHODOLOGY

Sampling

In February 2016, each MCO sent IPRO an electronic file containing their provider directory data for the most recent monthly provider data. The combined files contained a total of 485,183 records. IPRO excluded selected providers, such as providers whose address was not in Kentucky or any of its bordering states, providers missing data on NPI, and provider types such as pharmacies. After removing duplicate providers, the file contained 29,362 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 11 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 March 3, 2016. The second mailing was sent on April 15, 2016 to the 520 providers who did not respond to the first mailing, excluding surveys that were returned as undeliverable. The analysis was started in late June 2016.

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 September 2015 and March 2016 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 provider directory files, 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 Provider Directory Data Files

Among the survey items, there were four items that had a substantial percentage of providers with missing data in the provider directory data files (**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 394 providers licensed in Kentucky, 24.9% were missing license number in the provider directory files. A total of 98.9% of the providers had no secondary specialty in the provider directory files, even though IPRO captured specialties from different rows in the file prior to conducting the survey. The Spanish field was missing for 57.6% 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 68.7% of the rows in the provider directory files.

Table 2: Missing Provider Directory Data

Survey Item	n	%
License Number*	98	24.9%
Secondary Specialty	462	98.9%
Spanish	269	57.6%
Other Languages Spoken	321	68.7%

*License Number is limited to providers licensed in Kentucky.

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

- Among the 98 missing data for License number, 52 providers added a License number, while 46 left the field blank;
- Among the 462 missing data for Secondary Specialty, 21 providers added a specialty, while 441 left the field blank, most likely because they do not have a secondary specialty;
- Among the 269 missing data for Spanish, 155 added a response, while 114 left the field blank; and
- Among the 321 missing data for Language, 59 added a response (most frequently English), while 262 left the field blank.

Due to the high number of providers with missing data in the provider directory files, 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 149 surveys were returned to IPRO as "undeliverable" due to inaccurate addresses. Specialists had a higher rate of undeliverable surveys than PCPs (18.8% vs. 11.0%).

There were 516 returned surveys, yielding a response rate of 60.6%. PCPs responded at a significantly higher rate than specialists, at 67.9% and 52.7%, respectively, at $p < .05$. As seen in **Appendix A**, response rates ranged from 51.4% for Aetna Better Health to 71.2% for Passport Health Plan. A total of 49 returns were excluded from the analysis because:

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

Anthem Blue Cross Blue Shield, Humana-CareSource, and Passport Health Plan had the highest number of exclusions with 12 each, followed by WellCare of Kentucky (7 exclusions), and Aetna Better Health (6 exclusions).

As a result, 467 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	55	94	149
Adjusted Population	445	406	851
Returned Surveys	302	214	516
Response Rate	67.9%	52.7%	60.6%
Exclusions	*29*	*20*	*49*
Completed Surveys	273	194	467

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, 46.9% of completed surveys included at least one revision. PCPs were more likely than specialists to return surveys with revisions (55.6% vs. 35.0%), at a significance of $p<.05$. 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 2.00 revisions per provider, among the 219 providers that had at least one correction. **Appendix B** provides a list of revisions per provider by health plan. Accuracy rates ranged from 43.0% for Passport Health Plan to 62.0% for Anthem Blue Cross Blue Shield Medicaid.

Table 4: Status of Surveys by Provider Type

Completed Surveys	Total (n = 467)		PCPs (n = 270)		Specialists (n = 197)		Significance
	n	%	n	%	n	%	
With Revisions	219	46.9%	150	**55.6%**	69	35.0%	*
Without Revisions	248	53.1%	120	44.4%	128	**65.0%**	*

Note: Bold values represent the significantly higher value in the row.
* Statistically significant difference between PCPs and specialists at $p < 0.05$.

Comparison between September 2015 and March 2016 Results

Table 5 provides a summary and comparison of September 2015 and March 2016 statewide rates of accuracy. Overall accuracy decreased by 1.7 percentage points from 54.8% in September 2015 to 53.1% in March 2016, although differences were not statistically significant. Among the individual items, none of the accuracy rates differed significantly over time.

Table 5: Statewide Rates of Accuracy for September 2015 and March 2016

Field Name	September 2015 Statewide Results	March 2016 Statewide Results	Significance
Last Name	98.0%	98.1%	n.s.
First Name	99.8%	99.6%	n.s.
License Number	85.4%	81.7%	n.s.
National Provider ID (NPI)	99.8%	100.0%	n.s.
Street Address	89.5%	87.2%	n.s.
City	95.8%	95.1%	n.s.
State	100.0%	100.0%	n.s.
Zip Code	93.9%	92.1%	n.s.
Phone Number	86.6%	85.0%	n.s.
Accepts Medicaid	98.0%	98.3%	n.s.
Provider Type	96.1%	97.0%	n.s.
PCP, Specialist, or Both	92.8%	94.9%	n.s.
Primary Specialty	95.4%	95.7%	n.s.
Secondary Specialty	96.7%	95.3%	n.s.
Open or Closed Panel (PCPs Only)	91.3%	86.8%	n.s.
Panel Size (PCPs Only)	96.9%	95.5%	n.s.
Spanish	65.1%	64.5%	n.s.
Other Languages Spoken	81.6%	85.0%	n.s.
Overall Accuracy	54.8%	53.1%	n.s.

Note: n.s. denotes not significant 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 81.7%, partially due to the high number of missing data in the original data file. Note that License number is only based on the 394 providers who were licensed in Kentucky. "Phone Number" was the next element most likely to be revised with an accuracy rate of 85.0%. Among the 70 providers who revised "Phone Number," 47 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 11.5% for Passport Health Plan to 21.5% for Humana-CareSource, with an overall rate of 14.9% (**Appendix A**).

With the exception of "Street Address," "Phone Number," "Zip Code," 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," and "State"). For "License Number," 72 providers recorded a change. However, for 52 of these providers, the provider directory data file did not contain a License Number, so these represent both an addition and revision.

The only field where PCPs and specialists differed significantly was "License Number", where the accuracy rate for specialists was higher than for PCPs.

Table 6: Provider Identification Elements – Statewide

Provider Identification Elements	Total Records without Revisions	Total Records with Revisions	% Correct			Significance
			Total Records	PCPs	Specialists	
Last Name	458	9	98.1%	97.8%	98.5%	n.s.
First Name	465	2	99.6%	99.3%	100.0%	n.s.
License Number**	322	72	81.7%	76.3%	**90.6%**	*
NPI	467	0	100.0%	100.0%	100.0%	n.s.
Street Address	407	60	87.2%	87.4%	86.8%	n.s.
City	444	23	95.1%	95.2%	94.9%	n.s.
State	467	0	100.0%	100.0%	100.0%	n.s.
Zip Code***	430	37	92.1%	91.9%	92.4%	n.s.
Phone Number	397	70	85.0%	86.3%	83.2%	n.s.

Note: n.s. denotes not significant at $p < 0.05$.
Note: Bold values represent the significantly higher value in the row.
* Statistically significant difference between PCPs and specialists 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, 36 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 98.3% (459 out of 467) of surveys. In all eight cases with corrections, a Yes was changed to a No response. Accuracy rates were 97.4% for PCPs and 99.5% 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 97.0% (453 out of 467) of providers. Among the 14 corrections, 8 were changed from "Physician Individual" to "Physician Group." Accuracy rates were similar for PCPs and specialists (96.3% and 98.0%, respectively).

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 94.9% (443 out of 467). Among the 24 who recorded a change, the most common changes were from "PCP" to "Both" (n = 8), "PCP" to "Specialist" (n = 7), "Specialist" to "PCP" (n = 4). This field was accurate for 94.1% of PCPs and 95.9% of specialists.

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 447 (95.7%) records. "Secondary Specialty" was correctly reported in 445 (95.3%) records. Of the 22 records with corrections, 21 were originally blank and the provider added a specialty.

Accuracy rates for "Primary Specialty" were 94.4% for PCPs and 97.5% for specialists. The percentage of correct records for "Secondary Specialty" for PCPs was 95.9%, compared with 94.4% for specialists.

Table 7: Specialty – Statewide and by Provider Group

Specialty	Records without Revisions	Records with Revisions	% Correct			Significance
			Total Records	PCPs	Specialists	
Primary Specialty	447	20	95.7%	94.4%	97.5%	n.s.
Secondary Specialty	445	22	95.3%	95.9%	94.4%	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 270 PCPs, 5 providers were excluded from this analysis, since they were originally classified as specialists (but corrected their data to 'PCP' or 'Both' on the previous item), so this item did not appear on their survey. Among the 265 PCPs with data for this field, 230 (86.8%) were returned with no revisions to the element. Among the 35 PCPs with corrections, 27 revised their panel from "Open" to "Closed," while 8 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 265 completed PCP surveys, 253 (95.5%) 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 (64.5%), 155 out of the 166 revisions were additions, because the original data for the field were blank in the provider directory files. Accuracy rates on this field did not differ significantly between PCPs and specialists (62.6% and 67.0%, respectively). Due to the high number of providers with missing data in the provider directory files, 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 11 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 85.0% of records (**Table 8**).

Provider revisions to this field indicated that the element is underreported. Of the 467 completed surveys, 70 (15.0%) providers reported revisions to the "Languages Spoken" field. A total of 68 (14.6%) providers added at least one language, while 3 (0.6%) 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 (n = 10) and Hindi (n = 4), no other languages were reported more than twice by providers.

Accuracy rates did not differ significantly between PCPs (84.4%) and specialists (85.8%).

Note that although the accuracy rate appears high for this field, with no changes for 397 providers, a total of 262 of these providers did not have any languages in the original provider directory files and did not add a language, so they are included in the count of 397. Also, because "English" was added by 56 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 = 467	%
Same languages	397	85.0%
At least one language added	68	14.6%
At least one language dropped	3	0.6%

Note: One provider added and dropped at least one language, and was 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 = 270)	Specialist (n = 197)	Total (n = 467)
Last Name	97.8%	98.5%	98.1%
First Name	99.3%	100.0%	99.6%
License Number	76.3%	90.6%	81.7%
National Provider ID (NPI)	100.0%	100.0%	100.0%
Street Address	87.4%	86.8%	87.2%
City	95.2%	94.9%	95.1%
State	100.0%	100.0%	100.0%
Zip Code	91.9%	92.4%	92.1%
Phone Number	86.3%	83.2%	85.0%
Accepts Medicaid	97.4%	99.5%	98.3%
Provider Type	96.3%	98.0%	97.0%
PCP, Specialist, or Both	94.1%	95.9%	94.9%
Primary Specialty	94.4%	97.5%	95.7%
Secondary Specialty	95.9%	94.4%	95.3%
PCP Open or Closed Panel	86.8%	N/A	86.8%
PCP Panel Size	95.5%	N/A	95.5%
Spanish	62.6%	67.0%	64.5%
Other Languages Spoken	84.4%	85.8%	85.0%
Overall Accuracy	44.4%	65.0%	53.1%

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,” “PCP Open or Closed Panel,” “Spanish,” and “Languages Spoken.”

Limitations

The major limitations in interpreting the results of this audit center on the missing data in the provider directory 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 provider directory data fields 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 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

- Follow up with health plans to correct provider records for the errors identified by this audit;
- Work with plans to enhance the accuracy and completion of critical fields in the provider directory data files, especially fields relating to license number, phone number, address, and languages spoken;
- Expand 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;
- Consider 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;
- Consider 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;
- Consider recording "Secondary Specialty" on the same row as "Primary Specialty" instead of on separate rows; and
- Consider 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

- Furnish 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
Aetna Better Health	200	25	175	90	51.4%
Anthem Blue Cross Blue Shield Medicaid	200	32	168	104	61.9%
Humana-CareSource	200	43	157	84	53.5%
Passport Health Plan	200	23	177	126	71.2%
WellCare of Kentucky	200	26	174	112	64.4%
TOTAL	**1,000**	**149**	**851**	**516**	**60.6%**
ALL PCPs	**500**	**55**	**445**	**302**	**67.9%**
ALL Specialists	**500**	**94**	**406**	**214**	**52.7%**

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
Aetna Better Health	84	41	43	51.2%	1.95
Anthem Blue Cross Blue Shield Medicaid	92	35	57	62.0%	1.91
Humana-CareSource	72	38	34	47.2%	1.76
Passport Health Plan	114	65	49	43.0%	2.23
WellCare of Kentucky	105	40	65	61.9%	2.00
TOTAL	**467**	**219**	**248**	**53.1%**	**2.00**
ALL PCPs*	**270**	**150**	**120**	**44.4%**	**2.03**
ALL Specialists*	**197**	**69**	**128**	**65.0%**	**1.96**

*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		Y=Yes, N=No		Y=Yes, N=No
Provider Type				
PCP, Specialist, or Both		P=PCP, S=SPECIALIST, B=BOTH		P=PCP, S=SPECIALIST, B=BOTH
Specialty: Primary				
Secondary				
Spanish		Y=Yes, N=No		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

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Specialty: Primary				
Secondary				
PCP Open or Closed Panel		O=Open, C=Closed		O=Open, C=Closed
PCP Panel Size				
Spanish		Y=Yes, N=No		Y=Yes, N=No
Languages spoken by Physician and/ or Clinical staff at this site:				

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

Focused Study: Prenatal Smoking

FINAL EXECUTIVE SUMMARY
June 2016

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Introduction

Smoking has been reported to be among the most prevalent, modifiable causes of adverse pregnancy outcomes, with increased prevalence associated with low socioeconomic status (American College of Obstetricians and Gynecologists [ACOG], 2010; Institute of Medicine [IOM], 2007). It has been estimated that 5–8% of preterm births and 13–19% of low-birthweight-term deliveries can be attributed to maternal smoking (ACOG, 2010).According to the Kentucky Department of Public Health (KDPH), among Kentucky women who smoked during pregnancy had twice the odds for delivering a low-birthweight baby compared to nonsmokers, and 25% higher odds for preterm delivery (KDPH, 2013). Historically, Kentucky had the second highest rate of prenatal smoking in the U.S. (KDPH, 2013).

The Affordable Care Act (ACA) requires Medicaid coverage for counseling and pharmacotherapy for cessation of tobacco use by pregnant women, in accordance with the Public Health Service (PHS) Guidelines. The U.S. Preventive Services Task Force (USPSTF, 2015) recommends clinicians ask all pregnant women about tobacco use, citing strong evidence that augmented, pregnancy-tailored counseling is of benefit for pregnant women who smoke. The PHS guidelines recommend that all identified pregnant smokers be offered person-to-person counseling beyond the minimal advice to quit, as well as case-by-case evaluation for pharmacotherapy; the latter is not universally recommended due to limited data on safety and effectiveness (Centers for Medicare and Medicaid Services [CMS], 2011; USPSTF, 2015). Further, ACOG (2010) recommends the following set of interventions, sometimes referred to as "the 5 A's," for smoking cessation during pregnancy: (1) Ask about tobacco use; (2) Advise to quit; (3) Assess willingness to make a quit attempt; (4) Assist in quit attempt; and (5) Arrange follow-up.

Since smoking cessation at any point during pregnancy provides benefit, ACOG advocates that providers encourage persistent smokers to quit at every visit and review prevention strategies in the third trimester for smokers who have already quit to help ensure continued abstinence. (ACOG, 2010) Assessing receipt of these guideline-recommended interventions among the general prenatal Medicaid managed care (MMC) population would help to identify gaps in service provision and highlight specific opportunities for actionable improvements.

Study Aims

The aims of the proposed focused study are:

1. assess smoking prevalence, member characteristics, and receipt of prenatal smoking cessation services among the Kentucky MMC population who delivered a singleton live or non-live birth;
2. for the identified smoker subpopulation, evaluate the relationships between smoking cessation benefit utilization and demographic, clinical and health care access characteristics;
3. identify clinical, demographic and smoking-related factors that impact selected adverse perinatal outcomes; and
4. profile provider prenatal and postpartum interventions relative to guidelines, including the 5 A's, managed care organization (MCO) care coordination and case management of prenatal and postpartum interventions, whether or not smoking abstinence was achieved and, if it was achieved, whether it was achieved during the prenatal period or the postpartum period.

Methodology

Two types of investigations were utilized: an administrative study using claims data to identify associations related to receipt of cessation services and outcomes and a chart review study to investigate in more depth the smoking cessation interventions that were used and their impact on improving smoking-related outcomes.

Administrative Study

The administrative eligible population included the entire MMC population of members who delivered a singleton live or non-live birth (excluding induced abortions) during the period of June 1, 2014–May 31, 2015, with continuous enrollment from 43 days prior to delivery through 56 days after delivery (aligned with the Healthcare Effectiveness Data and Information Set [HEDIS®[1]] criteria for the Prenatal and Postpartum Care measure). Preliminary examination of the eligible population did not show a significant association between smoking and spontaneous abortion, which occurs at less than 20 weeks gestation. To include members of comparable prenatal duration, and as a result, with similar time frame for opportunity for receipt of smoking cessation benefits, the International Classification of Diseases, Revision 9 (ICD-9) code for spontaneous abortion was used as a proxy for gestational age of < 20 weeks, and these members were

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

excluded from the analytic sample. Administrative claims/encounter data were used to evaluate the study associations among the administrative analytic sample. Statistical methods included the *chi*-squared test for differences in proportions and multiple logistic regression analysis to generate adjusted odds ratios (AORs) and 95% confidence intervals (CIs).

Chart Review

A random sample of 500 members was selected from the eligible population, stratified by MCO and smoking status per ICD-9 diagnosis codes. The identified sample included 100 records per MCO, each consisting of 50 identified smokers and 50 nonsmokers per administrative data. For each member in the chart review sample, MCOs were asked to submit a copy of the provider prenatal and postpartum outpatient care records, as well as the complete care coordination/case management record, including all documentation for prenatal, delivery inpatient, and postpartum care coordination.

IPRO developed a medical record abstraction tool for the study in collaboration with the Kentucky Department for Medicaid Services (KDMS). Trained nurse reviewers used the tool to abstract the, including the 5 A's from provider prenatal and postpartum outpatient visit charts, care coordination and case management prenatal and postpartum interventions for smoking cessation referrals and both prenatal and postpartum smoking abstinence outcomes.

Results

Administrative Study Findings for the Eligible Population

There were a total of 26,002 MMC enrollees who delivered a singleton live or non-live birth, or had a spontaneous abortion (excluding induced abortions), from June 1, 2014 to May 31, 2015, continuously enrolled from 43 days prior through 56 days after delivery. Smoking prevalence, as identified by either ICD-9 codes for smoking or smoking cessation benefit claims, was 30.83% (8,017/26,002).

Administrative Study Findings for the Analytic Sample

Smoking Cessation Benefit Receipt Rates by Demographic and Clinical Characteristics, and Access-Related Factors

The vast majority of smokers (n = 6,814, 89.59%) had neither a pharmaceutical smoking cessation claim nor a counseling smoking cessation claim. Overall, 4.30% (n = 327) of the smokers only had a counseling claim, while 5.72% (n = 435) only had a pharmaceutical claim. Very few smokers had a claim for both a pharmaceutical and counseling cessation benefit (n = 30; 0.39%). Notable findings are summarized as follows:

Demographic Characteristic Rates for Receipt of Smoking Cessation Benefit(s)

- Among smokers aged 11–19 years, 92.38% had no claims for cessation benefits, a higher percentage compared to older age groups. Compared to members residing in non-urban areas, a greater proportion of women residing in urban areas had no claims for prenatal smoking cessation benefits (91.72%).

Clinical Characteristic Rates for Receipt of Smoking Cessation Benefit(s)

- Smokers diagnosed with COPD, depression, drug abuse or alcohol abuse had lower rates of receiving neither pharmaceutical nor counseling smoking cessation benefits compared to smokers without these diagnoses.

Access-Related Factor Rates for Receipt of Smoking Cessation Benefit(s)

- A large proportion of members both with and without a diagnosis code for insufficient prenatal care did not receive pharmaceutical or counseling smoking cessation benefits (92.03% and 89.19%, respectively).

Risk Factors with Statistically Significant Differences in the Odds for Receipt of Smoking Cessation Benefits

Demographic Characteristics Associated with Receipt of Smoking Cessation Benefit(s)

- Age group: compared to smokers aged 20–34 years,
  - adolescent smokers were less likely to receive smoking cessation benefits (AOR = 0.734; 95% CI = 0.548, 0.983).
- Geographic area of residence: compared to smokers residing in non-Appalachian urban counties,
  - smokers residing in Appalachian counties were more likely to receive smoking cessation benefits (AOR = 1.400; 95% CI = 1.155, 1.696); and
  - smokers residing in non-Appalachian rural counties were more likely to receive smoking cessation benefits (AOR = 2.216; 95% CI = 1.816, 2.705).

Clinical Characteristics Associated with Receipt of Smoking Cessation Benefit(s)

- Smokers diagnosed with asthma, depression, drug abuse or alcohol abuse were more likely to receive smoking cessation benefits compared to smokers without these diagnoses.

Access-Related Factors Associated with Receipt of Smoking Cessation Benefit(s)

- Relative to women without a diagnosis of insufficient prenatal care, women with a diagnosis of insufficient prenatal care were less likely to receive smoking cessation benefits (AOR = 0.697; 95% CI = 0.545, 0.891).

Perinatal Outcome Rates by Demographic and Clinical Characteristics, and Access-Related Factors

Two perinatal outcomes were evaluated: preterm delivery and a composite indicator of adverse perinatal outcomes. There were 1,741 (7.14%) members with preterm delivery and 5,984 (24.53%) members with the composite outcome, i.e., any one of placental abruption, placenta previa, small-for-gestational age (SGA), still birth, or preterm delivery. Notable findings are:

Demographic Characteristic Rates for Perinatal Outcomes

- Demographic characteristics were associated with the composite outcome, but not with the preterm delivery outcome.
- Among adolescents aged 11–19 years, 26.17% had the composite outcome, a higher percentage compared to older age groups. Compared to members residing in non-urban areas, a greater proportion of women residing in urban areas had the composite outcome (25.69%).

Clinical Characteristic Rates for Perinatal Outcomes

- Smokers had a higher rate of the composite outcome compared to nonsmokers (29.67% and 22.20%, respectively).
- Members with a diagnosis of depression or drug abuse has higher rates of the composite outcome compared to those without the diagnosis.
- Smokers had a higher rate of preterm delivery compared to nonsmokers (8.74% and 6.41%, respectively).
- Members with a diagnosis of depression or drug abuse has a higher rate of preterm delivery compared to members without the diagnosis.

Access-Related Factor Rates for Perinatal Outcomes

- Rates of the composite outcome varied significantly across MCO membership at the time of delivery, ranging from 22.99% to 27.01%.
- Members with a diagnosis of insufficient prenatal care had a higher rate of the composite outcome compared to members without this diagnosis (28.50% and 24.14%, respectively).
- Members with a diagnosis of insufficient prenatal care had a higher rate of preterm delivery compared to members without this diagnosis (10.57% and 6.80%, respectively).

Risk Factors with Statistically Significant Differences in the Odds for Preterm Delivery and the Composite Perinatal Outcomes

Demographic Characteristics Associated with Perinatal Outcomes

- Compared to women aged 20–34 years, adolescent smokers were more likely to have the composite outcome (AOR = 1.175; 95% CI = 1.078, 1.280), whereas older women were less likely.
- Compared to women residing in non-Appalachian urban counties, women residing in non-Appalachian rural counties were less likely to have the composite outcome (AOR = 0.819; 95% CI = 0.752, 0.893).

Clinical Characteristics Associated with Perinatal Outcomes

- Smoking: relative to nonsmokers, smokers were more likely to have the composite outcome (AOR = 1.389; 95% CI = 1.302, 1.482) and to deliver preterm (AOR = 1.270; 95% CI = 1.141, 1.413).
- Depression: relative to women without depression, women with depression were more likely to deliver preterm (AOR = 1.203; 95% CI = 1.021, 1.417); however, depression did not show increased odds for the composite outcome.
- Drug abuse: relative to women without drug abuse, women with drug abuse were more likely to deliver preterm (AOR = 1.550; 95% CI = 1.301, 1.847) and to have the composite outcome (AOR = 1.844; 95% CI = 1.646, 2.067).

Access-Related Factors Associated with Perinatal Outcomes

- MCO: Two MCOs showed higher odds for the composite outcome, with AORs ranging from 1.111 (95% CI = 1.031, 1.196) to 1.252 (95% CI = 1.152, 1.362)
- Insufficient prenatal care: relative to women without a diagnosis of insufficient prenatal care, women with a diagnosis of insufficient prenatal care were more likely to deliver preterm (AOR = 1.473; 95% CI = 1.269, 1.710).

Chart Review Findings

Chart Disposition

There were a total of 500 members for whom prenatal care provider, postpartum care provider and MCO care management (CM) charts were requested, based upon a random member sample stratified by MCO (n = 100) and by ICD-9–defined smokers (n = 50) and nonsmokers (n = 50). There were a total of 424 members for whom at least one of the three chart types was received, but only 108 members had all three types of charts submitted (prenatal care provider, postpartum care provider and MCO CM charts).

Prenatal Chart Review Findings

Prenatal provider adherence to guidelines for assessment and management of maternal smokers, including the ACOG 5-A recommendations for smoking cessation during pregnancy, were assessed using the sample for which a prenatal provider record was received, excluding women with spontaneous abortion or ectopic pregnancy (n = 349).

- Most members' first prenatal visit occurred during the first trimester (199/349; 57.02%).
- The majority of members (89.97%) were assessed for smoking status during a prenatal visit; however, only 49.28% had an initial smoking assessment conducted at a first prenatal visit that occurred during the first trimester.
- Only 6.88% of pregnant members were assessed for secondhand smoke exposure by the prenatal provider.
- Less than half (46.98%) of prenatal smokers were advised to quit at any prenatal visit, 22.15% were advised to quit during the first trimester and 16.11% during the second trimester.
- Only 2.01% of prenatal smokers were referred to the Kentucky quit line.
- There were 57 (38.36%) of 149 smokers who received perinatal provider counseling.
    - Of these 57 smokers, medical record documentation indicated that a total of 5 members quit smoking during pregnancy; 2 quit smoking with abstinence from the first trimester through delivery, 1 abstained from the second trimester through delivery, and 2 abstained from the third trimester through delivery.
    - More than half (31/57; 54.39%) of these members had at least one follow-up visit that addressed smoking status and 22.81% were encouraged by the provider to talk about the process of quitting.
    - Advice regarding the risks to the fetus was received by 17.54% of these 57 members and 8.77% received advice regarding the risks to the newborn.

Postpartum Chart Review Findings

Of the total 228 postpartum records received, 91 (39.91%) did not have a smoking assessment documented by the provider. A total of 137 (60.09%) postpartum records (including 4 members without a prenatal chart) were considered valid for review of provider smoking interventions as they had at least one postpartum visit, as defined by HEDIS[2], and included a provider smoking assessment documented in the review period.

- Most members (126/137; 92.07%) were asked about smoking status by their provider at their first postpartum visit; 11 members had a smoking assessment at a subsequent postpartum visit. A lesser percentage (20.44%) had secondhand smoke exposure assessed at a postpartum visit.
- A total of 31.39% (43/137) reported smoking the same amount as prior to or during pregnancy.
- Three members reported to the postpartum care provider that they quit postpartum, but there was no documentation that the provider congratulated or otherwise reinforced smoking cessation.

Postpartum smoking subsample (n = 43):

- There were no postpartum smoking cessation provider interventions for the majority of the postpartum smoker subset (83.72%).
- Only four postpartum smokers (9.30%) were asked whether they had a plan to quit, and only one had a plan to quit.

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[2] HEDIS specifications for postpartum visit to an obstetrician/gynecologist practitioner or midwife, family practitioner or other PCP on or between 21 and 56 days after delivery: medical record must include the date and *one* of the following: (1) pelvic exam; (2) evaluation of weight, blood pressure, breasts and abdomen; and/or (3) notation of postpartum care, including, but not limited to notation of "postpartum care," "PP care," "PP check," "6-week check," *or* a preprinted "postpartum care" form in which information was documented during the visit

- Five postpartum smokers were advised to quit, and three members (6.98%) received other smoking cessation counseling at the postpartum visit.
- None of the postpartum smokers were referred to the Kentucky quit line.
- Among the 15 members with smoking assessed at a follow-up postpartum visit (and therefore, an opportunity for the postpartum provider to have documented smoking abstinence), there were no members who reported quitting.

MCO CM Chart Review Findings

MCO CM records were received for 230 members.

- Of the 230 MCO CM records received, about 17% of members did not receive any CM outreach. Corresponding MCO-specific rates for lack of any CM outreach ranged from 0% to 35.14%.
- About half (53.04%) of members with a CM record were asked about their smoking status. MCO-specific smoking assessment rates ranged from 32.43% to 82.54%.
- Only 3.48% were assessed for secondhand smoke exposure.
- Only 9.57% were outreached for any purpose during the first trimester, 29.57% were outreached during the second trimester and 30.43% were outreached during the third trimester.
- Only 5.65% were outreached for any purpose during the delivery hospitalization, whereas 38.26% were outreached during the postpartum period.
- Adolescents comprised 10% of the MCO CM chart review sample. Of the 5 adolescent smokers, 0 were engaged with CM for smoking cessation and 1 received care coordination for smoking cessation.
- Of the women with asthma (9.57%), drug abuse (8.26%), or a diagnosis of depression (7.83%), 0 were engaged with CM for smoking cessation.

Of the 230 members with MCO CM records, 48 members were identified as smokers by care managers (CM-identified smokers), whereas 96 were identified as smokers by the prenatal care provider (provider-identified smokers). Key findings for CM- and provider-identified smokers are as follows:

CM Outreach to Smokers for Any Purpose

- Among CM-identified smokers, 22.92% were outreached for any purpose during the first trimester. However, among the provider-identified smokers, the corresponding percentage was 15.63%.
- Among CM-identified smokers, 45.83% were outreached for any purpose during the second trimester. However, among the provider-identified smokers, the corresponding percentage was 36.46%.
- Among CM-identified smokers, 39.58% were outreached for any purpose during the third trimester. However, among the provider-identified smokers, the corresponding percentage was 26.04%.
- Among CM-identified smokers, 31.25% were outreached for any purpose during the postpartum period, with a comparable proportion (34.38%) of provider-identified smokers outreached postpartum.
- Among the provider-identified smokers, 14.58% received no CM outreach.

CM Outreach for Smoking Cessation

- Among CM-identified smokers, about half (52.08%) were contacted by the care manager and smoking cessation was discussed. However, only one-fourth of provider-identified smokers were contacted by the care manager regarding smoking cessation.
- Only four smokers were contacted by the care manager and smoking cessation discussed during the first trimester. This represents 8.33% of CM-identified smokers and 4.17% of provider-identified smokers.
- Among CM-identified smokers, 93.75% were not engaged in CM for smoking cessation (documentation that member agreed to CM smoking cessation services or documented receipt of smoking cessation services). The corresponding proportion among provider-identified smokers was 98.96%.
- Among the CM-identified smokers not engaged in CM for smoking cessation, 37.50% were offered care coordination for smoking cessation , but there was no documentation that member was engaged in smoking cessation services. However, the corresponding proportion among provider-identified smokers was 17.71%.
- None of the members' providers were contacted by CM staff to either provide notification of the member's smoking status or to coordinate smoking cessation interventions with the provider.

CM-Facilitated Referrals for Smoking Cessation

- CM staff facilitated 10 referrals regarding smoking cessation during the prenatal period; this represents 20.83% of CM-identified smokers, but only 10.42% of provider-identified smokers.
- CM staff facilitated referrals to the Kentucky quit line during the prenatal period for 8 of 48 (16.67%) CM-identified smokers and 8 of 96 (8.33%) of the provider-identified smokers. Most of these referrals (7/8; 87.50%) were attributable to one MCO.
- Only two referrals to the Kentucky quit line were made during the first trimester, with most (five) made during the second trimester.
- Only two members had documentation reflecting receipt of smoking cessation services from the Kentucky quit line.
- CM staff facilitated four referrals to a smoking cessation counseling provider during the prenatal period, with only one referral made during the first trimester.
- Only two members received services from the smoking cessation counseling provider.
- No CM-identified smokers had documentation of a quit attempt, although there were two members in CM who had provider-documented successful quit attempts.
- None of the CM- or provider-identified smokers had CM documentation of postpartum CM smoking cessation services or coordination.

Discussion

Administrative data provide evidence to suggest that prenatal smoking prevalence among Kentucky MMC women is higher than previously reported, yet smoking cessation claims data indicate benefit underutilization among this susceptible subpopulation. Smoking during pregnancy is a major factor in preterm birth and other adverse birth outcomes (ACOG, 2010). Smoking prevalence among Kentucky MMC enrollees with a delivery code during June 1, 2014–May 31, 2015, as identified by either ICD-9 codes for smoking or smoking cessation benefit claims prior to and/or including delivery, was 30.8%; a higher rate than previously reported based upon ICD-9 codes only (20.3%; IPRO/KDMS, 2014) and vital records (22.9%; KDPH, 2013). Smoking was highly prevalent among women with alcohol or substance abuse, and smoking was more prevalent among women with asthma/COPD or depression when compared to women without these diagnoses. Although most (46.95%) smokers resided in urban areas, the geographic subgroups with the greatest proportion of smokers were the Appalachian (33.22%) and rural (31.59%) subgroups. The American Lung Association (ALA) has identified a culture of tobacco use as a root cause of tobacco use and a challenge to smoking cessation in Appalachian and rural areas (ALA, 2012). These high risk subgroups among which smoking is prevalent could be targeted by MCOs for identification of smoking and cessation intervention.

The vast majority of smokers (89.32%) had no claims for smoking cessation benefits. Thus, there is substantial opportunity for improving member utilization of prenatal, as well as preconception, smoking cessation benefits. Younger maternal smokers, particularly those aged 11–19 years, had lower rates of cessation services than smokers in other age groups; this finding is consistent with national findings (Nugent et al., 2014). Lack of access to sufficient prenatal care and primary care were also risk factors for lack of receipt of smoking cessation benefits. This high-risk subgroup would benefit from targeted intervention. Interestingly, members with alcohol and substance abuse had higher rates of receipt of cessation benefits compared to members without these diagnoses.

Consistent with findings from the National Health Interview Survey (Nugent et al., 2014), healthier smokers were less likely to have received smoking cessation interventions; though there is ample room for improvement in this area for both groups, since most members in both groups received no cessation benefits. This finding suggests there may be increased access to providers among sicker smokers, resulting in increased interventions for smoking cessation. Urban residence was also a risk factor for lack of receipt of smoking cessation benefits, and merits further exploration by the MCOs. Chart review findings indicate that member receipt of smoking assessment and timely cessation interventions was lacking from both providers and MCO care management. Risk factors for lack of receipt of smoking cessation benefits included younger age (adolescents and women younger than 35 years).

Asking pregnant women about smoking status and offering pregnancy-tailored cessation counseling are level A recommendations from the USPSTF, signifying a high certainty of substantial benefit from these interventions (USPSTF 2009). The majority of members were assessed for smoking status during a visit to their prenatal care provider, with about half assessed during the first trimester. Less than half of smokers' records had documentation of advice to quit by the prenatal care provider, and 59.73% of the prenatal smoking subsample had any documented smoking cessation interventions. The most prevalent specific prenatal provider intervention documented was perinatal provider counseling (38.26%), yet only 2.01% of pregnant smokers were referred to the Kentucky quit line. General assistive-type interventions, such as encouraging the member to talk about the process of quitting (28.86%), also indicate opportunities for improvement. Only 39.60% of pregnant smokers had their smoking status monitored at a follow-up visit, although there is evidence that smoking cessation at any time during pregnancy is of benefit (ACOG, 2010).

MCO care managers identified only half of all pregnant smokers who were identified by the prenatal care provider and had an MCO care management record. One-fourth of members who were identified as smokers by the prenatal care provider were contacted by the MCO care coordinator for smoking cessation and only four members were contacted during the first trimester. Consequently, there was considerable missed opportunities for MCO care managers to have potential impact on adverse fetal outcomes by facilitating smoking cessation, since cessation at any time during pregnancy has been found to reduce the risk for preterm delivery (Moore et al., 2016) and fetal growth restriction (Blatt et al., 2015).

The vast majority of prenatal smokers were not engaged with CM for smoking cessation, and there was no care coordination with the prenatal care provider for smoking cessation. Coordination with prenatal care providers may have allowed the MCO to continue support for the two members who providers identified as abstinent to prevent relapse.

MCO care managers referred just eight members to the Kentucky quit line; most of these referrals were attributable to one MCO, and only two were documented to have received these services.

Study Limitations and Strengths

The administrative study was limited by unmeasured factors that could have influenced the relationship between the possible risk factor and the outcome, as in any observational study. For example, teen mothers may have lower rates of cessation benefits due to late presentation for care, which could not be reliably measured with claims data. Further, the current study was not designed to be a validation study. Therefore, the use of ICD-9 codes and smoking cessation benefit claims codes to identify smokers was not validated against chart review findings, and coding practices among Kentucky MMC providers are not known. For example, ICD-9 codes identified as smokers 16 of 34 women identified by prenatal care providers as former smokers, and so ICD-9 codes may not be a reliable way to identify current smokers. Former smokers who quit would not have the same need for intervention as current smokers. Another limitation was that race/ethnicity was either not reported or reported as "other" for a substantial proportion of the sample; therefore precluding meaningful analysis of this demographic factor.

Chart review study limitations include the possibility that the services were undocumented, rather than not rendered. The sample was chosen, in part, by identifying a cohort of maternal smokers by ICD-9 codes, and therefore results may not be generalizable to the Kentucky MMC perinatal population. For example, since a diagnostic code was submitted for smoking status for half of the sample, it could be assumed that smoking status was assessed for this cohort. Another limitation is the variability in MCO response rates for prenatal care provider chart provision, which ranged from 58% to 88%, postpartum care provider chart provision, which ranged from 20% to 31%, and MCO CM chart provision, which ranged from 11% to 85%. Further, provision of postpartum charts was low across MCOs.

Chart review study strengths include sufficient sample size to determine the statistically significant findings among the groups analyzed, i.e., ≥ 30 charts. In addition, the focus of this study was on prenatal smoking, and the prenatal care provider chart submission rate was high at 74%.

Conclusion

Prenatal smoking is prevalent among the Kentucky MMC population, and there are subgroups with higher risk for smoking and lack of services that could be targeted for intervention. Members with comorbidities, i.e., alcohol abuse, depression and COPD, were more likely to receive smoking cessation benefits, whereas teen mothers and members with insufficient prenatal care were less likely. Many prenatal smokers enrolled in Kentucky MMC did not receive ACOG-recommended smoking cessation interventions from providers. With few exceptions, neither prenatal care providers nor MCO care managers referred prenatal smokers to the Kentucky quit line. What's more, there were considerable missed opportunities for care managers to identify, contact and engage prenatal smokers in smoking cessation programs early in the pregnancy, as well as missed opportunities to contact prenatal care providers for coordination of smoking cessation interventions. Consequently, only a handful of pregnant smokers achieved smoking abstinence during the critical prenatal period.

Recommendations

KDMS can provide guidance to the plans by initiating a statewide collaborative performance improvement project (PIP) for prenatal smoking cessation and by working with the plans to address prenatal access and availability issues, in accordance with the specific MCO recommendations outlined below.

Kentucky Medicaid MCOs can address the problems and risk factors identified in this focused study by identifying and sharing current gaps and best practices, as well as collaborating with providers for quality improvements by drawing on the following recommendations:

- target and tailor care coordination/case management to susceptible subpopulations as indicated by risk factors identified in this report;
- conduct a collaborative PIP to improve preconception/prenatal smoker identification, contact, engagement, coordination and referral for smoking cessation;
- build on existing efforts with the CMS smoking affinity group to refine the focus on prenatal smoking cessation and to address known challenges, such as lack of Kentucky quit line data on MMC pregnant smokers who have contacted the quit line; and

- work with obstetricians and gynecologists to improve preconception and prenatal identification of smokers and to coordinate prenatal smoking cessation services. Specifically:
    - develop and implement a Notice of Pregnancy form for provider use to inform MCO CM of pregnant women who smoke;
    - develop an MCO smoker registry to identify all members who smoke;
    - develop a high-risk obstetric CM program that targets the smoking subpopulation for smoking cessation and ongoing support of identified smokers;
    - develop provider-based listings of smokers to distribute to providers with information on smoking cessation benefits, the Kentucky quit line and how to refer members for smoking cessation services; and
    - encourage, educate and facilitate provider implementation of the ACOG recommendations for smoking cessation during pregnancy, including augmented, pregnancy-tailored counseling and the 5 A's.

Findings from this focused study reinforce the importance of IPRO's recommendation in the Access and Availability Survey (IPRO/KDMS, 2015) that MCOs increase obstetrician/gynecologist contact and appointment rates in order to improve access to appropriate prenatal care.

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

Focused Study: Prenatal Smoking

FINAL REPORT
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Table of Contents

INTRODUCTION 3

RESULTS 5

ADMINISTRATIVE STUDY FINDINGS FOR THE ELIGIBLE POPULATION 5

Factors Associated with Smoking Status 5

ADMINISTRATIVE STUDY FINDINGS FOR THE ANALYTIC SAMPLE 7

Smoking Cessation Benefit Receipt Rates by Demographic and Clinical Characteristics, and Access-Related Factors 7

Multiple Logistic Regression Findings for Receipt of Any Smoking Cessation Benefits for Smokers 9

Perinatal Outcome Rates by Demographic and Clinical Characteristics, and Access-Related Factors 10

Multiple Logistic Regression Findings for Perinatal Outcomes 12

CHART REVIEW FINDINGS 14

DISCUSSION 27

REFERENCES 30

List of Tables

Table 1: Eligible Population Characteristics 6

Table 2: Analytic Subsample of Smokers: Smoking Cessation Benefit Receipt Rates 8

Table 3: Analytic Subsample of Smokers: Multiple Logistic Regression Results for Prenatal Receipt of Smoking Cessation Benefit(s) 10

Table 4: Analytic Sample of Smokers and Nonsmokers: Perinatal Outcome Rates 11

Table 5: Analytic Sample of Smokers and Nonsmokers: Multiple Logistic Regression Results for Perinatal Outcomes 13

Table 6: Chart Disposition 15

Table 7: Chart Review Sample Characteristics 16

Table 8: Prenatal Chart Review – Provider Adherence to Recommendations for Smoking Cessation During Pregnancy 17

Table 9: Prenatal Care Provider Interventions and Smoking Abstinence Outcomes 19

Table 10: Postpartum Chart Review – Provider Adherence to Recommendations for Smoking Cessation During Pregnancy 20

Table 11: MCO CM Chart Review – Identification of Smokers by CM Staff and Provider 22

Table 12: MCO CM Chart Review – Perinatal CM Outreach, Contact, Engagement and Interventions 23

Table 13: MCO CM Chart Review – Perinatal CM Outreach by MCO 25

Table 14: MCO Chart Review of CM-Identified Prenatal Smokers – CM Contact, Engagement and Interventions by MCO 26

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Introduction

Smoking has been reported to be among the most prevalent, modifiable causes of adverse pregnancy outcomes, with increased prevalence associated with low socioeconomic status (American College of Obstetricians and Gynecologists [ACOG], 2010; Institute of Medicine [IOM], 2007). It has been estimated that 5–8% of preterm births and 13–19% of low-birthweight-term deliveries can be attributed to maternal smoking (ACOG, 2010).

Prenatal smoking is associated with more than double the risk for delivering a small-for-gestational-age (SGA) baby (Aliyu et al., 2011), with the greatest risk among women who smoke throughout the duration of pregnancy (Blatt et al., 2015). SGA (a.k.a., fetal growth-restriction; March of Dimes, 2015) is a medical indication for preterm delivery (ACOG, 2013) and prenatal smoking has been shown to increase the risk for medically indicated preterm delivery (Melville, 2010). SGA and preterm delivery are the most prevalent medical/obstetric complications among smokers (Aliyu et al., 2011), and are the primary drivers of low birthweight delivery outcomes (March of Dimes, 2014). Increased risk for the adverse perinatal outcomes of placental abruption, placenta previa, stillbirth (Aliyu et al., 2011) and spontaneous abortion (Pineles et al., 2014) has also been reported.

According to the Kentucky Department of Public Health (KDPH), among Kentucky women who smoked during pregnancy had twice the odds for delivering a low-birthweight baby compared to nonsmokers, and 25% higher odds for preterm delivery (KDPH, 2013). Historically, Kentucky had the second highest rate of prenatal smoking in the U.S. (KDPH, 2013). Using administrative claims data, the Island Peer Review Organization (IPRO)/Kentucky Department of Medicaid Services (KDMS) Postpartum Readmission Study found a 20.3% smoking prevalence rate among Medicaid managed care (MMC) enrollees who delivered during the period of 11/6/2011–9/5/2012 (IPRO/KDMS, 2014). This finding is similar to the 22.9% smoking prevalence rate among all women in Kentucky who delivered in 2011, according to a vital records study (KDPH, 2013). It is anticipated that the findings of this study—which will evaluate the relationships of prenatal smoking status, receipt of cessation services, managed care organization (MCO) membership, prenatal visits, and demographic characteristics with the outcomes of prenatal SGA and SGA-indicated preterm birth—will inform knowledge about susceptible subpopulations and opportunities to improve birth outcomes among the Kentucky MMC population.

The Affordable Care Act (ACA) requires Medicaid coverage for counseling and pharmacotherapy for cessation of tobacco use by pregnant women, in accordance with the Public Health Service (PHS) Guidelines. The U.S. Preventive Services Task Force (USPSTF, 2015) recommends clinicians ask all pregnant women about tobacco use, citing strong evidence that augmented, pregnancy-tailored counseling is of benefit for pregnant women who smoke. The PHS guidelines recommend that all identified pregnant smokers be offered person-to-person counseling beyond the minimal advice to quit, as well as case-by-case evaluation for pharmacotherapy; the latter is not universally recommended due to limited data on safety and effectiveness (Centers for Medicare and Medicaid Services [CMS], 2011; USPSTF, 2015). Further, ACOG (2010) recommends the following set of interventions, sometimes referred to as "the 5 A's," for smoking cessation during pregnancy: (1) Ask about tobacco use; (2) Advise to quit; (3) Assess willingness to make a quit attempt; (4) Assist in quit attempt; and (5) Arrange follow-up. Yet, a recent study found inconsistent adherence to the 5 A's. For example, only 25% of providers surveyed asked about tobacco use at the initial visit, if they suspected that pregnant patients were smoking, even though smoking was not indicated on the intake form (Coleman-Cowger et al., 2014).

Since smoking cessation at any point during pregnancy provides benefit, ACOG advocates that providers encourage persistent smokers to quit at every visit and review prevention strategies in the third trimester for smokers who have already quit to help ensure continued abstinence. (ACOG, 2010) Assessing receipt of these guideline-recommended interventions among the general prenatal MMC population would help to identify gaps in service provision and highlight specific opportunities for actionable improvements.

Study Aims

The aims of the proposed focused study are:

1. assess smoking prevalence, member characteristics, and receipt of prenatal smoking cessation services among the Kentucky MMC population who delivered a singleton live or non-live birth;
2. for the identified smoker subpopulation, evaluate the relationships between smoking cessation benefit utilization and demographic, clinical and health care access characteristics;
3. identify clinical, demographic and smoking-related factors that impact selected adverse perinatal outcomes; and
4. profile provider prenatal and postpartum interventions relative to guidelines, including the 5 A's, MCO care coordination and case management of prenatal and postpartum interventions, whether or not smoking abstinence was achieved and, if it was achieved, whether it was achieved during the prenatal period or the postpartum period.

Methodology

Two types of investigations were utilized: an administrative study using claims data to identify associations related to receipt of cessation services and outcomes and a chart review study to investigate in more depth the smoking cessation interventions that were used and their impact on improving smoking-related outcomes.

Administrative Study

The administrative eligible population included the entire MMC population of members who delivered a singleton live or non-live birth (excluding induced abortions) during the period of June 1, 2014–May 31, 2015, with continuous enrollment from 43 days prior to delivery through 56 days after delivery (aligned with the Healthcare Effectiveness Data and Information Set [HEDIS®] criteria for the Prenatal and Postpartum Care measure). Preliminary examination of the eligible population did not show a significant association between smoking and spontaneous abortion, which occurs at less than 20 weeks gestation. To include members of comparable prenatal duration, and as a result, with similar time frame for opportunity for receipt of smoking cessation benefits, the International Classification of Diseases, Revision 9 (ICD-9) code for spontaneous abortion was used as a proxy for gestational age of < 20 weeks, and these members were excluded from the analytic sample. Administrative claims/encounter data were used to evaluate the study associations described in the Study Aims section among the administrative analytic sample. To accomplish this analysis, *chi*-squared analysis and multiple logistic regression were used. The same ICD-9 codes to define smoking status were used as those in the IPRO/KDMS Postpartum Hospital Readmission Study (2014) across all care settings during the 280 days prior to and including the delivery date (i.e., the expected prenatal period for a term pregnancy). Claims data identified smokers using codes for smoking diagnosis, smoking cessation pharmaceutical claims and smoking cessation counseling claims for this same time period. ICD-9 codes were also used to define perinatal outcomes and clinical risk factors.

Chart Review – Sample Selection

A random sample of 500 members was selected from the eligible population, stratified by MCO and smoking status per ICD-9 diagnosis codes. The selected sample size of 500 had sufficient power to yield a significant proportion estimate, as would subsamples as small as 30. The identified sample included 100 records per MCO, each consisting of 50 identified smokers and 50 nonsmokers per administrative data.

For each member in the chart review sample, MCOs were asked to submit a copy of the provider prenatal and postpartum outpatient care records, as well as the complete care coordination/case management record, including all documentation for prenatal, delivery inpatient, and postpartum care coordination.

Data Collection Methodology

In order to standardize the abstraction process, a medical record review tool and detailed instructions for each element, including requirements for indicator compliance, clear definitions for elements and likely location of the elements in the medical records were developed by IPRO in collaboration with KDMS. An electronic tool was created in Microsoft Access, with training provided for IPRO nurse reviewers. Each nurse reviewer achieved greater than 95% accuracy on test charts prior to chart abstraction. Inter-rater reliability (IRR) testing was conducted to evaluate the performance of the nurse reviewers at the outset, and regular oversight was conducted throughout the review process through weekly over-reads of a minimum of 5% of reviewed charts. All nurse abstractor reviewers maintained a performance of at least 95% accuracy throughout the oversight process. The cumulative abstraction accuracy rate for the over-read was 98%.

Abstraction Process

Using the standardized tool that was developed, nurse reviewers abstracted the information contained in provider medical records and MCO case management records related to smoking cessation interventions, including the 5 A's, from provider prenatal and postpartum outpatient visit charts, care coordination and case management prenatal and postpartum interventions for smoking cessation referrals and both prenatal and postpartum smoking abstinence outcomes.

Results

Administrative Study Findings for the Eligible Population

There were a total of 26,002 MMC enrollees who delivered a singleton live or non-live birth, or had a spontaneous abortion (excluding induced abortions), from June 1, 2014 to May 31, 2015, continuously enrolled from 43 days prior through 56 days after delivery. Smoking prevalence, as identified by either ICD-9 codes for smoking or smoking cessation benefit claims, was 30.83% (8,017/26,002).

Factors Associated with Smoking Status

Table 1 presents population demographic and clinical characteristics, as well as access-related factors, by smoking status. Demographic, clinical and access-related factors were significantly associated with smoking status. The make-up of the population of mothers who smoke and their access to prenatal care are summarized as follows:

Age and Gender

- Most (79.68%) of the study population were aged 20–34 years; 13.31% were aged 11–19 years (adolescents), 6.73% were aged 35–44 years; and less than 1% were aged 45–64 years.
- Most (83.65%) smokers were aged 20–34 years, followed by adolescents (9.63%). The age group with the greatest proportion of smokers was the oldest age group, i.e., 34.25% of women aged 45–64 years, followed by women aged 20–34 years (32.37%). Among adolescents aged 11–19 years, 22.31% were identified as smokers.

Race/Ethnicity

- Race and ethnicity were difficult to identify using administrative data. Most (76.71%) of the study population were of "Other" race/ethnicity and 7.49% had no race/ethnicity provided; 12.14 % were white and 3.42% black. Given the high proportion of members for whom race/ethnicity could not be determined, this factor was not included in any further analysis.

Geographic Area of Residence

- Non-Appalachian-urban residing members comprised the largest proportion of the study population (49.88%), followed by Appalachian (32.50%), non-Appalachian-rural (17.48%), and unknown county of residence (< 1%). Most (46.95%) smokers resided in non-Appalachian urban counties, followed by Appalachian counties (35.01%).

Clinical Characteristics

- Less than 1% of the study population had a diagnosis of alcohol abuse; however, 75% of women with a diagnosis of alcohol abuse were identified as smokers.
- Smoking was also prevalent among women with a diagnosis of drug abuse. Although only 5.78% of the study population had a diagnosis of drug abuse, 73.25% of this subgroup was identified as smokers.
- Women with a diagnosis of depression comprised 8.88% of the study population, and 48.87% of these women were smokers.
- Women with a diagnosis of asthma/chronic obstructive pulmonary disease (COPD) comprised 11.19% of the study population, and 44.74% of women with this diagnosis were identified as smokers.
- Women with a diagnosis of obesity comprised 12.66% of the study population, and 32.54% of this subgroup were smokers.

Access to Care

- MCO and smoking status:
  - WellCare of Kentucky enrollees comprised the largest proportion of the study population (36.23%) and Anthem Blue Cross Blue Shield (BCBS) Medicaid enrollees the smallest (4.73%). It should be noted that Anthem BCBS first began enrolling members in 2014, and this would have affected the proportion of Anthem BCBS Medicaid members eligible to be included in the study population.
  - The MCO with the greatest proportion of smokers was WellCare of Kentucky (32.83%) followed by Aetna Better Health of Kentucky (31.89%). The MCO with the smallest proportion of smokers was Humana-CareSource (26.88%).
- Any primary care provider (PCP)/obstetrician outpatient visit, 280 days prior to delivery:

- Administrative data were evaluated for evidence of prenatal care. More than one-third of the members (34.66%) had no administrative claim for a prenatal PCP/obstetrician outpatient visit. This result may have been affected by global maternity billing in which a provider is paid one fee for the entire maternity episode and may not always submit each detailed prenatal visit, and the eligible population included members with spontaneous abortions, who may not have had opportunity for a prenatal visit. Therefore, prenatal visits may not be reliably measured by administrative data.

- Insufficient prenatal care:
  - Less than one-tenth of members (8.56%) had a diagnosis code signifying supervision of high-risk pregnancy with insufficient prenatal care (ICD-9 code V 23.7). The proportion of smokers among women with this diagnosis code for insufficient prenatal care (47.57%) was higher compared to the proportion of members without this diagnosis code (29.26%). It should be noted that it is not known how the code for insufficient prenatal care is used among Kentucky MMC providers, and it is not possible to determine to what extent adequate prenatal care is lacking when this code is used.
- Prenatal smoking cessation benefit received:
  - Most smokers had no administrative claims for any smoking cessation benefit (89.32%), and only a few smokers received medication cessation benefits, but no counseling cessation benefits (5.91%). Overall, 4.38% of smokers received only counseling cessation benefits, and < 1% received both medication and counseling cessation benefits.

Table 1: Eligible Population Characteristics

Eligible Population Characteristics	Smoker[a] # (Row %) (Column %)	Nonsmoker[a] # (Row %) (Column %)
Eligible population: 26,002 (100%)[b]	8,017 (30.83%)	17,985 (69.17%)
Demographic characteristics		
Age group[c]		
11–19 years (n = 3,460; 13.31%)	772 (22.31%) (9.63%)	2,688 (77.69%) (14.95%)
20–34 years (n = 20,719; 79.68%)	6,706 (32.37%) (83.65%)	14,013 (67.63%) (77.91%)
35–44 years (n = 1,750; 6.73%)	514 (29.37%) (6.41%)	1,236 (70.63%) (6.87%)
45–64 years (n = 73; 0.28%)	25 (34.25%) (0.31%)	48 (65.75%) (0.27%)
Race/Ethnicity[c]		
Asian/Pacific Islander (n = 63; 0.24%)	2 (3.17%) (0.02%)	61 (96.83%) (0.34%)
Black (n = 888; 3.42%)	215 (24.21%) (2.68%)	673 (75.79%) (3.74%)
White (n = 3,157; 12.14%)	1,063 (33.67%) (13.26%)	2,094 (66.33%) (11.64%)
Other (n = 19,946; 76.71%)	6,108 (30.62%) (76.19%)	13,838 (69.38%) (76.94%)
Not provided (n = 1,948; 7.49%)	629 (32.29%) (7.85%)	1,319 (67.71%) (7.33%)
Geographic area of residence[c]		
Appalachian (n = 8451; 32.50%)	2,807 (33.22%) (35.01%)	5,644 (66.78%) (31.38%)
Non-Appalachian, rural (n = 4,546; 17.48%)	1,436 (31.59%) (17.91%)	3,110 (68.41%) (17.29%)
Non-Appalachian, urban (n = 12,971; 49.88%)	3,764 (29.02%) (46.95%)	9,207 (70.98%) (51.19%)
Unknown (n = 34; 0.13%)	10 (29.41%) (0.12%)	24 (70.59%) (0.13%)
Clinical characteristics[c]		
COPD (includes asthma; n = 2,910; 11.19%)	1,302 (44.74%) (16.24%)	1,608 (55.26%) (8.94%)
Depression (n = 2,310; 8.88%)	1,129 (48.87%) (14.08%)	1,181 (51.13%) (6.57%)
Drug abuse (n = 1,503; 5.78%)	1,101 (73.25%) (13.73)	402 (26.75%) (2.24%)
Alcohol abuse (n = 192; 0.74%)	144 (75.00%) (1.80%)	48 (25.00%) (0.27%)
Obesity (n = 3,291; 12.66%)	1,071 (32.54%) (13.36%)	2,220 (67.46%) (12.34%)
Access-related factors		
MCO at time of delivery[c]		
WellCare of Kentucky (n = 9,420; 36.23%)	3,093 (32.83%) (38.58%)	6,327 (67.17%) (35.18%)
Passport Health Plan (n = 5,973; 22.97%)	1,687 (28.24%) (21.04%)	4,286 (71.76%) (23.83%)
Humana-CareSource (n = 1,968; 7.57%)	529 (26.88%) (6.60%)	1,439 (73.12%) (8.00%)
Aetna Better Health of Kentucky (n = 7,411;	2,363 (31.89%) (29.47%)	5,048 (68.11%) (28.07%)

Eligible Population Characteristics	Smoker[a] # (Row %) (Column %)	Nonsmoker[a] # (Row %) (Column %)
28.50%)		
Anthem BCBS Medicaid (n = 1,230; 4.73%)	345 (28.05%) (4.30%)	885 (71.95%) (4.92%)
Any PCP/obstetrician visit, 280 days prior to delivery[c]		
1 or more outpatient visits (n = 16,989; 65.34%)	5,532 (32.56%) (69.00%)	11,457 (67.44%) (63.70%)
0 outpatient visits (n = 9,013; 34.66 %)	2,485 (27.57%) (31.00%)	6,528 (72.43%) (36.30%)
Insufficient prenatal care (ICD-9 code V23.7, 280 days prior through delivery)[c]		
Yes (n = 2,226; 8.56%)	1,059 (47.57%) (13.21%)	1,167 (52.43%) (6.49%)
No (n = 23,776; 91.44%)	6,958 (29.26%) (86.79%)	16,818 (70.74%) (93.51%)
Prenatal smoking cessation benefit[d]		
None received	7,161 (100%) (89.32%)	N/A
Medication dispensed, only	474 (100%) (5.91%)	N/A
Counseling claim, only	351 (100%) (4.38%)	N/A
Both medication and counseling	31 (100%) (0.39%)	N/A

[a] Smokers were defined as members with ICD-9 code for smoking and/or claims for smoking cessation benefit. Nonsmokers were defined as members without ICD-9 code for smoking or any claims for smoking cessation benefit.
[b] MMC member population who delivered a singleton live or non-live birth (excluding induced abortions) during June 1, 2014-May 31, 2015, continuously enrolled from 43 days prior through 56 days after delivery.
[c] Shows statistically significant association with smoking status based upon *chi*-squared test statistic (*P*-value < 0.05).
[d] Based on smoking cessation medications dispensed and claims for smoking cessation counseling, both prior to delivery date. Evaluation of statistically significant associations with smoking status is not relevant, since smoking cessation benefits only apply to smokers, but not to nonsmokers.
COPD: chronic obstructive pulmonary disease; MCO: managed care organization; BCBS: Blue Cross Blue Shield; PCP: primary care provider; ICD: International Classification of Diseases; N/A: not applicable.

Administrative Study Findings for the Analytic Sample

Smoking Cessation Benefit Receipt Rates by Demographic and Clinical Characteristics, and Access-Related Factors

Table 2 presents demographic and clinical characteristics, as well as access-related factors, by smoking cessation benefit receipt during the prenatal period, among the smoker subpopulation of the administrative analytic sample (excludes members with induced or spontaneous abortions; n = 7,606).

The vast majority of smokers (n = 6,814, 89.59%) had neither a pharmaceutical smoking cessation claim nor a counseling smoking cessation claim. Overall, 4.30% (n = 327) of the smokers only had a counseling claim, while 5.72% (n = 435) only had a pharmaceutical claim. Very few smokers had a claim for both a pharmaceutical and counseling cessation benefit (n = 30; 0.39%). MCO membership at the time of delivery was not significantly associated with receipt of smoking cessation benefit. However, a significant association was evident between smoking cessation benefit receipt and insufficient prenatal care. Notable findings are summarized as follows:

Demographic Characteristic Rates for Receipt of Smoking Cessation Benefits

- Among smokers aged 11–19 years, 92.38% had no claims for cessation benefits, a higher percentage compared to older age groups. Compared to members residing in non-urban areas, a greater proportion of women residing in urban areas had no claims for prenatal smoking cessation benefits (91.72%).

Clinical Characteristic Rates for Receipt of Smoking Cessation Benefits

- Smokers with COPD had a lower rate of receiving neither pharmaceutical nor counseling smoking cessation benefits compared to smokers without COPD (85.96% and 89.76%, respectively).
- Fewer smokers with depression received neither pharmaceutical nor counseling smoking cessation benefits compared to smokers without depression (77.47% and 91.51%, respectively).
- Fewer smokers with a diagnosis of drug abuse received neither pharmaceutical nor counseling smoking cessation benefits compared to smokers without a diagnosis of drug abuse (87.04% and 90.01%, respectively).

- Fewer smokers with a diagnosis of alcohol abuse received neither pharmaceutical nor counseling smoking cessation benefits compared to smokers without alcohol abuse. (68.89% and 89.96%, respectively).

Access-Related Factor Rates for Receipt of Smoking Cessation Benefits

- The proportion of members with a claim for smoking cessation benefits did not differ by MCO of enrollment at the time of delivery.
- A large proportion of members both with and without a diagnosis code for insufficient prenatal care did not receive pharmaceutical nor counseling smoking cessation benefits (92.03% and 89.19%, respectively).

Table 2: Analytic Subsample of Smokers: Smoking Cessation Benefit Receipt Rates

Smoker Subpopulation (n = 7,606)[a]	Only Pharmaceutical Cessation Benefit Claim (n = 435; 5.72%) # (Row %)	Only Cessation Counseling Benefit Claim (n = 327; 4.30%) # (Row %)	Both Types of Cessation Benefit Claims (n = 30; 0.39%) # (Row %)	Neither Type of Cessation Benefit Claims (n = 6,814; 89.59%) # (Row %)
Demographic characteristics				
Age group[b]				
11–19 years (722; 9.49%)	28 (3.88%)	25 (3.46%)	2 (0.28%)	667 (92.38%)
20–34 years (6,384; 83.93%)	351 (5.50%)	276 (4.32%)	21 (0.33%)	5,736 (89.85%)
35–44 years (477; 6.27%)	52 (10.90%)	25 (5.24%)	7 (1.47%)	393 (82.39%)
45–64 years (23; 0.30%)	4 (17.39%)	1 (4.35%)	0	18 (78.26%)
Geographic area of residence[b]				
Appalachian (2,690; 35.37%)	150 (5.58%)	123 (4.57%)	9 (0.33%)	2,408 (89.52%)
Non-Appalachian – rural (1,381; 18.16%)	105 (7.60%)	107 (7.75%)	5 (0.36%)	1,164 (84.29%)
Non-Appalachian – urban (3,526; 46.36%)	180 (5.10%)	96 (2.72%)	16 (0.45%)	3,234 (91.72%)
Unknown (9; 0.12%)	0	1 (11.11%)	0	8 (88.89%)
Clinical characteristics				
With asthma (856; 11.25%)	63 (7.36%)	44 (5.14%)	5 (0.58%)	744 (86.92%)
Without asthma (6,750; 88.75%)	372 (5.51%)	283 (4.19%)	25 (0.37%)	6,070 (89.93%)
With COPD (342; 4.50%)[b]	21 (6.14%)	26 (7.60%)	1 (0.29%)	294 (85.96%)
Without COPD (7,264; 95.50%)	414 (5.70%)	301 (4.14%)	29 (0.40%)	6,520 (89.76%)
With depression (1,043; 13.71%)[b]	161 (15.44%)	63 (6.04%)	11 (1.05%)	808 (77.47%)
Without depression (6,563; 86.29%)	274 (4.17%)	264 (4.02%)	19 (0.29%)	6,006 (91.51%)
With drug abuse (1,088; 14.30%)[b]	74 (6.80%)	62 (5.70%)	5 (0.46%)	947 (87.04%)
Without drug abuse (6,518; 85.70%)	361 (5.54%)	265 (4.07%)	25 (0.38%)	5,867 (90.01%)
With alcohol abuse (135; 1.77%)[b]	19 (14.07%)	19 (14.07%)	4 (2.96%)	93 (68.89%)
Without alcohol abuse (7,471; 98.23%)	416 (5.57%)	308 (4.12%)	26 (0.35%)	6,721 (89.96%)
With obesity (1,056; 13.88%)	58 (5.49%)	58 (5.49%)	5 (0.47%)	935 (88.54%)
Without obesity (6,550; 86.12%)	377 (5.76%)	269 (4.11%)	25 (0.38%)	5,879 (89.76%)
Access-related factors				
MCO				
WellCare of Kentucky (2,939; 38.64%)	178 (6.06%)	128 (4.36%)	10 (0.34%)	2,623 (89.25%)
Passport Health Plan (1,580; 20.77%)	78 (4.94%)	63 (3.99%)	10 (0.63%)	1,429 (90.44%)
Humana-CareSource (497; 6.53%)	34 (6.84%)	13 (2.62%)	0	450 (90.54%)
Aetna Better Health of Kentucky (2,268; 29.82%)	129 (5.69%)	114 (5.03%)	10 (0.44%)	2,015 (88.84%)
Anthem BCBS Medicaid (322; 4.23%)	16 (4.97%)	9 (2.80%)	0	297 (92.24%)

Smoker Subpopulation (n = 7,606)[a]	Only Pharmaceutical Cessation Benefit Claim (n = 435; 5.72%) # (Row %)	Only Cessation Counseling Benefit Claim (n = 327; 4.30%) # (Row %)	Both Types of Cessation Benefit Claims (n = 30; 0.39%) # (Row %)	Neither Type of Cessation Benefit Claims (n = 6,814; 89.59%) # (Row %)
Insufficient prenatal care (ICD-9 code V23.7, 280 days prior through delivery)[b]				
Yes (1,054; 13.86%)	34 (3.23%)	47 (4.46%)	3 (0.28%)	970 (92.03%)
No (6,552; 86.14%)	401 (6.12%)	280 (4.27%)	27 (0.41%)	5,844 (89.19%)

[a] MMC members who were identified as smokers (i.e., defined by ICD-9 diagnosis code or smoking cessation benefit claim) who delivered a singleton live or non-live birth (excluding induced and spontaneous abortions) during June 1, 2014–May 31, 2015, continuously enrolled from 43 days prior to delivery through 56 days after delivery.
[b] Shows statistically significant association between demographic, clinical or access-related characteristics/factors with receipt of any smoking cessation benefit prior to delivery versus no smoking cessation benefit receipt using *chi*-squared test statistic (*P*-value < 0.05).
COPD: chronic obstructive pulmonary disease; MCO: managed care organization; ICD: International Classification of Diseases.

Multiple Logistic Regression Findings for Receipt of Any Smoking Cessation Benefits for Smokers

Table 3 presents multiple logistic regression results for the associations between receipt of smoking cessation benefits and risk factors (analytic sample excludes members with induced or spontaneous abortions; n = 7,606). Values below or above the neutral 1.000 for the resulting adjusted odds ratio (AOR) for multiple logistic regression analyses indicate lesser or greater odds of receiving smoking cessation benefits, respectively. One group in each category was the referent, meaning the other groups' odds were compared to this group's odds for the same association. For factors without the referent group indicated, the referent group is members without the factor. Confidence intervals (CIs) that do not include the neutral 1.000 value indicate that the associations are statistically significant. Findings for risk factors with statistically significant differences in the odds for receipt of smoking cessation benefits are:

Demographic Characteristics Associated with Receipt of Smoking Cessation Benefit(s)

- Age group: compared to smokers aged 20–34 years,
  - adolescent smokers were less likely to receive smoking cessation benefits (AOR = 0.734; 95% CI = 0.548, 0.983); and
  - smokers aged 35–44 years were more likely to receive smoking cessation benefits (AOR = 1.682; 95% CI = 1.298, 2.179).
- Geographic area of residence: compared to smokers residing in non-Appalachian urban counties,
  - smokers residing in Appalachian counties were more likely to receive smoking cessation benefits (AOR = 1.400; 95% CI = 1.155, 1.696); and
  - smokers residing in non-Appalachian rural counties were more likely to receive smoking cessation benefits (AOR = 2.216; 95% CI = 1.816, 2.705).

Clinical Characteristics Associated with Receipt of Smoking Cessation Benefit(s)

- Alcohol abuse: relative to smokers without a diagnosis of alcohol abuse, smokers with alcohol abuse were more likely to have received smoking cessation benefits (AOR = 3.220; 95% CI = 2.169, 4.781).
- Depression: relative to smokers without a diagnosis of depression, smokers with depression were more likely to have received smoking cessation benefits (AOR = 2.825; 95% CI = 2.369, 3.370).
- Asthma: relative to smokers without a diagnosis of asthma, smokers with asthma were more likely to have received smoking cessation benefits (AOR = 1.294; 95% CI = 1.034, 1.620).
- Drug abuse: relative to smokers without a diagnosis of drug abuse, smokers with drug abuse were more likely to have received smoking cessation benefits (AOR = 1.234; 95% CI = 1.005, 1.516).

Access-Related Factors Associated with Receipt of Smoking Cessation Benefit(s)

- MCO: there were no statistically significant associations between MCO and receipt of smoking cessation benefits.
- Insufficient prenatal care: relative to women without a diagnosis of insufficient prenatal care, women with a diagnosis of insufficient prenatal care were less likely to receive smoking cessation benefits (AOR = 0.697; 95% CI = 0.545, 0.891).

Table 3: Analytic Subsample of Smokers: Multiple Logistic Regression Results for Prenatal Receipt of Smoking Cessation Benefit(s)

Total Smoker Population (n = 7,606)[a]	AOR[b]	95% CI
Demographic characteristics		
Age group		
11–19 years	0.734[c]	(0.548, 0.983)
20–34 years	1.000 (referent)	
35–44 years	1.682[d]	(1.298, 2.179)
45–64 years	1.766	(0.619, 5.036)
Geographic area of residence		
Appalachian	1.400[d]	(1.155, 1.696)
Non-Appalachian – rural	2.216[d]	(1.816, 2.705)
Non-Appalachian – urban	1.000 (referent)	
Unknown	1.787	(0.221, 14.427)
Clinical characteristics		
Asthma	1.294[d]	(1.034, 1.620)
COPD	1.229	(0.883, 1.710)
Depression	2.825[d]	(2.369, 3.370)
Drug abuse	1.234[d]	(1.005, 1.516)
Alcohol abuse	3.220[d]	(2.169, 4.781)
Obesity	1.200	(0.969, 1.486)
Access-related factors		
MCO		
WellCare of Kentucky	1.000 (referent)	
Passport Health Plan	0.954	(0.761, 1.198)
Humana-CareSource	0.918	(0.657, 1.282)
Aetna Better Health of Kentucky	1.072	(0.895, 1.284)
Anthem BCBS Medicaid	0.704	(0.455, 1.089)
Insufficient prenatal care (ICD-9 code V23.7, 280 days prior through delivery)	0.697[d]	(0.545, 0.891)

[a] MMC members who were identified as smokers (i.e., defined by ICD-9 diagnosis code or smoking cessation benefit claim) who delivered a singleton live or non-live birth (excluding induced and spontaneous abortions) during June 1, 2014–May 31, 2015, continuously enrolled from 43 days prior to delivery through 56 days after delivery. Of the 7,606 members included, 792 had some smoking cessation benefit claim, while 6,814 members did not.
[b] Adjusted odds ratio (AOR) was generated using SAS software to conduct multiple logistic regression analysis for the odds of receipt of any smoking cessation benefit, i.e., pharmaceutical or counseling.
[c] Shows significantly decreased odds for receipt of any smoking cessation benefit among those with the characteristic/factor compared to those without the characteristic/factor (referent group).
[d] Shows significantly increased odds for receipt of any smoking cessation benefit prior to delivery among those with the characteristic/factor compared to those without the characteristic/factor (referent group).
CI: confidence interval; COPD: chronic obstructive pulmonary disease; MCO: managed care organization; BCBS: Blue Cross Blue Shield; ICD: International Classification of Diseases.

Perinatal Outcome Rates by Demographic and Clinical Characteristics, and Access-Related Factors

Table 4 presents demographic and clinical characteristics, as well as access-related factors, by perinatal outcome for the administrative analytic sample that includes both smokers and nonsmokers (excludes members with induced or spontaneous abortions; n = 24,391). Two perinatal outcomes were evaluated: preterm delivery and a composite indicator of adverse perinatal outcomes. There were 1,741 (7.14%) members with preterm delivery and 5,984 (24.53%)

members with the composite outcome, i.e., any one of placental abruption, placenta previa, SGA, still birth or preterm delivery. Notable findings are:

Demographic Characteristic Rates for Perinatal Outcomes

- Demographic characteristics were associated with the composite outcome, but not with the preterm delivery outcome.
- Among adolescents aged 11–19 years, 26.17% had the composite outcome, a higher percentage compared to older age groups. Compared to members residing in non-urban areas, a greater proportion of women residing in urban areas had the composite outcome (25.69%).

Clinical Characteristic Rates for Perinatal Outcomes

- Smokers had a higher rate of the composite outcome compared to nonsmokers (29.67% and 22.20%, respectively).
- Members with depression had a higher rate of the composite outcome compared to those without depression (26.70% and 24.33%, respectively).
- Members with drug abuse had a higher rate of the composite outcome compared to those without drug abuse (39.50% and 23.57%, respectively).
- Members with obesity had a lower rate of the composite outcome compared to those without obesity (21.87% and 24.95%, respectively).
- Smokers had a higher rate of preterm delivery compared to nonsmokers (8.74% and 6.41%, respectively).
- Members with depression had a higher rate of preterm delivery compared to members without depression (8.87% and 6.98%, respectively).
- Members with drug abuse had a higher rate of preterm delivery compared to members without drug abuse (11.86% and 6.83%, respectively).

Access-Related Factor Rates for Perinatal Outcomes

- Rates of the composite outcome varied significantly across MCO membership at the time of delivery, ranging from 22.99% to 27.01%.
- Members with a diagnosis of insufficient prenatal care had a higher rate of the composite outcome compared to members without this diagnosis (28.50% and 24.14%, respectively).
- Members with a diagnosis of insufficient prenatal care had a higher rate of preterm delivery compared to members without this diagnosis (10.57% and 6.80%, respectively).

Table 4: Analytic Sample of Smokers and Nonsmokers: Perinatal Outcome Rates

Total Population (n = 24,391)[a]	Preterm Delivery Outcome (n = 1,741; 7.14%) # (Row %)	Perinatal Composite Outcome[b] (n = 5,984; 24.53%) # (Row %)
Demographic characteristics		
Age group		[c]
11–19 years (3,244; 13.30%)	240 (7.40%)	849 (26.17%)
20–34 years (19,499; 79.94%)	1,378 (7.07%)	4,780 (24.51%)
35–44 years (1,581; 6.48%)	122 (7.72%)	353 (22.33%)
45–64 years (67; 0.27%)	1 (1.49%)	2 (2.99%)
Geographic area of residence		[c]
Appalachian (7,945; 32.57%)	561 (7.06%)	1,928 (24.27%)
Non-Appalachian – rural (4,316; 17.70%)	297 (6.88%)	943 (21.85%)
Non-Appalachian – urban (12,099; 49.60%)	881 (7.28%)	3,108 (25.69%)
Unknown (31; 0.13%)	2 (6.45%)	5 (16.13%)
Clinical characteristics		
Smoker (7,606; 31.18%)	665 (8.74%)[c]	2,257 (29.67%)[c]
Nonsmoker (16,785; 68.82%)	1,076 (6.41%)	3,727 (22.20%)
With depression (2,064; 8.46%)	183 (8.87%)[c]	551 (26.70%)[c]
Without depression (22,327; 91.54%)	1,558 (6.98%)	5,433 (24.33%)

Total Population (n = 24,391)[a]	Preterm Delivery Outcome (n = 1,741; 7.14%) # (Row %)	Perinatal Composite Outcome[b] (n = 5,984; 24.53%) # (Row %)
With drug abuse (1,476; 6.05%)	175 (11.86%)[c]	583 (39.50%)[c]
Without drug abuse (22,915; 93.95%)	1,566 (6.83%)	5,401 (23.57%)
With alcohol abuse (179; 0.73%)	12 (6.70%)	50 (27.93%)
Without alcohol abuse (24,212; 99.27%)	1,729 (7.14%)	5,934 (24.51%)
With obesity (3,265; 13.39%)	232 (7.11%)	714 (21.87%)[c]
Without obesity (21,126; 86.61%)	1,509 (7.14%)	5,270 (24.95%)
Access-related factors		
MCO		[c]
WellCare of Kentucky (8,857; 36.31%)	632 (7.14%)	2,036 (22.99%)
Passport Health Plan (5,550; 22.75%)	382 (6.88%)	1,499 (27.01%)
Humana-CareSource (1,831; 7.51%)	122 (6.66%)	446 (24.36%)
Aetna Better Health of Kentucky (7,026; 28.81%)	533 (7.59%)	1,738 (24.74%)
Anthem BCBS Medicaid (1,127; 4.62%)	72 (6.39%)	265 (23.51%)
Insufficient prenatal care (ICD-9 code V23.7, 280 days prior through delivery)[c]		
Yes (2,214; 9.08%)	234 (10.57%)	631 (28.50%)
No (22,177; 90.92%)	1,507 (6.80%)	5,353 (24.14%)

[a] MMC members who delivered a singleton live or non-live birth (excluding induced and spontaneous abortions) during June 1, 2014–May 31, 2015, continuously enrolled from 43 days prior through 56 days after delivery.
[b] The perinatal composite outcome included any one or more of placental abruption, placenta previa, small-for-gestational age (SGA), still birth or preterm delivery.
[c] Shows a statistically significant association with perinatal outcome based upon *chi*-squared test statistic (*P*-value < 0.05).
MCO: managed care organization; BCBS: Blue Cross Blue Shield; ICD: International Classification of Diseases.

Multiple Logistic Regression Findings for Perinatal Outcomes

Table 5 presents multiple logistic regression results for the associations between preterm delivery outcome or the composite indicator for adverse perinatal outcomes and risk factors. Findings for risk factors with statistically significant differences in the odds for the preterm delivery outcome and for the composite outcome are:

Demographic Characteristics Associated with Perinatal Outcomes

- Age group showed significant associations with the composite outcome, but not with preterm delivery. Compared to women aged 20–34 years, adolescent smokers were more likely to have the composite outcome (AOR = 1.175; 95% CI = 1.078, 1.280), whereas older women were less likely.
- Geographic area of residence showed significant association with the composite outcome, but not with preterm delivery. Compared to women residing in non-Appalachian urban counties, women residing in non-Appalachian rural counties were less likely to have the composite outcome (AOR = 0.819; 95% CI = 0.752, 0.893).

Clinical Characteristics Associated with Perinatal Outcomes

- Smoking: relative to nonsmokers, smokers were more likely to have the composite outcome (AOR = 1.389; 95% CI = 1.302, 1.482) and to deliver preterm (AOR = 1.270; 95% CI = 1.141, 1.413).
- Depression: relative to women without depression, women with depression were more likely to deliver preterm (AOR = 1.203; 95% CI = 1.021, 1.417); however, depression did not show increased odds for the composite outcome.
- Drug abuse: relative to women without drug abuse, women with drug abuse were more likely to deliver preterm (AOR = 1.550; 95% CI = 1.301, 1.847) and to have the composite outcome (AOR = 1.844; 95% CI = 1.646, 2.067).
- Obesity: relative to women without obesity, women with obesity were less likely to have the composite outcome (AOR = 0.825; 95% CI = 0.754, 0.903); however, a significant relationship was not observed with preterm delivery.

Access-Related Factors Associated with Perinatal Outcomes

- MCO: compared to the referent MCO (WellCare of Kentucky), two MCOs (Passport Health Plan and Aetna Better Health of Kentucky) showed higher odds for the composite outcome, with AORs ranging from 1.111 (95% CI = 1.031, 1.196) to 1.252 (95% CI = 1.152, 1.362); however, MCO membership was not associated with preterm delivery.
- Insufficient prenatal care: relative to women without a diagnosis of insufficient prenatal care, women with a diagnosis of insufficient prenatal care were more likely to deliver preterm (AOR = 1.473; 95% CI = 1.269, 1.710); however, insufficient prenatal care was not associated with the composite outcome.

Table 5: Analytic Sample of Smokers and Nonsmokers: Multiple Logistic Regression Results for Perinatal Outcomes

Total Population (n = 24,391)[a]	Preterm Delivery Outcome[a] AOR[c] (95% CI)	Perinatal Composite Outcome[a,b] AOR[c] (95% CI)
Demographic characteristics		
Age group		
11–19 years	1.109 (0.960, 1.281)	1.175 (1.078, 1.280)[d]
20–34 years	1.000 (referent)	1.000 (referent)
35–44 years	1.101 (0.907, 1.337)	0.882 (0.779, 0.999)[e]
45–64 years	0.207 (0.029, 1.491)	0.097 (0.024, 0.397)[e]
Geographic area of residence		
Appalachian	0.942 (0.836, 1.062)	0.941 (0.876, 1.011)
Non-Appalachian – rural	0.929 (0.807, 1.069)	0.819 (0.752, 0.893)[e]
Non-Appalachian – urban	1.000 (referent)	1.000 (referent)
Unknown	0.841 (0.199, 3.548)	0.544 (0.207, 1.429)
Clinical characteristics		
Smoker	1.270 (1.141, 1.413)[d]	1.389 (1.302, 1.482)[d]
Depression	1.203 (1.021, 1.417)[d]	1.034 (0.931, 1.148)
Drug abuse	1.550 (1.301, 1.847)[d]	1.844 (1.646, 2.067)[d]
Alcohol abuse	0.680 (0.375, 1.233)	0.874 (0.625, 1.222)
Obesity	0.990 (0.856, 1.145)	0.825 (0.754, 0.903)[e]
Access-related factors		
MCO		
WellCare of Kentucky	1.000 (referent)	1.000 (referent)
Passport Health Plan	0.942 (0.818, 1.085)	1.252 (1.152, 1.362)[d]
Humana-CareSource	0.921 (0.752, 1.130)	1.097 (0.972, 1.236)
Aetna Better Health of Kentucky	1.066 (0.945, 1.202)	1.111 (1.031, 1.196)[d]
Anthem BCBS Medicaid	0.908 (0.705, 1.169)	1.065 (0.919, 1.234)
Insufficient prenatal care (ICD-9 code V23.7, 280 days prior through delivery)	1.473 (1.269, 1.710)[d]	1.080 (0.977, 1.194)

[a] MMC members who delivered a singleton live or non-live birth (excluding induced and spontaneous abortions) during June 1, 2014-May 31, 2015, continuously enrolled from 43 days prior through 56 days after delivery. Of the 24,391 members in this analysis, 1,741 members had a preterm delivery outcome and 22,650 members did not, while 5,984 members had the composite outcome and 18,407 did not.

[b] The perinatal composite outcome included any one or more of placental abruption, placenta previa, small-for-gestational age (SGA), still birth or preterm delivery.

[c] Adjusted odds ratio (AOR) generated using SAS software to conduct multiple logistic regression analysis.

[d] Shows significantly increased odds for the outcome among those with the risk factor compared to those without the risk factor (referent group).

[e] Shows significantly decreased odds for the outcome among those with the risk factor compared to those without the risk factor (referent group).

CI: confidence interval; MCO: managed care organization; BCBS: Blue Cross Blue Shield; ICD: International Classification of Diseases.

Chart Review Findings

Coding practices for smoking status and smoking cessation interventions for pregnant women among Kentucky MMC providers are not known. In addition, MCO care management (CM) identification of pregnant smokers and care coordination for cessation services cannot be determined from administrative data. Therefore, a review of perinatal provider medical records for a sample of pregnant women in Kentucky MMC and any corresponding MCO CM records was conducted.

Chart Disposition

There were a total of 500 members for whom prenatal care provider, postpartum care provider and MCO CM charts were requested, based upon a random member sample stratified by MCO (n = 100) and by ICD-9–defined smokers (n = 50) and nonsmokers (n = 50; Table 6). There were a total of 424 members for whom at least one of the three chart types was received, but only 108 members had all three types of charts submitted (prenatal care provider, postpartum care provider and MCO CM charts). The number of prenatal care provider charts received that were valid for review was 349, the number of postpartum care provider charts received that were valid for review was 137, and the number of MCO CM charts received was 230.

The denominator of 230 CM charts included any CM submitted by the MCO that contained documentation for that member. Some of the submitted CM charts had very limited documentation, including statements such as "hospital delivery record received" or some type of notation by the CM such as "member not eligible for CM," without evidence of outreach to the member.

Prenatal care provider medical records for the members in the sample were reviewed to evaluate provider prenatal and postpartum identification of maternal smokers and interventions implemented to facilitate smoking cessation.

Prenatal care provider adherence to guidelines for assessment and management of maternal smokers, including the ACOG 5-A recommendations for smoking cessation during pregnancy, were assessed using the sample for which a prenatal care provider record was received (n = 349; Table 6). A prenatal record was considered valid for review if at least one prenatal visit, as defined by HEDIS specifications[1], was documented in the medical record during the review period. Trimester of prenatal visit was calculated based upon the estimated date of delivery abstracted from the chart.

[1]HEDIS specifications for prenatal care visit to an obstetrician/gynecologist or PCP with diagnosis of pregnancy: medical record must include the date and *one* of the following: (1) a basic physical obstetrical exam that includes auscultation for fetal heart tone, *or* pelvic exam with obstetric observations, *or* measurement of fundus height; (2) evidence a prenatal care procedure was performed: screening test in the form of an obstetric panel, *or* TORCH antibody panel alone, *or* a rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, *or* echography of a pregnant uterus; (3) documentation of LMP or EDD in conjunction with *either* prenatal risk assessment and counseling/education *or* complete obstetrical history.

Table 6: Chart Disposition

MCO	Charts Requested	Valid Charts Received							Charts Excluded	Prenatal Chart Retrieval Rate[f]	Total Member Chart Retrieval Rate[f]
		Prenatal	Postpartum[a]	Case Management[b]	All Three	Prenatal Study Sample[c]	Prenatal Study Reported Subset[d]	Final Study Sample[e]			
Anthem BCBS Medicaid	100	71	30	63	28	71	67	90	0	71%	90%
Aetna Better Health of Kentucky[g]	100	59	20	37	9	58	55	72	1[h]	59%	72%
Humana-CareSource	100	75	31	11	8	75	69	79	0	75%	79%
Passport Health Plan	100	88	29	85	48	88	84	95	0	88%	95%
WellCare of Kentucky	100	79	27	34	15	79	74	88	0	79%	88%
Total	500	372	137	230	108	371	349	424	1	74%	85%

[a] Postpartum excludes 221 provider records submitted for the postpartum care provider record request that were submitted without documentation of a postpartum assessment (n = 91) or visit (n = 130).
[b] This sample includes all MCO records with member specific documentation, including records documenting that member was not eligible for CM, and therefore with no outreach documented.
[c] Prenatal study sample includes members for whom at least a prenatal chart was received.
[d] Prenatal reported subset includes prenatal study sample (for whom at least a prenatal chart was received) and excluding those members with spontaneous abortion or ectopic pregnancy as documented in the chart.
[e] Final sample includes members for whom at least one of the three charts was received.
[f] Chart retrieval rate = number of valid charts received / (number of charts requested – number of charts excluded).
[g] Aetna Better Health of Kentucky operated as CoventryCares of Kentucky when the data were requested/submitted.
[h] Exclusion for one prenatal medical record received because only an ultrasound was provided for member.
MCO: managed care organization; BCBS: Blue Cross Blue Shield.

Characteristics of the Chart Review Sample

Table 7 presents characteristics of the chart review sample, with findings summarized as follows:

- Among the entire chart review sample, there were 172 members (40.57%) identified as smokers by chart review; however, 216 members (50.94%) were identified as smokers by administrative data using ICD-9 diagnosis and claims for smoking cessation benefits.
- Women aged 20–34 years comprised the majority of the chart review sample (84.20%).
- White women comprised most of the sample (42.92%), followed by the "other" race/ethnicity category (32.78%), black/non-Hispanic (7.78%) and race/ethnicity "not provided" (6.13%).

Table 7: Chart Review Sample Characteristics

Total Charts Received (n = 424)	Smoker Based on Chart[a] (n = 172; 40.57%) # (Column %)	Nonsmoker Based on Chart[a] (n = 252; 59.43%) # (Column %)
Smoker based on administrative analysis[b] (n = 216; 50.94%)	148 (86.05%)	68 (26.98%)
Age group		
11–19 years (n = 45; 10.61%)	11 (6.40%)	34 (13.49%)
20–34 years (n = 357; 84.20%)	154 (89.53%)	203 (80.56%)
35–44 years (n = 22; 5.19%)	7 (4.07%)	15 (5.95%)
Race/Ethnicity[c]		
American Indian or Alaskan Native (n = 1; 0.24%)	1 (0.58%)	0
Asian or Pacific Islander (n = 3; 0.71%)	1 (0.58%)	2 (0.79%)
Black/Non-Hispanic (n = 33; 7.78%)	10 (5.81%)	23 (9.13%)
Black/Not otherwise specified (n = 5; 1.18%)	1 (0.58%)	4 (1.59%)
White/Non-Hispanic (n = 182; 42.92%)	86 (50.00%)	96 (38.10%)
White/Not otherwise specified (n = 30; 7.08%)	13 (7.56%)	17 (6.75%)
Hispanic (n = 3; 0.71%)	1 (0.58%)	2 (0.79%)
Bi-racial (n = 2; 0.47%)	1 (0.58%)	1 (0.40%)
Other (n = 139; 32.78%)	51 (29.65%)	88 (34.92%)
Not provided (n = 26; 6.13%)	7 (4.07%)	19 (7.54%)

[a] Members were documented as a prenatal smoker by prenatal care provider or, if no prenatal chart was received but a case management chart was received, then members were documented as prenatal smokers by the case manager. If no documentation of smoking status in either, then administrative data was used to identify smoking status.

[b] Members were identified as smokers in the administrative analysis if there was an ICD-9 diagnosis code for any encounter during the 280 days prior to delivery or if there was a pharmacy claim or counseling claim for smoking cessation benefit during the 280 days prior to delivery; however, the sample selection was based upon ICD-9 diagnosis code, only, with 50 smokers and 50 nonsmokers randomly selected from each MCO.

[c] Race/Ethnicity was abstracted from the prenatal care provider chart, but if not documented, then race/ethnicity was obtained from the administrative database.

Table 8 presents prenatal chart review findings overall and for the subset that excludes members with diagnoses indicative of gestation periods less than 20 weeks, e.g., either spontaneous abortion or ectopic pregnancy, as determined from chart review. Findings for the sample that excludes women with spontaneous abortions or ectopic pregnancy are as follows:

- Most members' first prenatal visit occurred during the first trimester (199/349 = 57.02%).
- The majority of members were assessed for smoking status during a prenatal visit (89.97%); however, only 49.28% had an initial smoking assessment conducted at a first prenatal visit that occurred during the first trimester.
- Only 6.88% of pregnant members were assessed for secondhand smoke exposure by the prenatal care provider.
- Less than half (46.98%) of prenatal smokers were advised to quit at any prenatal visit, 22.15% were advised to quit during the first trimester and 16.11% during the second trimester.
- Only 2.01% of prenatal smokers were referred to the Kentucky quit line.

The pregnant former-smoker subsample was comprised of 30 members.

- Eight of thirty (26.67%) of pregnant former smokers had their smoking status monitored at one or more prenatal follow-up visits.

Table 8: Prenatal Chart Review – Provider Adherence to Recommendations for Smoking Cessation During Pregnancy

Adherence to Recommendations[a]	Prenatal Charts Received[b] (n = 349) N/D (% Column)
Timing of first prenatal visit	
1st trimester	199/349 (57.02%)
2nd trimester	100/349 (28.65%)
3rd trimester	50/349 (14.33%)
Did the provider ASK about smoking status during the prenatal period?	
No smoking assessment conducted at any prenatal visit	35/349 (10.03%)
Yes, initial smoking assessment conducted at any prenatal visit	314/349 (89.97%)
Initial smoking assessment conducted at:	
First prenatal visit	288/349 (82.52%)
First prenatal visit: 1st trimester	172/349 (49.28%)
First prenatal visit: 2nd trimester	84/349 (24.07%)
First prenatal visit: 3rd trimester	32/349 (9.17%)
Any subsequent visit	26/349 (7.45%)
Subsequent visit: 1st trimester	0
Subsequent visit: 2nd trimester	12/349 (3.44%)
Subsequent visit: 3rd trimester	14/349 (4.01%)
Did the provider ASK about secondhand smoke exposure during the prenatal period?	
Any prenatal assessment of secondhand smoke exposure	24/349 (6.88%)
Members with secondhand smoke exposure among those assessed for secondhand smoke exposure	17/24 (70.83%)
Smoker subsample	149
Did the provider ADVISE the member to quit smoking during the prenatal period?	
Advised to quit at any prenatal visit	70/149 (46.98%)
Provider first advised member to quit smoking:	
1st trimester	33/149 (22.15%)
2nd trimester	24/149 (16.11%)
3rd trimester	8/149 (5.37%)
Undetermined trimester	5/149 (3.36%)
Did not advise member to quit at any prenatal visit	79/149 (53.02%)
Did the provider ASSESS the member's willingness to quit smoking during the prenatal period?	
Provider did not assess willingness to quit at any prenatal visit	129/149 (86.58%)
Provider did assess willingness to quit at any prenatal visit	20/149 (13.42%)
Member had a plan to quit within 30 days	1/20 (5.00%)
Member had a plan to quit, but no plans for next 30 days	1/20 (5.00%)
Member did not have a plan to quit	18/20 (90.00%)
Did the provider ASSIST with or ARRANGE for any prenatal smoking cessation interventions?	
No prenatal smoking cessation provider interventions	60/149 (40.27%)
Yes, provider arranged for or assisted with any smoking cessation intervention	89/149 (59.73%)
Any specific smoking cessation interventions arranged for member by provider	60/149 (40.27%)

Adherence to Recommendations[a]	Prenatal Charts Received[b] (n = 349) N/D (% Column)
Specific smoking cessation interventions arranged:	
Referral to Kentucky quit line	3/149 (2.01%)
Perinatal provider counseling[c]	57/149 (38.26%)
Counseling session with health educator	3/149 (2.01%)
Referral to other cessation program	1/149 (0.67%)
Pharmacotherapy	0
Refer to PCP	0
Any general smoking cessation assistance by provider	43/149 (28.86%)
General smoking cessation assistance:	
Encourage member to talk about process for quitting	43/149 (28.86%)
Support, e.g., discussed importance of quitting "buddy"	1/149 (0.67%)
Self-help, e.g., brochure	0
Smoking status monitored at 1+ follow-up prenatal visit	59/149 (39.60%)
Smoking status monitored at 1+ follow-up telephone call during prenatal period	0
Former-smoker subsample	30
Smoking status monitored at 1+ follow-up prenatal visit	8/30 (26.67%)

[a] ACOG (2010) recommendations, sometimes referred to as "the 5 A's," for smoking cessation during pregnancy, were adapted for data abstraction, and included the following key elements: (1) Ask about smoking status at the first prenatal visit; (2) Advise smoking cessation by providing clear, strong and personalized messages; (3) Assess the patient's willingness to attempt smoking cessation within the next 30 days; (4) Arrange specific smoking cessation interventions; (5) Assist patients who express an interest in quitting by providing general smoking cessation support/guidance.
[b] This table reports prenatal care provider chart review findings for the chart review sample with a prenatal care provider chart, excluding women with a spontaneous abortion or ectopic pregnancy (n = 22). The intent was to report for the subset with a more comparable prenatal period because women with a spontaneous abortion or ectopic pregnancy would have had less opportunity for prenatal visits due to the shortened prenatal period, e.g., delivery prior to 20 weeks gestation.
[c] This was the only intervention arranged by the provider received by members with successful smoking abstinence during the prenatal period through delivery.
N: numerator; D: denominator; PCP: primary care provider.

Table 9 presents specific prenatal care provider interventions and smoking abstinence outcomes among the subset of members who received prenatal care provider counseling and who did not have the outcomes of either spontaneous abortion or ectopic pregnancy. Findings for this analysis are as follows:

- There were 57 of 149 members (38.26%) who received prenatal care provider counseling.
  - Of these 57 members, medical record documentation indicated that a total of 5 members quit smoking during pregnancy; 2 quit smoking with abstinence from the first trimester through delivery, 1 abstained from the second trimester through delivery, and 2 abstained from the third trimester through delivery.
  - More than half (31/57; 54.39%) of these members had at least one follow-up visit that addressed smoking status and 22.81% were encouraged by the provider to talk about the process of quitting.
  - Advice regarding the risks to the fetus was received by 17.54% of these 57 members, and 8.77% received advice regarding the risks to the newborn.

Table 9: Prenatal Care Provider Interventions and Smoking Abstinence Outcomes

Provider Advice, Follow-up Received	N/D (% Smokers with Counseling)[a]	Achieved Smoking Abstinence Through Delivery by Trimester of Initiation[b]		
		1st trimester	2nd trimester	3rd trimester
Received prenatal care provider counseling	57/57 (100%)[c]	2[d]	1[e]	2[f]
Received the following provider advice or follow-up				
Provider follow-up visit	31/57 (54.39%)[g]	0	1	2
Provider encouraged member to talk about the process of quitting	13/57 (22.81%)	0	1	1
Advice regarding risks to fetus	10/57 (17.54%)	0	0	0
Advice regarding risks to newborn	5/57 (8.77%)	0	0	0
Advice regarding risks to mother	2/57 (3.51%)	0	0	0
Referral to Kentucky quit line	3/57 (5.26%)	0	0	0
Counseling by a health educator	1/57 (1.75%)	0	0	0
Support[h]	1/57 (1.75%)	0	0	0
Discussed roadblock of being around other smokers	1/57 (1.75%)	0	0	0
None of the above	2/57 (3.51%)	2	0	0

[a] Restricted to subsample without spontaneous abortion or ectopic pregnancy.
[b] There were 57 members (38.26%) among the 149 smokers who received prenatal care provider counseling for smoking cessation. Of these 57 members, 5 members (8.77%) achieved smoking abstinence during the prenatal period. None of the remaining interventions (i.e., smoking cessation counseling by a health educator, smoking cessation medication, referral to Kentucky quit line, referral to other smoking cessation program, referral to other provider, referral to primary care provider) were received by members with reported smoking abstinence through delivery.
[c] One member did not quit during prenatal period, but did quit prior to first postpartum visit.
[d] Both members quit when they learned that they were pregnant and did receive counseling during the 1st trimester; 1 member relapsed during postpartum.
[e] Member received counseling during the 1st and 2nd trimesters; had no postpartum record.
[f] Both members received counseling during the 2nd trimester, and one also received counseling in the 3rd trimester; neither had any postpartum records.
[g] This includes member who quit prior to first postpartum visit. Counting this member, there were three members reporting at the first postpartum visit that they quit smoking postpartum. An additional member who quit prior to the postpartum visit received follow-up prenatal care but not perinatal provider counseling for smoking cessation. A third member also quit smoking prior to the first postpartum visit, but had no prenatal chart. These three members are categorized as former smokers in the postpartum chart analysis presented in Table 10.
[h] Examples of support: importance of smoke-free spaces at home and seeking out a "quitting buddy."
N: numerator; D: denominator.

Table 10 presents findings from the subsample with a postpartum chart. Of the total 228 postpartum records received, 91 (39.91%) did not have a smoking assessment documented by the provider. A total of 137 (60.09%) postpartum records (including 4 members without a prenatal chart) were considered valid for review of provider smoking interventions as they had at least one postpartum visit, as defined by HEDIS[2], and included a provider smoking assessment documented in the review period.

- Most members (126/137; 92.07%) were asked about smoking status by their provider at their first postpartum visit; 11 members had a smoking assessment at a subsequent postpartum visit. A lesser percentage (20.44%) had secondhand smoke exposure assessed at a postpartum visit.

[2] HEDIS specifications for postpartum visit to an obstetrician/gynecologist practitioner or midwife, family practitioner or other PCP on or between 21 and 56 days after delivery: medical record must include the date and *one* of the following: (1) pelvic exam; (2) evaluation of weight, blood pressure, breasts and abdomen; and/or (3) notation of postpartum care, including, but not limited to notation of "postpartum care," "PP care," "PP check," "6-week check," *or* a preprinted "postpartum care" form in which information was documented during the visit

- A total of 31.39% (43/137) reported smoking the same amount as prior to or during pregnancy.
- Three members reported to the postpartum care provider that they quit postpartum, but there was no documentation that the provider congratulated or otherwise reinforced smoking cessation.
- Slightly more than one third (15/43, 34.88%) had smoking status monitored at one or more visits following the initial postpartum visit.

Among the postpartum smokers subsample (n = 43; Table 10), the following findings apply to the postpartum period:

- There were no postpartum smoking cessation provider interventions for the majority of the postpartum smoker subset (83.72%).
- Five (11.63%) postpartum smokers were encouraged to talk about the process for quitting.
- Only four postpartum smokers (9.30%) were asked whether they had a plan to quit, and only one had a plan to quit.
- Five postpartum smokers were advised to quit, and three members (6.98%) received other smoking cessation counseling at the postpartum visit.
- None of the postpartum smokers were referred to the Kentucky quit line.
- Among the 15 members with smoking assessed at a follow-up postpartum visit (and therefore, an opportunity for the postpartum provider to have documented smoking abstinence), there were no members who reported quitting.

There were 27 members in the postpartum subsample of members who were identified as former smokers. Former smokers include 3 members whose smoking status was assessed by the postpartum provider as having quit postpartum, as well as 24 members identified by the prenatal provider as former smokers (Table 10).

- Three (11.11%) of the 27 former smokers had their smoking status monitored at one or more postpartum follow-up visits.

Table 10: Postpartum Chart Review – Provider Adherence to Recommendations for Smoking Cessation During Pregnancy

Adherence to Recommendations[a,b]	N/D (%)
Total postpartum charts received	228/228 (100.00%)
Postpartum charts without a documented smoking assessment	91/228 (39.91%)
Postpartum charts received with smoking assessment	137/228 (60.09%)[c]
Postpartum care provider asked about smoking status at first postpartum visit	126/137 (92.07%)
Postpartum care provider asked about smoking status at a visit subsequent to first postpartum visit	11/137 (8.0%)
Postpartum care provider asked about exposure to secondhand smoke	28/137 (20.44%)
Members with secondhand smoke exposure	7/28 (25.00%)
Members who reported at postpartum visit that they quit smoking postpartum	3/137 (2.19%)
Members who reported quitting postpartum who were congratulated by provider	0
Members who reported at postpartum visit that they are smoking the same amount as before	43/137 (31.39%)[d]
Prenatal smokers with both a prenatal and postpartum chart and who reported at postpartum visit that they are smoking the same amount as before	36/53 (67.92%)[e]
Postpartum smokers subsample	43/137 (31.39%)
Provider asked if member had plan to quit	4/43 (9.30%)
Member had a plan to quit	1/4 (25%)
Provider advised the member to quit	5/43 (11.63%)
Members who quit smoking postpartum subsequent to provider smoking assessment	0
No postpartum smoking cessation provider interventions	36/43 (83.72%)
Any specific postpartum smoking cessation interventions arranged for member by provider	3/43 (6.98%)
Specific postpartum smoking cessation interventions arranged:	
Referral to Kentucky quit line	0
Perinatal provider counseling	3/43 (6.98%)
Counseling session with health educator	0
Referral to other cessation program	0
Pharmacotherapy	0
Refer to PCP	0

Adherence to Recommendations[a,b]	N/D (%)
Any general postpartum smoking cessation assistance by provider	6/43 (13.95%)
General postpartum smoking cessation assistance:	
Encourage member to talk about process for quitting	5/43 (11.63%)
Support[f]	1/43 (2.33%)
Self-help, e.g., brochure	0
Smoking status monitored at 1+ follow-up postpartum visit	15/43 (34.88%)
Smoking status monitored at 1+ follow-up telephone call during postpartum period	0
Members who reported quitting smoking at a follow-up postpartum visit or telephone call	0
Former-smoker subsample[g]	27
Smoking status monitored at 1+ follow-up postpartum visit	3/27 (11.11%)

[a] ACOG (2010) recommendations, sometimes referred to as "the 5 A's," for smoking cessation during pregnancy, were adapted for data abstraction, and included the following key elements: (1) Ask about smoking status at the first prenatal visit; (2) Advise smoking cessation by providing clear, strong and personalized messages; (3) Assess the patient's willingness to attempt smoking cessation within the next 30 days; (4) Arrange specific smoking cessation interventions; (5) Assist patients who express an interest in quitting by providing general smoking cessation support/guidance.
[b] One smoker with spontaneous abortion is included in this table.
[c] This numerator included four members without a prenatal chart.
[d] Of the 137 members with documentation of a postpartum smoking assessment, 43 reported smoking the same amount as before.
[e] A total of 53 prenatal smokers had both a prenatal and a postpartum chart with a documented smoking assessment Of these 53 members, 36 reported at a postpartum visit that they smoke the same amount as before.
[f] Examples of support: importance of smoke-free spaces at home and seeking out a "quitting buddy."
[g] Former smokers include 3 members whose smoking status was assessed by the postpartum care provider as having quit postpartum, as well as 24 members identified by the prenatal care provider as former smokers.
N: numerator; D: denominator; PCP: primary care provider.

Tables 11, 12, 13 and 14 present findings abstracted from MCO CM records (n = 230). Key findings are highlighted below for smokers and nonsmokers, combined.

- About half (53.04%) of members with a CM record were asked about their smoking status. Only 3.48% were assessed for secondhand smoke exposure (Table 11).
- Adolescents comprised 10% of the MCO CM chart review sample (Table 11). Of the 5 adolescent smokers, none were engaged with CM for smoking cessation and 1 received care coordination for smoking cessation (data not shown).
- Women with asthma comprised almost 10% of the MCO CM chart review sample (9.57%; Table 11). Of the 8 women with asthma who were smokers, none were engaged with CM for smoking cessation and 3 received care coordination for smoking cessation (data not shown).
- Women with a diagnosis of drug abuse comprised 8.26% of the MCO CM chart review sample (Table 11). Of the 13 women with drug abuse who were smokers, none were engaged with CM for smoking cessation and 4 received care coordination for smoking cessation (data not shown).
- Women with a diagnosis of depression comprised 7.83% of the MCO CM chart review sample (Table 11). Of the 10 women with depression who were smokers, none were engaged with CM for smoking cessation and 3 received care coordination for smoking cessation (data not shown).
- About 17% of members did not receive CM outreach (Table 12). Corresponding MCO-specific rates for lack of any CM outreach ranged from 0% to 35.14% (Table 13).
- MCO-specific smoking assessment rates ranged from 32.43% to 82.54% (Table 13).
- Only 9.57% were outreached for any purpose during the first trimester, 29.57% were outreached during the second trimester and 30.43% were outreached during the third trimester (Table 12).
- Only 5.65% were outreached for any purpose during the delivery hospitalization, whereas 38.26% were outreached during the postpartum period (Table 12).

Table 11: MCO CM Chart Review – Identification of Smokers by CM Staff and Provider

Smoker Identification	n (%)
MCO charts received	230 (100.00%)
Age group	
11–19 years	23 (10%)
20–34 years	198 (86.09%)
35–44 years	9 (3.91%)
Health conditions	
Asthma	22 (9.57%)
COPD (excluding asthma)	5 (2.17%)
Depression	18 (7.83%)
Drug abuse	19 (8.26%)
Alcohol abuse	2 (0.87%)
CM staff asked about smoking status	122 (53.04%)
Members identified by CM staff as current smokers[a]	48 (20.87%)
Current smokers as identified by provider[b]	96 (41.74%)
CM staff asked about exposure to secondhand smoke	8 (3.48%)
Members identified by CM staff with secondhand smoke exposure	1 (0.43%)
Members identified by provider with secondhand smoke exposure	12 (5.22%)

[a] Members identified by care management (CM) staff as smoking during current pregnancy. This includes four members identified as smokers by the CM staff, but as never- or former-smokers by the provider.

[b] Members identified by prenatal care provider as smoker, as well as members without a prenatal chart who were identified by CM as smoker, as in Table 7, restricted to managed care organization (MCO) chart subsample. This does not include the four members identified as either never- or former-smokers by the provider, but who were identified as smokers by the CM staff.

Of the 230 members with MCO CM records, 48 members were identified as smokers by care managers (CM-identified smokers), whereas 96 were identified as smokers by the prenatal care provider (provider-identified smokers; Table 11). The results for CM- and provider-identified smokers are presented in Table 12 and key findings are as follows:

- Among CM-identified smokers, 22.92% were outreached for any purpose during the first trimester. However, among the provider-identified smokers, the corresponding percentage was 15.63%.
- Among CM-identified smokers, 45.83% were outreached for any purpose during the second trimester. However, among the provider-identified smokers, the corresponding percentage was 36.46%.
- Among CM-identified smokers, 39.58% were outreached for any purpose during the third trimester. However, among the provider-identified smokers, the corresponding percentage was 26.04%.
- Among CM-identified smokers, 31.25% were outreached for any purpose during the postpartum period, with a comparable proportion (34.38%) of provider-identified smokers outreached postpartum.
- Among the provider-identified smokers, 14.58% received no CM outreach.

Table 12: MCO CM Chart Review – Perinatal CM Outreach, Contact, Engagement and Interventions

CM Outreach, Contact, Engagement and Interventions: Smoker Subsamples[a]	MCO Chart Subsample (n = 230)	CM-Identified Smoker Subsample[b] (n = 48)	Provider-Identified Smoker Subsample[c] (n = 96)
Any CM outreach			
Prenatal – 1st trimester	22 (9.57%)	11 (22.92%)	15 (15.63%)
Prenatal – 2nd trimester	68 (29.57%)	22 (45.83%)	35 (36.46%)
Prenatal – 3rd trimester	70 (30.43%)	19 (39.58%)	25 (26.04%)
Prenatal – unable to determine trimester	9 (3.91%)	1 (2.08%)	3 (3.13%)
Delivery hospitalization	13 (5.65%)	2 (4.17%)	6 (6.25%)
Postpartum	88 (38.26%)	15 (31.25%)	33 (34.38%)
No CM outreach	39 (16.96%)	0	14 (14.58%)
CM staff contacted member regarding smoking cessation		25 (52.08%)	24 (25.00%)
Prenatal – 1st trimester		4 (8.33%)	4 (4.17%)
Prenatal – 2nd trimester		11 (22.92%)	10 (10.42%)
Prenatal – 3rd trimester		10 (20.83%)	7 (7.29%)
Prenatal – unable to determine trimester		0	0
Delivery hospitalization		1 (2.08%)	1 (1.04%)
Postpartum		6 (12.50%)	6 (6.25%)
No CM outreach		23 (47.92%)	72 (75.00%)
CM staff engaged member regarding smoking cessation		3 (6.25%)	1 (1.04%)
Prenatal – 1st trimester		1 (2.08%)	1 (1.04%)
Prenatal – 2nd trimester		1 (2.08%)	0
Prenatal – 3rd trimester		1 (2.08%)	0
Prenatal – unable to determine trimester		0	0
Delivery hospitalization		0	0
Postpartum		0	0
No CM outreach		45 (93.75%)	95 (98.96%)
No CM engagement, but care coordination was offered[d]		18 (37.50%)	17 (17.71%)
No CM engagement and no care coordination was offered[e]		27 (56.25%)	78 (81.25%)
CM staff notified provider of member's smoking status		0	0
CM staff coordinated smoking cessation interventions with provider		0	0
CM facilitated referrals to the Kentucky quit line during the prenatal period		8 (16.67%)	8 (8.33%)
1st trimester		2 (4.17%)	2 (2.08%)
2nd trimester		5 (10.42%)	5 (5.21%)
3rd trimester		1 (2.08%)	1 (1.04%)
CM staff facilitated referrals to smoking cessation counseling provider during the prenatal period		4 (8.33%)	4 (4.17%)
1st trimester		1 (2.08%)	1 (1.04%)
2nd trimester		2 (4.17%)	2 (2.08%)
3rd trimester		1 (2.08%)	1 (1.04%)
Any CM-facilitated referral regarding smoking cessation during the prenatal period		10 (20.83%)	10 (10.42%)
Any CM-facilitated referral regarding smoking cessation during delivery		4 (8.33%)	4 (4.17%)
Any CM-facilitated referral regarding smoking cessation during the		0	0

CM Outreach, Contact, Engagement and Interventions: Smoker Subsamples[a]	MCO Chart Subsample (n = 230)	CM-Identified Smoker Subsample[b] (n = 48)	Provider-Identified Smoker Subsample[c] (n = 96)
postpartum period			
Smoking cessation services received by the member (as documented in MCO chart)		4 (8.33%)	4 (4.17%)
Kentucky quit line services received		2 (4.17%)	2 (2.08%)
Counseling provider services received		2 (4.17%)	2 (2.08%)
CM staff documented that member initiated a quit attempt		0	0
Prenatal care provider chart documented successful quit attempt		2 (4.17%)	2 (2.08%)

[a] Five members with spontaneous abortion, including one smoker, are included in this table.
[b] Members identified by care management (CM) staff as smoking during current pregnancy. This includes four members identified as smokers by the CM staff, but as never- or former-smokers by the provider.
[c] Members identified by prenatal care provider as smoker, as well as members without a prenatal chart who were identified by CM as smoker, as in Table 7, restricted to managed care organization (MCO) chart subsample. This does not include the four members identified as either never- or former-smokers by the provider, but who were identified as smokers by the CM staff.
[d] Member refused care coordination for smoking cessation; or there was documentation of a discussion of cessation options without documentation of member agreeing to cessation services; or there was documentation of coordination of referrals for smoking cessation without member's documented consent.
[e] Neither CM coordination nor engagement for smoking cessation was documented.

Key findings regarding CM member contact, engagement and care coordination for smoking cessation are as follows:

- Among CM-identified smokers, about half (52.08%) were contacted by the care manager and smoking cessation was discussed. However, only one-fourth of provider-identified smokers were contacted by the care manager regarding smoking cessation (Table 12).
- MCO-specific rates ranged from 0% to 100% (4/4), and contact volumes ranged as high as 13 members (Table 14).
- Only four smokers were contacted by the care manager and smoking cessation discussed during the first trimester. This represents 8.33% of CM-identified smokers and 4.17% of provider-identified smokers (Table 12).
- Among CM-identified smokers, 22.92% were contacted and smoking cessation discussed during the second trimester and about one-fifth (20.83%) during the third trimester. Corresponding percentages among provider-identified smokers were 10.42% and 7.29%, respectively (Table 12).
- Among CM-identified smokers, 93.75% were not engaged in CM for smoking cessation (documentation that member agreed to CM smoking cessation services or documented receipt of smoking cessation services). The corresponding proportion among provider-identified smokers was 98.96% (Table 12).
- Among the CM-identified smokers not engaged in CM for smoking cessation, 37.50% were offered care coordination for smoking cessation , but there was no documentation that member was engaged in smoking cessation services. However, the corresponding proportion among provider-identified smokers was 17.71% (Table 12). Corresponding MCO-specific rates ranged from 16.67% to 75.00% (Table 14).
- None of the members' providers were contacted by CM staff to either provide notification of the member's smoking status or to coordinate smoking cessation interventions with the provider (Table 12).

Table 13: MCO CM Chart Review – Perinatal CM Outreach by MCO

CM Outreach	MCO				
	WellCare of Kentucky N/D (%)	Passport Health Plan N/D (%)	Humana-CareSource N/D (%)	Aetna Better Health of Kentucky N/D (%)	Anthem BCBS Medicaid N/D (%)
MCO CM charts (n = 230)	34/230 (14.78%)	85/230 (36.96%)	11/230 (4.78%)	37/230 (16.09%)	63/230 (27.39%)
CM staff asked about smoking status	18/34 (52.94%)	36/85 (42.35%)	4/11 (36.36%)	12/37 (32.43%)	52/63 (82.54%)
Any CM outreach, not limited to smoking cessation	31/34 (91.18%)	67/85 (78.82%)	11/11 (100%)	24/37 (64.86%)	58/63 (92.06%)
Prenatal – 1st trimester	5/34 (14.71%)	2/85 (2.35%)	0	2/37 (5.41%)	13/63 (20.63%)
Prenatal – 2nd trimester	8/34 (23.53%)	23/85 (27.06%)	4/11 (36.36%)	6/37 (16.22%)	27/63 (42.86%)
Prenatal – 3rd trimester	5/34 (14.71%)	30/85 (35.29%)	1/11 (9.09%)	13/37 (35.14%)	21/63 (33.33%)
Prenatal – unable to determine trimester	2/34 (5.88%)	4/85 (4.71%)	1/11 (9.09%)	1/37 (2.70%)	1/63 (1.59%)
Delivery hospitalization	0	7/85 (8.24%)	4/11 (36.36%)	1/37 (2.70%)	1/63 (1.59%)
Postpartum	14/34 (41.18%)	46/85 (54.12%)	7/11 (63.64%)	15/37 (40.54%)	6/63 (9.52%)
No CM outreach of any kind	3/34 (8.82%)	18/85 (21.18%)	0	13/37 (35.14%)	5/63 (7.94%)

CM: care management; MCO: managed care organization; BCBS: Blue Cross Blue Shield; N: numerator; D: denominator.

Key findings regarding CM-facilitated referrals for smoking cessation are as follows:

- CM staff facilitated 10 referrals regarding smoking cessation during the prenatal period; this represents 20.83% of CM-identified smokers, but only 10.42% of provider-identified smokers (Table 12).
- CM staff facilitated referrals to the Kentucky quit line during the prenatal period for 8 of 48 (16.67%) CM-identified smokers and 8 of 96 (8.33%) of the provider-identified smokers (Table 12). Most of these referrals (7/8; 87.50%) were attributable to one MCO (Anthem BCBS Medicaid; Table 14).
- Only two referrals to the Kentucky quit line were made during the first trimester, with most (five) made during the second trimester (Table 12).
- Only two members had documentation reflecting receipt of smoking cessation services from the Kentucky quit line (Table 12).
- CM staff facilitated four referrals to a smoking cessation counseling provider during the prenatal period, with only one referral made during the first trimester (Table 12).
- Only two members received services from the smoking cessation counseling provider (Table 12).
- No CM-identified smokers had documentation of a quit attempt, although there were two members in CM who had provider-documented successful quit attempts (Table 12).
- None of the CM- or provider-identified smokers had CM documentation of postpartum CM smoking cessation services or coordination (Table 12).

Table 14: MCO Chart Review of CM-Identified Prenatal Smokers – CM Contact, Engagement and Interventions by MCO

CM Contact, Engagement and Interventions: CM-Identified Prenatal Smokers (n = 48)	WellCare of Kentucky (n = 8)	Passport Health Plan (n = 12)	Humana-CareSource (n = 2)	Aetna Better Health of Kentucky (n = 4)	Anthem BCBS Medicaid (n = 22)
CM contact with member regarding smoking cessation – any time during perinatal period	5 (62.50%)	3 (25.00%)	0	4 (100.00%)	13 (59.09%)
CM 1st trimester contact with member regarding smoking cessation	0	0	0	2 (50.00%)	2 (9.09%)
Any CM prenatal contact with member regarding smoking cessation	4 (50.00%)	2 (16.67%)	0	4 (100.00%)	13 (59.09%)
CM postpartum contact with member regarding smoking cessation	2 (25.00%)	2 (16.67%)	0	1 (25.00%)	1 (4.55%)
CM contact with prenatal care provider regarding smoking cessation	0	1 (8.33%)	0	0	2 (9.09%)
CM contact with postpartum care provider regarding smoking cessation	0	0	0	0	0
CM coordination with provider for smoking cessation interventions	0	0	0	0	0
Member engagement with CM regarding prenatal smoking cessation	0	1 (8.33%)	0	1 (25.00%)	1 (4.55%)
No CM engagement, but care coordination was offered	3 (37.50%)	2 (16.67%)	1 (50%)	3 (75.00%)	9 (40.91%)
CM referred member to Kentucky quit line	0	0	0	1 (25.00%)[a]	7 (31.82%)[b]
CM referred member to smoking cessation counselor	1 (12.5%)[a]	0	0	1 (25.00%)[c]	2 (9.09%)[d]
CM referred member to other smoking cessation service/program	3 (37.50%)[e]	1 (8.33%)[a,f]	0	2 (50.00%)[a,g]	2 (9.09%)[d,h]
Prenatal care provider documented smoking cessation success	0	1 (8.33%)[d]	0	0	0
Postpartum care provider documented smoking cessation success	0	0	0	0	0

[a] Third trimester.
[b] Two in the first trimester and five in the second trimester.
[c] First trimester.
[d] Second trimester.
[e] Two in the second trimester and one in the third trimester. Included: referral to CM for smoking, smoking cessation resources, and smoking packet provided.
[f] Included: secondhand smoke information.
[g] Included: Krames literature on smoking during pregnancy and "not specified."
[h] Included: referral to smokefree.gov.
CM: care management; BCBS: Blue Cross Blue Shield.

Discussion

Administrative data provide evidence to suggest that prenatal smoking prevalence among Kentucky MMC women is higher than previously reported, yet smoking cessation claims data indicate benefit underutilization among this susceptible subpopulation. Smoking during pregnancy is a major factor in preterm birth and other adverse birth outcomes (ACOG, 2010). Smoking prevalence among Kentucky MMC enrollees with a delivery code during June 1, 2014–May 31, 2015, as identified by either ICD-9 codes for smoking or smoking cessation benefit claims prior to and/or including delivery, was 30.8%; a higher rate than previously reported based upon ICD-9 codes only (20.3%; IPRO/KDMS, 2014) and vital records (22.9%; KDPH, 2013). Smoking was highly prevalent among women with alcohol or substance abuse, and smoking was more prevalent among women with asthma/COPD or depression when compared to women without these diagnoses. Although most (46.95%) smokers resided in urban areas, the geographic subgroups with the greatest proportion of smokers were the Appalachian (33.22%) and rural (31.59%) subgroups. The American Lung Association (ALA) has identified a culture of tobacco use as a root cause of tobacco use and a challenge to smoking cessation in Appalachian and rural areas (ALA, 2012). These high risk subgroups among which smoking is prevalent could be targeted by MCOs for identification of smoking and cessation intervention.

The vast majority of smokers (89.32%) had no claims for smoking cessation benefits. Thus, there is substantial opportunity for improving member utilization of prenatal, as well as preconception, smoking cessation benefits. Younger maternal smokers, particularly those aged 11–19 years, had lower rates of cessation services than smokers in other age groups; this finding is consistent with national findings (Nugent et al., 2014). Lack of access to sufficient prenatal care and primary care were also risk factors for lack of receipt of smoking cessation benefits. This high-risk subgroup would benefit from targeted intervention. Interestingly, members with alcohol and substance abuse had higher rates of receipt of cessation benefits compared to members without these diagnoses.

Consistent with findings from the National Health Interview Survey (Nugent et al., 2014), healthier smokers were less likely to have received smoking cessation interventions; though there is ample room for improvement in this area for both groups, since most members in both groups received no cessation benefits. This finding suggests there may be increased access to providers among sicker smokers, resulting in increased interventions for smoking cessation. Urban residence was also a risk factor for lack of receipt of smoking cessation benefits, and merits further exploration by the MCOs. Chart review findings indicate that member receipt of smoking assessment and timely cessation interventions was lacking from both providers and MCO care management. Risk factors for lack of receipt of smoking cessation benefits included younger age (adolescents and women younger than 35 years).

Asking pregnant women about smoking status and offering pregnancy-tailored cessation counseling are level A recommendations from the USPSTF, signifying a high certainty of substantial benefit from these interventions (USPSTF 2009). The majority of members were assessed for smoking status during a visit to their prenatal care provider, with about half assessed during the first trimester. Less than half of smokers' records had documentation of advice to quit by the prenatal care provider, and 59.73% of the prenatal smoking subsample had any documented smoking cessation interventions. The most prevalent specific prenatal provider intervention documented was perinatal provider counseling (38.26%), yet only 2.01% of pregnant smokers were referred to the Kentucky quit line. General assistive-type interventions, such as encouraging the member to talk about the process of quitting (28.86%), also indicate opportunities for improvement. Only 39.60% of pregnant smokers had their smoking status monitored at a follow-up visit, although there is evidence that smoking cessation at any time during pregnancy is of benefit (ACOG, 2010).

MCO care managers identified only half of all pregnant smokers who were identified by the prenatal care provider and had an MCO care management record. One-fourth of members who were identified as smokers by the prenatal care provider were contacted by the MCO care coordinator for smoking cessation and only four members were contacted during the first trimester. Consequently, there was considerable missed opportunities for MCO care managers to have potential impact on adverse fetal outcomes by facilitating smoking cessation, since cessation at any time during pregnancy has been found to reduce the risk for preterm delivery (Moore et al., 2016) and fetal growth restriction (Blatt et al., 2015).

The vast majority of prenatal smokers were not engaged with CM for smoking cessation, and there was no care coordination with the prenatal care provider for smoking cessation. Coordination with prenatal care providers may have allowed the MCO to continue support for the two members who providers identified as abstinent to prevent relapse. MCO care managers referred just eight members to the Kentucky quit line; most of these referrals were attributable to one MCO, and only two were documented to have received these services.

Study Limitations and Strengths

The administrative study was limited by unmeasured factors that could have influenced the relationship between the possible risk factor and the outcome, as in any observational study. For example, teen mothers may have lower rates of cessation benefits due to late presentation for care, which could not be reliably measured with claims data. Further, the current study was not designed to be a validation study. Therefore, the use of ICD-9 codes and smoking cessation benefit claims codes to identify smokers was not validated against chart review findings, and coding practices among Kentucky MMC providers are not known. For example, ICD-9 codes identified as smokers 16 of 34 women identified by prenatal care providers as former smokers, and so ICD-9 codes may not be a reliable way to identify current smokers. Former smokers who quit would not have the same need for intervention as current smokers. Another limitation was that race/ethnicity was either not reported or reported as "other" for a substantial proportion of the sample; therefore precluding meaningful analysis of this demographic factor.

Chart review study limitations include the possibility that the services were undocumented, rather than not rendered. The sample was chosen, in part, by identifying a cohort of maternal smokers by ICD-9 codes, and therefore results may not be generalizable to the Kentucky MMC perinatal population. For example, since a diagnostic code was submitted for smoking status for half of the sample, it could be assumed that smoking status was assessed for this cohort. Another limitation is the variability in MCO response rates for prenatal care provider chart provision, which ranged from 58% to 88%, postpartum care provider chart provision, which ranged from 20% to 31%, and MCO CM chart provision, which ranged from 11% to 85%. Further, provision of postpartum charts was low across MCOs.

Chart review study strengths include sufficient sample size to determine the statistically significant findings among the groups analyzed, i.e., ≥ 30 charts. In addition, the focus of this study was on prenatal smoking, and the prenatal care provider chart submission rate was high at 74%.

Conclusion

Prenatal smoking is prevalent among the Kentucky MMC population, and there are subgroups with higher risk for smoking and lack of services that could be targeted for intervention. Members with comorbidities, i.e., alcohol abuse, depression and COPD, were more likely to receive smoking cessation benefits, whereas teen mothers and members with insufficient prenatal care were less likely. Many prenatal smokers enrolled in Kentucky MMC did not receive ACOG-recommended smoking cessation interventions from providers. With few exceptions, neither prenatal care providers nor MCO care managers referred prenatal smokers to the Kentucky quit line. What's more, there were considerable missed opportunities for care managers to identify, contact and engage prenatal smokers in smoking cessation programs early in the pregnancy, as well as missed opportunities to contact prenatal care providers for coordination of smoking cessation interventions. Consequently, only a handful of pregnant smokers achieved smoking abstinence during the critical prenatal period.

Recommendations

KDMS can provide guidance to the plans by initiating a statewide collaborative performance improvement project (PIP) for prenatal smoking cessation and by working with the plans to address prenatal access and availability issues, in accordance with the specific MCO recommendations outlined below.

Kentucky Medicaid MCOs can address the problems and risk factors identified in this focused study by identifying and sharing current gaps and best practices, as well as collaborating with providers for quality improvements by drawing on the following recommendations:

- target and tailor care coordination/case management to susceptible subpopulations as indicated by risk factors identified in this report;
- conduct a collaborative PIP to improve preconception/prenatal smoker identification, contact, engagement, coordination and referral for smoking cessation;
- build on existing efforts with the CMS smoking affinity group to refine the focus on prenatal smoking cessation and to address known challenges, such as lack of Kentucky quit line data on MMC pregnant smokers who have contacted the quit line; and
- work with obstetricians and gynecologists to improve preconception and prenatal identification of smokers and to coordinate prenatal smoking cessation services. Specifically:
    - develop and implement a Notice of Pregnancy form for provider use to inform MCO CM of pregnant women who smoke;

- develop an MCO smoker registry to identify all members who smoke;
- develop a high-risk obstetric CM program that targets the smoking subpopulation for smoking cessation and ongoing support of identified smokers;
- develop provider-based listings of smokers to distribute to providers with information on smoking cessation benefits, the Kentucky quit line and how to refer members for smoking cessation services; and
- encourage, educate and facilitate provider implementation of the ACOG recommendations for smoking cessation during pregnancy, including augmented, pregnancy-tailored counseling and the 5 A's.

Findings from this focused study reinforce the importance of IPRO's recommendation in the Access and Availability Survey (IPRO/KDMS, 2015) that MCOs increase obstetrician/gynecologist contact and appointment rates in order to improve access to appropriate prenatal care.

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Kentucky
UNBRIDLED SPIRIT

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

Web-Based Provider Directory Validation Study
Summary Report – Final

July 2016

Table of Contents

INTRODUCTION 3
METHODOLOGY 4
Table 1: Survey Response Rates and Sample Size 4
RESULTS 6
Table 2: Rate of Providers Found in Web Directory 6
Table 3: Overall Accuracy Rates by MCO 6
Table 4: Findings for Each Validation Field 7
Table 5: Accuracy Rates by Field 8
Table 6: Web Validation of Undeliverable Provider Network Surveys 9
LIMITATIONS 10
RECOMMENDATIONS 10
APPENDIX A: Listing of Sampled Providers not Found in the MCO Web-Based Directories 11
APPENDIX B: Listing of Providers with Inconsistent Information in the MCOs' Provider Files/Provider Network Survey and the Web-Based Provider Directories 14
APPENDIX C: Results of the Web Validation of Undeliverable Surveys 20

INTRODUCTION

As part of the newly founded Kentucky managed care system, validation of each managed care organization (MCO)'s web-based provider directory should be conducted by the external quality review organization (EQRO) to ensure information provided to members is consistent with the information that the MCOs report to the Kentucky Department for Medicaid Services (DMS).

In accordance with the Code of Federal Regulations (CFR) 42(4) § 438.10 (f) (6i), managed care enrollees have the right to access a listing of all providers who participate in the managed care plan. This listing is to contain contact information for each participating provider, as well as other pertinent information useful to enrollees including: address, phone number, languages spoken other than English, primary specialty and provider's panel status. MCOs are required to keep their provider directory current and accurate. The web directory must contain information as required by statute, regulation and the Medicaid contract.

The Web-Based Provider Directory Validation Study is one of a variety of activities performed to ensure enrollees are being provided accurate information regarding the providers comprising the health plans' provider networks. It is essential that enrollees have up-to-date and accurate information to enable them to contact their providers and schedule appointments that are timely and within easy access to their homes.

The objectives of this study were to determine the following:

a) All providers included in the MCO provider file submission for each MCO are displayed in the web-based provider directory.
b) Provider information published in the MCOs' web directories is consistent with the information reported in the MCO FILE and/or the provider network survey responses.

METHODOLOGY

In February 2016, the five Medicaid MCOs submitted to Island Peer Review Organization (IPRO) their most recent monthly provider data. The MCOs are Aetna Better Health, Anthem Blue Cross and Blue Shield Medicaid, Humana-CareSource, Passport Health Plan and WellCare of Kentucky.

IPRO conducted a two-phase mailing to validate the accuracy of the MCO provider files for primary care providers (PCPs) and specialists participating with any of the five MCOs operating in Kentucky with a Medicaid product line. Survey responses were compared to information in the MCO FILE and an error rate was computed for each data element that is validated. The resulting report is the *Validation of Managed Care Provider Network Submissions: Audit Report, July 2016*. For this audit, a random sample of 100 PCPs and 100 specialists was drawn for each plan, resulting in a total sample size of 1,000 providers. These providers received a survey by mail asking them to validate their information based on the MCO provider file information. For this web validation study, a random sample of 50% of providers who responded to the survey was drawn, but no more than 50 providers from each MCO, i.e., 25 PCPs and 25 specialists. Reasons for exclusions included surveys that were undeliverable, providers no longer being present at the location reported in the provider file or providers no longer participating in the MCO's provider network.

The response rate summary for the provider network survey and the final sample size for the Web-Based Provider Directory Validation Study by MCO are presented in Table 1.

Table 1: Survey Response Rates and Sample Size

MCO	Provider Network Survey					Web Validation Sample Size
	Initial Sample Size	Undeliverable Surveys	Adjusted Sample Size	Returns	Response Rate	
Aetna Better Health[1]	200	25	175	90	51%	50
Anthem Blue Cross and Blue Shield Medicaid	200	32	168	104	62%	50
Humana-CareSource[2]	200	43	157	84	54%	50
Passport Health Plan	200	23	177	126	71%	50
WellCare of Kentucky	200	26	174	112	64%	50
Total	1,000	149	851	516	61%	250
All PCPs	500	55	445	302	68%	125
All specialists	500	94	406	214	53%	125

For each survey that was included in the web validation sample, the reported provider information was validated against the corresponding MCO's web directory within one week of receiving the survey response in order to minimize the chance that any differences were due to real provider information changes over time. Web-based directories were searched using the sampled providers' names.

A Microsoft Access database was developed by IPRO, which presented MCO provider data and provider network survey responses side by side. If the information published in the MCO's web directories matched either the MCO provider data or the provider's survey response, the information was considered accurate.

Pertinent provider information that was validated included:

1) Provider Name (Last Name, First Name),
2) Address (Address Line 1, Address Line 2, City, State, Zip Code),
3) Telephone Number,
4) Primary Specialty,
5) Provider Type (PCP or specialist),
6) Panel Status (Open or Closed), and
7) Languages Spoken by Provider/Staff.

Calculating Rates of Accuracy

The following accuracy rates were calculated:

1) Rate of Providers Found in Web Directory – This rate was calculated to identify the number of providers in the web validation sample that were found in the corresponding MCO's web-based directory. Sampled providers were searched by their first and last names in the web-based directory; therefore, this rate is equal to the accuracy rate of providers' names. It is defined as the number of providers in the validation sample that were found in the web directory, divided by the total number of providers in the validation sample.

2) MCO Overall Accuracy Rate – This rate identifies the number of providers in the validation sample that had accurate information when checked against the web-based directory. It is defined as the number of providers in the web validation sample that had accurate data reported for all the fields, divided by the total number of providers from the validation sample that were found in the web-based directory.

3) MCO Accuracy Rate by Field – This computes the accuracy rates (per field) reviewed. For each field, the rate is the number of providers in the web validation sample that had accurate data for a specific field, divided by the total number of providers from the validation sample that were found in the web-based directory.

Web Validation of Undeliverable Provider Network Surveys

As a sub analysis, a random sample of 30 providers (3 PCPs and 3 specialists from each MCO) was drawn from the pool of undeliverable provider network surveys for the purpose of validating the addresses of these providers against the addresses published in the MCO's web directory.

There were three outcomes observed in this sub analysis:

1. The provider was found in the web directory with the same address reported in the MCO's provider file.
2. The provider was found in the web directory with a different address reported in the MCO's provider file.
3. The provider could not be found in the web directory.

The results of the sub analysis can be found in Table 6.

RESULTS

As shown in Table 2, 97% of PCPs and 79% of specialists in the web validation sample were found in the web directories. Aetna Better Health had the lowest PCP match rate, where 23 out of the 25 (92%) sampled PCPs were found in the web directories and had the lowest specialist match rate, where only 13 out of the 25 (60%) sampled specialists were found in the web directory. Appendix A shows the full listing of sampled providers that were not found in the web directories listed by MCO.

Table 2: Rate of Providers Found in Web Directory

Type of Provider	Aetna Better Health		Anthem Blue Cross and Blue Shield Medicaid		Humana-CareSource		Passport Health Plan		WellCare of Kentucky		Total	
Primary care provider	n = 25		n = 25		n = 25		n = 25		n = 25		n = 125	
Found in web directory	23	92%	24	96%	25	100%	25	100%	24	96%	121	97%
Specialist	n = 25		n = 25		n = 25		n = 25		n = 25		n = 125	
Found in web directory	15	60%	19	76%	24	96%	16	64%	25	100%	99	79%

Table 3 shows each MCO's overall accuracy rate, which is the percentage of providers in the web validation sample that had consistent information reported for all fields between the web directories and the MCOs' provider files or the provider network survey. Note that the denominator has been adjusted for this rate to include only those providers that were found in the MCOs' web directories.

Overall, 68% of sampled PCPs across all the plans and 83% of sampled specialists had accurate information published in the web directories. Aetna Better Health had the lowest overall accuracy rate for PCPs (35%), while Passport Health Plan had the lowest overall accuracy rate for specialists (69%). Humana-CareSource had the highest accuracy rate for PCPs (84%), while WellCare of Kentucky had the highest accuracy rate for specialists (92%).

Table 3: Overall Accuracy Rates by MCO

Type of Provider	Aetna Better Health	Anthem Blue Cross and Blue Shield Medicaid	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	Total
Primary care provider	n = 23	n = 24	n = 25	n = 25	n = 24	n = 121
With accurate information	8	19	21	16	18	82
Accuracy rate	35%	79%	84%	64%	75%	68%
Specialist	n = 15	n = 19	n = 24	n = 16	n = 25	n = 99
With accurate information	12	16	20	11	23	82
Accuracy rate	80%	84%	83%	69%	92%	83%

The results of the web validation of each field are presented in Table 4. Table 5 shows the rate of accuracy for each field that was validated against the web directory. Appendix B is a listing of providers that were found to have inconsistent information listed between the web directories and the MCOs provider file and/or the provider network survey by field.

Table 4: Findings for Each Validation Field

Validation Field	Findings
Site Address	High percentages of sampled PCPs and specialists across all the MCOs had consistent site addresses published in the web directories that were consistent with the site address found in the MCOs' provider files or the provider network survey. For sampled PCPs that were listed in the web directories, the vast majority (97%) had accurate addresses listed: Anthem Blue Cross and Blue Shield Medicaid and WellCare of Kentucky had accuracy rates of 100%, while Aetna Better Health and Humana-CareSource had a 96% accuracy rate. Passport Health Plan had the lowest accuracy rate, for which 92% of listed addresses were correct. For specialists, there was a similar level of consistency (98%) among site addresses published in the web directories that were consistent with the MCOs provider file or the provider network survey: Aetna Better Health, Anthem Blue Cross and Blue Shield Medicaid and Humana-CareSource had a 100% accuracy rate. WellCare of Kentucky had a 96% accuracy rate and Passport Health Plan had a 94% accuracy rate.
Telephone Number	Moderately high percentages of sampled PCPs (93%) and specialists (93%) across all the MCOs had consistent telephone numbers listed in the web directories and the MCOs provider file or the provider network survey. Humana-CareSource had the highest accuracy rate of 100% for both PCPs and specialists.
Primary Specialty	All the MCOs had an accuracy rate of 100% with regard to the accuracy of primary specialties for PCPs listed in the web directories and the MCOs provider file or the provider network survey with the exception of Passport Health Plan, which had an accuracy rate of 80%. All the MCOs had an accuracy rate of 100% with regard to the accuracy of primary specialties for specialists listed in the web directories and the MCOs provider file or the provider network survey with the exception of Humana-CareSource (96%) and Passport Health Plan (81%).
Provider Type	All PCPs and specialists in the validation sample had the same provider type listed in the web directories as in the MCOs provider file or the provider network survey.
Panel Status	Eighty-four percent of the PCPs from the validation sample had the same panel status information published in the web directories as in the MCOs provider file or the provider network survey. Humana-CareSource had a 100% accuracy rate, followed by Passport Health Plan (96%), Anthem Blue Cross and Blue Shield Medicaid (92%), WellCare of Kentucky (75%) and then Aetna Better Health (52%) with the lowest accuracy. Note: For WellCare of Kentucky, the web directory noted for some providers the following status: "Accepting New Patients: Unknown." Note: Panel status was not validated for specialists, since the MCOs provider file data requires this field for PCPs only.
Languages Spoken – Spanish	The majority of PCPs (94%) and specialists (98%) in the validation sample, who had Spanish listed as one of the other languages spoken in the MCOs provider file or the provider network survey, had consistent information published in the web directories.
Languages Spoken – other	High percentages of PCPs (98%) and specialists (99%) in the validation sample that had other spoken languages listed in the MCOs provider file or the provider network survey had consistent information published in the web directories.

Table 5: Accuracy Rates by Field

Accuracy Rates by Web Field	Aetna Better Health	Anthem Blue Cross and Blue Shield Medicaid	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	Total
Site address						
PCP	n = 23	n = 24	n = 25	n = 25	n = 24	n = 121
With accurate information	22	24	24	23	24	117
Accuracy rate	96%	100%	96%	92%	100%	97%
Specialist	n = 15	n = 19	n = 24	n = 16	n = 25	n = 99
With accurate information	15	19	24	15	24	97
Accuracy rate	100%	100%	100%	94%	96%	98%
Telephone number						
PCP	n = 23	n = 24	n = 25	n = 25	n = 24	n = 121
With accurate information	17	24	25	22	24	112
Accuracy rate	74%	100%	100%	88%	100%	93%
Specialist	n = 15	n = 19	n = 24	n = 16	n = 25	n = 99
With accurate information	12	18	24	14	24	92
Accuracy rate	80%	95%	100%	88%	96%	93%
Primary specialty						
PCP	n = 23	n = 24	n = 25	n = 25	n = 24	n = 121
With accurate information	23	24	25	20	24	116
Accuracy rate	100%	100%	100%	80%	100%	96%
Specialist	n = 15	n = 19	n = 24	n = 16	n = 25	n = 99
With accurate information	15	19	23	13	25	95
Accuracy rate	100%	100%	96%	81%	100%	96%
Provider type						
PCP	n = 23	n = 24	n = 25	n = 25	n = 24	n = 121
With accurate information	23	24	25	25	24	121
Accuracy rate	100%	100%	100%	100%	100%	100%
Specialist	n = 15	n = 19	n = 24	n = 16	n = 25	n = 99
With accurate information	15	19	24	16	25	99
Accuracy rate	100%	100%	100%	100%	100%	100%
Panel status						
PCP	n = 23	n = 24	n = 25	n = 25	n = 24	n = 121
With accurate information	12	22	25	24	18	101
Accuracy rate	52%	92%	100%	96%	75%	84%
Specialist[1]						
With accurate information						
Accuracy rate						

Accuracy Rates by Web Field	Aetna Better Health	Anthem Blue Cross and Blue Shield Medicaid	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	Total
Language spoken – Spanish						
PCP	n = 23	n = 24	n = 25	n = 25	n = 24	n = 121
With accurate information	23	22	22	23	24	114
Accuracy rate	100%	92%	88%	92%	100%	94%
Specialist	n = 15	n = 19	n = 24	n = 16	n = 25	n = 99
With accurate information	15	19	23	15	25	97
Accuracy rate	100%	100%	96%	94%	100%	98%
Language spoken – other						
PCP	n = 23	n = 24	n = 25	n = 25	n = 24	n = 121
With accurate information	23	22	24	25	24	118
Accuracy rate	100%	92%	96%	100%	100%	98%
Specialist	n = 15	n = 19	n = 24	n = 16	n = 25	n = 99
With accurate information	15	19	23	16	25	98
Accuracy rate	100%	100%	96%	100%	100%	99%

[1]Panel status for specialists is not applicable (grey shade).
PCP: primary care provider.

Table 6 displays the results of the subanalysis, which validated the names and addresses of providers whose surveys were returned as undeliverable, against the information published in the web directories. According to Table 1, 149 out of the 1,000 (15%) surveys mailed for the provider network audit were returned as undeliverable. For this sub-analysis, 30 were sampled from this pool of undeliverable surveys.

Fifty percent (15/30) of these "undeliverables" had the same addresses published in the MCO web directories (Table 6). Since these surveys were undeliverable by the US Postal Service, we assume these addresses were incorrect for these providers. The MCO FILE data is from the February 2016 submission, while the web validation of the undeliverable provider network survey was conducted in July 2015, which means that there is a delay between the time that the provider changed location, for example, and the time that this information is received by the MCOs and, subsequently, reflected in the web directories.

Only five of the 30 providers (17%) among the undeliverable surveys were found in the web directory listed with a different address, and ten of the 30 (33%) providers among the undeliverable surveys could not be found in the web directory (Table 6).

The full listing of the 30 sampled undeliverable surveys can be found in Appendix C.

Table 6: Web Validation of Undeliverable Provider Network Surveys

MCO	In Web Directory Same Address		In Web Directory Different Address		Not in Web Directory		Total
Aetna Better Health	2	33%	1	17%	3	50%	6
Anthem Blue Cross and Blue Shield Medicaid	3	50%	1	17%	2	33%	6
Humana-CareSource	6	100%	0	0%	0	0%	6
Passport Health Plan	2	33%	2	33%	2	33%	6
WellCare of Kentucky	2	33%	1	17%	3	50%	6
Validation outcome total	15	50%	5	17%	10	33%	30

LIMITATIONS

1. The validation study sample only includes providers that responded to the provider network survey and, therefore, does not take into account the entire population of providers in the MCOs' provider files.
2. The validation study considers the provider information "accurate" if the information listed in the web directory matches either the MCO's provider file dataset or the provider network survey, which means that the accuracy rates may be slightly inflated.
3. The methodology mentioned above also means that there is no measure of the rate of accuracy of the web directories with respect to the MCOs' provider files and the provider network survey separately.
4. The small number of providers in the validation sample means that the rates should be interpreted with caution.

RECOMMENDATIONS

Based on the findings of this validation study, IPRO recommends:

<u>DMS:</u>

1) Follow up with MCOs to ensure that any inaccuracies in provider information from this validation study and the provider network survey are corrected, and those corrections are reflected in the MCOs' provider files and the web directories.
2) Work with MCOs to enhance the accuracy and completion of critical fields in the MCO provider files, especially with respect to phone numbers, addresses and languages spoken.
3) Work with MCOs to enhance the accuracy of the web directories, emphasizing the importance of ensuring that the members have access to the most up-to-date provider information online.

<u>IPRO:</u>

1) Create a measure that would indicate whether the web directory information is more consistent with the MCOs' provider files or the provider network survey. Since the provider network survey provides us with the most up-to-date information on these providers, if it is observed that the web directories are more consistent with the provider network survey responses than with the MCOs' provider files, it is a positive indication that the web directories are kept up-to-date, even more so than the data source of the MCOs' provider files. Conversely, if we observe that the web directory information is more consistent with the MCOs' provider files; it is an indication that the MCOs have to improve on keeping the web directories and other systems updated with the most current information on their provider network.

APPENDIX A: Listing of Sampled Providers not Found in the MCO Web-Based Directories

Aetna Better Health

MCO[1]	Type	NPI	Name	Address Line 1	Address Line 2	City	State	Zip Code	Phone	Specialty
Aetna	PCP	1013947449	SAMAAN, ZEINA	3430 BURNET AVE	GENERAL PEDIATRICS PPC ML 5026	CINCINNATI	OH	45229	(513) 636-7722	General Pediatrician
Aetna	PCP	1245209402	PATEL, HARESH	1520 SLATE CREEK RD		GRUNDY	VA	24614	(276) 935-2148	Internist
Aetna	Spec	1922027705	LYNCH, DANIEL	1808 SHERMAN DR		PRINCETON	IN	47670	(812) 385-1701	Anesthesiologist
Aetna	Spec	1871703132	DUBE, AJEET	3131 QUEEN CITY AVE		CINCINNATI	OH	45238	(513) 865-1307	Emergency Medicine Practitioner
Aetna	Spec	1477797355	WARRICK, DENISE	7777 YANKEE RD	ML 16026 - LIBERTY CAMPUS HMU	LIBERTY TOWNSHIP	OH	45044	(513) 803-9649	General Pediatrician
Aetna	Spec	1144663451	MCGEE, SUZANNE	4420 DIXIE HWY	STE 112	LOUISVILLE	KY	40216	(502) 449-6444	Internist
Aetna	Spec	1568894814	CAMPBELL, ASHLEY	200 NEW YORK AVE	STE 320	OAK RIDGE	TN	37830	(615) 824-3737	Nurse Practitioner (Other)
Aetna	Spec	1184029894	KELLEY, JODI	7777 YANKEE RD	ML 16026	LIBERTY TOWNSHIP	OH	45044	(513) 803-9649	Nurse Practitioner (Other)
Aetna	Spec	1578694022	WILLIAMS, CELENA	160 N EAGLE CREEK DR	STE 205	LEXINGTON	KY	40509	(859) 277-3135	Nurse Practitioner (Other)
Aetna	Spec	1265408553	HAQ, JAMSHED	6501 DEANE HILL DR		KNOXVILLE	TN	37919	(865) 766-8818	Pathologist
Aetna	Spec	1538105853	WEBSTER, KRISTA	5796 NASHVILLE RD		BOWLING GREEN	KY	42101	(270) 745-0987	Physical Therapist
Aetna	Spec	1386683118	BLOUNT, STEVEN	3024 BUSINESS PARK CIR		GOODLETTSVILLE	TN	37072	(615) 851-6033	Radiologist

Anthem Blue Cross and Blue Shield Medicaid

MCO[1]	Type	NPI	Name	Address Line 1	Address Line 2	City	State	Zip Code	Phone	Specialty
Anthem	PCP	1326345513	DUNCAN, ROBIN	166 HOSPITAL ST		MONTICELLO	KY	42633	(606) 340-3251	Nurse Practitioner (Other)
Anthem	Spec	1982603353	DUBAL, SAROJ	101 PROSPEROUS PL STE 300		LEXINGTON	KY	40509	(859) 271-3114	Anesthesiologist
Anthem	Spec	1194755868	SANTAPURAM, MURALIDHAR	206 W CHERRY ST		GLASGOW	KY	42141	(270) 651-8338	Anesthesiologist
Anthem	Spec	1932232097	WILLIAMS, KEITH	914 E BROADWAY FL 2		LOUISVILLE	KY	40204	(502) 589-1000	Licensed Marriage & Family Therapist
Anthem	Spec	1346383460	COLLINS, YASHANA	1311 N DIXIE AVE		ELIZABETHTOWN	KY	42701	(270) 769-1304	Licensed Professional Clinical Counselor
Anthem	Spec	1780712695	JACKSON, DAVID	2050 VERSAILLES RD		LEXINGTON	KY	40504	(859) 367-7110	Physical Medicine and Rehabilitation Practitioner
Anthem	Spec	1033247259	HIGDON, MICHELLE	6184 RINEYVILLE RD		RINEYVILLE	KY	40162	(270) 765-5633	Physical Therapist

Humana-CareSource

MCO[1]	Type	NPI	Name	Address Line 1	Address Line 2	City	State	Zip Code	Phone	Specialty
Humana	Spec	1063406031	YUNKUN, JEFFREY	100 E LIBERTY ST STE 800		LOUISVILLE	KY	40202	(502) 315-1458	Anesthesiologist

Passport Health Plan

MCO[1]	Type	NPI	Name	Address Line 1	Address Line 2	City	State	Zip Code	Phone	Specialty
Passport	Spec	1770527780	DOSSETT, ALAN	4305 NEW SHEPHERDSVILLE RD		BARDSTOWN	KY	40004	(502) 350-5032	Anesthesiologist
Passport	Spec	1609964832	HOBACK, VIRGIL	1000 ST CHRISTOPHER DR		ASHLAND	KY	41101	(606) 833-3791	Anesthesiologist
Passport	Spec	1033247721	ADAMS, ANGELA	4123 DUTCHMANS LN STE 515		LOUISVILLE	KY	40207	(502) 899-6907	Certified Clinical Social Worker
Passport	Spec	1104071042	BROWN, ANNE	3715 BARDSTOWN RD STE 415		LOUISVILLE	KY	40218	(502) 458-4530	Certified Clinical Social Worker
Passport	Spec	1316915176	BAKER, CHRISTINE	1 MEDICAL VILLAGE DR		FT MITCHELL	KY	41017	(859) 341-7246	Certified Registered Nurse Anesthetist (CRNA)
Passport	Spec	1376548842	LEWIS, RONALD	639 N MULBERRY ST		ELIZABETHTOWN	KY	42701	(270) 737-4600	Certified Registered Nurse Anesthetist (CRNA)
Passport	Spec	1558343442	PERELLIS, DAVID	9467 WESTPORT		LOUISVILLE	KY	40241	(502) 412-5900	General Dentistry Practitioner
Passport	Spec	1124027719	AHMED, AFTAB	220 ABRAHAM FLEXNER WAY		LOUISVILLE	KY	40202	(502) 426-9680	Internist
Passport	Spec	1073604096	BURCHETT, KAREN	4328 13TH STREET		ASHLAND	KY	41102	(606) 327-1160	Obstetrician/Gynecologist

WellCare of Kentucky

MCO[1]	Type	NPI	Name	Address Line 1	Address Line 2	City	State	Zip Code	Phone	Specialty
WellCare	PCP	1932287174	STAFFORD, WILLIAM	413 S LOOP RD		FORT MITCHELL	KY	41017	(859) 301-3800	Family Practitioner

[1]Some fields that appear in all uppercase letters in databases have been modified in letter case to better fit the page; content or spelling has not been altered.

APPENDIX B: Listing of Providers with Inconsistent Information in the MCOs' Provider Files/Provider Network Survey and the Web-Based Provider Directories

1) SITE ADDRESS

Aetna Better Health

MCO	Type	NPI	Name	MCO FILE Address	Survey Address	Web Address
Aetna	PCP	1417920554	KELLY, KEVIN	20 MEDICAL VILLAGE DR, EDGEWOOD, KY, 41017	20 MEDICAL VILLAGE DR, EDGEWOOD, KY, 41017	20 MEDICAL VILLAGE DR, FORT MITCHELL, KY, 41017

Anthem Blue Cross and Blue Shield Medicaid

MCO	Type	NPI	Name	MCO FILE Address	Survey Address	Web Address
Anthem	Spec	1346330909	MORALES POZZO, ALBA	740 S LIMESTONE ST, LEXINGTON, KY, 40536	740 S LIMESTONE ST, LEXINGTON, KY, 40536	740 N LIMESTONE, LEXINGTON, KY, 40508
Anthem	Spec	1336147065	SIMON, FRANK	1404 BROWNS LN STE B, LOUISVILLE, KY, 40206	1404 BROWNS LN STE B, LOUISVILLE, KY, 40206	712 E MUHAMMAD ALI BLVD, LOUISVILLE, KY, 40202

Humana-CareSource

MCO	Type	NPI	Name	MCO FILE Address	Survey Address	Web Address
Humana	PCP	1770546822	BUSKIRK, CAROLE	1169 EASTERN PKWY STE 2211, LOUISVILLE, KY, 40217	1169 EASTERN PKWY STE 2211, LOUISVILLE, KY, 40217	1169 EASTERN PKWY STE 2200, LOUISVILLE, KY, 40217

Passport Health Plan

MCO	Type	NPI	Name	MCO FILE Address	Survey Address	Web Address
Passport	PCP	1407811722	ANDERSON, JEFFREY	1930 BISHOP LN STE 1200, LOUISVILLE, KY, 40218	1930 BISHOP LN STE 1200, LOUISVILLE, KY, 40218	3992 DUTCHMANS LN, LOUISVILLE, KY, 40207
Passport	PCP	1730144296	CICCHIELLO, JAMES	1930 BISHOP LN STE 1200, LOUISVILLE, KY, 40218	1930 BISHOP LN STE 1200, LOUISVILLE, KY, 40218	7430 JEFFERSON BLVD, LOUISVILLE, KY, 40219
Passport	Spec	1912122581	REDDY, SUJATA	312 N LROGERS WELLS BLVD, GLASGOW, KY, 42141	312 N LROGERS WELLS BLVD, GLASGOW, KY, 42141	1301 N RACE ST, GLASGOW, KY, 42141

WellCare of Kentucky

MCO	Type	NPI	Name	MCO FILE Address	Survey Address	Web Address
WellCare	Spec	1841265519	NEWMAN, SAMUEL	238 BARNES RD, WILLIAMSTOWN, KY, 41097	580 SOUTH LOOP ROAD, EDGEWOOD, KY, 41017	580 SOUTH LOOP ROAD, FORT MITCHELL, KY, 41017

2) TELEPHONE NUMBER

Aetna Better Health

MCO	Type	NPI	Name	MCO FILE Phone	Survey Phone	Web Phone
Aetna	PCP	1912973173	CLAPP, WILLIAM	(270) 389-5000		(270) 830-8032
Aetna	PCP	1891178851	COMBS, JACQUELINE	(606) 589-5514		(606) 598-2627
Aetna	PCP	1366406258	HUMPHRIES, VINNA	(270) 707-0303		(270) 886-9229
Aetna	PCP	1487835732	OGAZ, VELETTA	(270) 686-8008		(270) 927-8585
Aetna	PCP	1982683629	SEYLER, JANE	(859) 257-5536		(859) 323-0303
Aetna	PCP	1871550913	THOMSON, ELLEN	(502) 327-9100		(866) 460-3567
Aetna	Spec	1336189778	BAZ, MAHER	(859) 323-6494		(859) 323-0295
Aetna	Spec	1467436469	CONDRA, COLE	(502) 446-5300		(502) 629-6000
Aetna	Spec	1841481546	PULSKAMP, SARA	(513) 584-4318	(513) 929-0104	(513) 584-8500

Anthem Blue Cross and Blue Shield Medicaid

MCO	Type	NPI	Name	MCO FILE Phone	Survey Phone	Web Phone
Anthem	Spec	1336147065	SIMON, FRANK	(502) 895-5088		(502) 568-6972

Passport Health Plan

MCO	Type	NPI	Name	MCO FILE Phone	Survey Phone	Web Phone
Passport	PCP	1407811722	ANDERSON, JEFFREY	(999) 999-9999		(502) 899-6170
Passport	PCP	1730144296	CICCHIELLO, JAMES	(999) 999-9999		(502) 966-8675
Passport	PCP	1265692123	SIU, CHERIE	(606) 528-0305		(606) 528-0306
Passport	Spec	1912122581	REDDY, SUJATA	(270) 651-1111		(270) 659-3381
Passport	Spec	1801948898	WALKER, JON DAVID	(999) 999-9999		(502) 636-0800

WellCare of Kentucky

MCO	Type	NPI	Name	MCO FILE Phone	Survey Phone	Web Phone
WellCare	Spec	1942514203	KUMAR, PRAMOD	(304) 399-7212		(304) 526-7246

3) PRIMARY SPECIALTY

Humana-CareSource

MCO	Type	NPI	Name	MCO FILE Primary Specialty	Survey Primary Specialty	Web Primary Specialty
Humana	Spec	1245254150	CLOAR, ROBERT	General Practitioner		Urgent Care/After Hours

Passport Health Plan

MCO	Type	NPI	Name	MCO FILE Primary Specialty	Survey Primary Specialty	Web Primary Specialty
Passport	PCP	1407811722	ANDERSON, JEFFREY	General Practitioner		Internal Medicine
Passport	PCP	1982925004	BLACKMON, LINDSAY	General Practitioner		Pediatrics
Passport	PCP	1043339419	DALY, WENDY	General Practitioner		Pediatrics
Passport	PCP	1912990607	PEDDICORD, CAROL	General Practitioner		Internal Medicine
Passport	PCP	1881662633	RILEY, JOHN	General Practitioner		Pediatrics
Passport	Spec	1588654735	PADMANABHAN, PRADEEP	Physician		Pediatrics, Emergency Medicine
Passport	Spec	1912122581	REDDY, SUJATA	Internist		Nephrology
Passport	Spec	1437113776	WERTHAMMER, JOSEPH	General Practitioner		Neonatology

4) PROVIDER TYPE

All of the providers and specialists in the validation sample had accurate information listed in the web directories.

5) PANEL STATUS

Aetna Better Health

MCO	Type	NPI	Name	MCO FILE Panel	Survey Panel	Web Panel
Aetna	PCP	1477596542	BATES, RODNEY	OPEN		CLOSED
Aetna	PCP	1598838294	BRIONES, FE	OPEN		CLOSED
Aetna	PCP	1255314498	BROOKS, HAZEL	OPEN		CLOSED
Aetna	PCP	1770594210	CALHOUN, TRAVIS	OPEN		CLOSED
Aetna	PCP	1124013776	CASPER, BARBARA	OPEN		CLOSED
Aetna	PCP	1891178851	COMBS, JACQUELINE	OPEN		CLOSED
Aetna	PCP	1366406258	HUMPHRIES, VINNA	OPEN		CLOSED
Aetna	PCP	1487835732	OGAZ, VELETTA	OPEN		CLOSED
Aetna	PCP	1942268933	OOTEN, SANDRA	OPEN		CLOSED
Aetna	PCP	1659389294	SANDOVAL, ARMANDO	OPEN		CLOSED
Aetna	PCP	1245222504	SAXENA, SURESH	OPEN		CLOSED

Anthem Blue Cross and Blue Shield Medicaid

MCO	Type	NPI	Name	MCO FILE Panel	Survey Panel	Web Panel
Anthem	PCP	1124029160	CHANEY, BRIAN	CLOSED		OPEN
Anthem	PCP	1225270515	SWEIGART, LACEY	CLOSED		OPEN

Passport Health Plan

MCO	Type	NPI	Name	MCO FILE Panel	Survey Panel	Web Panel
Passport	PCP	1043339419	DALY, WENDY	OPEN		CLOSED

WellCare of Kentucky

MCO	Type	NPI	Name	MCO FILE Panel	Survey Panel	Web Panel
WellCare	PCP	1962629766	CROWLEY, KIBBE	CLOSED		Accepting New Patients - Unknown
WellCare	PCP	1346674884	ELM, KATELIN	OPEN		Accepting New Patients - Unknown
WellCare	PCP	1578823696	FLETCHER-JONES, CRYSTAL	CLOSED		OPEN
WellCare	PCP	1063496412	HARDIN, MELISSA	CLOSED		Accepting New Patients - Unknown
WellCare	PCP	1073517843	LOSEKAMP, CRAIG	CLOSED		Accepting New Patients - Unknown
WellCare	PCP	1023075173	SAXON, DAVID	CLOSED		Accepting New Patients - Unknown

6) LANGUAGE SPOKEN: SPANISH

Anthem Blue Cross and Blue Shield Medicaid

MCO	Type	NPI	Name	MCO FILE Spanish	Survey Spanish	Web Spanish
Anthem	PCP	1790740868	SALISBURY, EVELYN		No	Yes
Anthem	PCP	1225270515	SWEIGART, LACEY		Yes	No

Humana-CareSource

MCO	Type	NPI	Name	MCO FILE Spanish	Survey Spanish	Web Spanish
Humana	PCP	1972585065	BURCH, KIMBERLY		Yes	No
Humana	PCP	1306093828	STRUNK, POLLYANNA		Yes	No
Humana	PCP	1366544827	WILLIAMS, WAYNE		Yes	No
Humana	Spec	1922102391	GOODIN, DONALD		Yes	No

Passport Health Plan

MCO	Type	NPI	Name	MCO FILE Spanish	Survey Spanish	Web Spanish
Passport	PCP	1619958097	BUTLER, DANIEL		Yes	No
Passport	PCP	1659336188	GEER, WENDY		Yes	No
Passport	Spec	1881689693	WARDROP, PELL		No	Yes

7) LANGUAGE SPOKEN: OTHER

Anthem Blue Cross and Blue Shield Medicaid

MCO	Type	NPI	Name	MCO FILE Lang 1	MCO FILE Lang 2	MCO FILE Lang 3	MCO FILE Lang 4	Survey Lang 1	Survey Lang 2	Survey Lang 3	Survey Lang 4	Web Lang 1	Web Lang 2	Web Lang 3	Web Lang 4
Anthem	PCP	1437190287	MALIK, INDU	Hindi											
Anthem	PCP	1700982188	AGOMAA, JESUS			Tagalog									

Humana-CareSource

MCO	Type	NPI	Name	MCO FILE Lang 1	MCO FILE Lang 2	MCO FILE Lang 3	MCO FILE Lang 4	Survey Lang 1	Survey Lang 2	Survey Lang 3	Survey Lang 4	Web Lang 1	Web Lang 2	Web Lang 3	Web Lang 4
Humana	PCP	1366544827	WILLIAMS, WAYNE		Limited Italian			Limited German							
Humana	Spec	1700865771	COHEN, COREY		Phone Interpreter When Needed										

APPENDIX C: Results of the Web Validation of Undeliverable Surveys

MCO[1]	Type	NPI	Name	MCO FILE Address Line 1	MCO FILE Address Line 2	MCO FILE City	MCO FILE State	MCO FILE ZIP	MCO FILE Phone Number	Validation Date	Validation Status
Aetna	PCP	1861408809	ELMORE, LUANN	511 MIDDLEBURG ST		LIBERTY	KY	42539	(606) 787-5963	7/11/2016	In Web Directory - Different Address
Aetna	PCP	1588869192	JEAN, GERALDINE	736 N ELM ST		HENDERSON	KY	42420	(270) 827-4000	7/11/2016	In Web Directory
Aetna	PCP	1114201795	SPEGAL, MELANIE	11901 STANDIFORD PLAZA DR		LOUISVILLE	KY	40229	(502) 969-0526	7/11/2016	In Web Directory
Aetna	Spec	1912227661	CASTELBUONO, ANDRE	900 OAK RIDGE TPKE		OAK RIDGE	TN	37830	(865) 835-1000	7/11/2016	Not Found in Web Directory
Aetna	Spec	1972506145	ROSE, STEPHEN	106 COLUMNS PLAZA DR		GLASGOW	KY	42141	(270) 651-9390	7/11/2016	Not Found in Web Directory
Aetna	Spec	1891928537	SANNING, MICAH	1140 LEXINGTON RD		GEORGETOWN	KY	40324	(502) 868-1100	7/11/2016	Not Found in Web Directory
Anthem	PCP	1790977395	DOTSON, LESLIEANN	236 COLLEGE ST		PAINTSVILLE	KY	41240	(606) 789-6844	7/11/2016	In Web Directory
Anthem	PCP	1639327018	PATEL, AMEE	5100 OUTER LOOP		LOUISVILLE	KY	40219	(502) 968-6226	7/11/2016	In Web Directory
Anthem	PCP	1184976151	YOUNG, SHANNON	1417 N MAIN ST		JAMESTOWN	KY	42629	(270) 343-2597	7/11/2016	In Web Directory
Anthem	Spec	1497771406	BECKES, KIRT	6480 HARRISON AVE STE 200		CINCINNATI	OH	45247	(513) 354-7787	7/11/2016	Not Found in Web Directory
Anthem	Spec	1336148832	LEIBOLD, JOHN	10550 MONTGOMERY RD		CINCINNATI	OH	45242	(513) 745-1114	7/11/2016	Not Found in Web Directory
Anthem	Spec	1730420100	RIGGS, RHIANNA	1111 RING RD		ELIZABETHTOWN	KY	42701	(270) 706-1111	7/11/2016	In Web Directory - Different Address
Humana	PCP	1225240682	BOBORODEA, VIOREL	7629 KY ROUTE 979		GRETHEL	KY	41631	(606) 598-7900	7/11/2016	In Web Directory
Humana	PCP	1982671855	JOHNSON, DOUGLAS	1325 ANDREA ST STE 200		BOWLING GREEN	KY	42104	(270) 782-5002	7/11/2016	In Web Directory
Humana	PCP	1033167697	FREEMAN, ANDREW	2000 HOLIDAY LN		FULTON	KY	42041	(615) 778-0509	7/11/2016	In Web Directory

MCO[1]	Type	NPI	Name	MCO FILE Address Line 1	MCO FILE Address Line 2	MCO FILE City	MCO FILE State	MCO FILE ZIP	MCO FILE Phone Number	Validation Date	Validation Status
Humana	Spec	1174651608	HALL, THOMAS	260 HOSPITAL DR		SOUTH WILLIAMSON	KY	41503	(954) 838-2685	7/11/2016	In Web Directory
Humana	Spec	1649316753	LYON, CHRISTOPHER	1401 HARRODSBURG RD STE 205C		LEXINGTON	KY	40504	(859) 276-5344	7/11/2016	In Web Directory
Humana	Spec	1710920558	SWIKERT, NANCY	8780 US HIGHWAY 42		FLORENCE	KY	41042	(859) 384-2660	7/11/2016	In Web Directory
Passport	PCP	1982950432	HUDSON, SAMANTHA	1756 E CENTER ST		MADISONVILLE	KY	42431	(270) 821-3300	7/11/2016	In Web Directory - Different Address
Passport	PCP	1174796742	NEAMTU, DANIELA	1941 BISHOP LN STE 900		LOUISVILLE	KY	40218	(502) 588-2500	7/11/2016	In Web Directory
Passport	PCP	1255303814	PARKER, JEFFREY	8000 SPRUCE DR		NEWPORT	KY	41071	(859) 655-6100	7/11/2016	In Web Directory - Different Address
Passport	Spec	1588695977	GATES, WILLIAM	1313 ST ANTHONY PL		LOUISVILLE	KY	40204	(502) 587-7001	7/11/2016	Not Found in Web Directory
Passport	Spec	1588617195	MCCLENDON, MARY	9820 THIRD STREET RD		LOUISVILLE	KY	40272	(502) 636-7449	7/11/2016	Not Found in Web Directory
Passport	Spec	1629207253	TUCKER, MATTHEW	4015 GATEWAY BLVD STE 2121		NEWBURGH	IN	47630	(812) 450-7720	7/11/2016	In Web Directory
WellCare	PCP	1497702039	BRAHMAMDAM, ANANTHA	3130 HIGHLAND AVE		CINCINNATI	OH	45219	(513) 584-4505	7/11/2016	Not Found in Web Directory
WellCare	PCP	1255317244	DIONISIO, MARIA JOY SANDRA	185 NEWCOMB AVE		MT VERNON	KY	40456	(606) 256-2143	7/11/2016	In Web Directory - Different Address
WellCare	PCP	1518365881	EATON, JENNIFER	295 MAIN ST		CALHOUN	KY	42327	(270) 273-9310	7/11/2016	Not Found in Web Directory
WellCare	Spec	1124372768	CAMPBELL, SALLY	2400 GREATSTONE PT		LEXINGTON	KY	40504	(859) 257-9800	7/11/2016	In Web Directory
WellCare	Spec	1386617470	TOBIAS, DERRICK	601 S FLOYD ST	STE 45	LOUISVILLE	KY	40202	(502) 629-5552	7/11/2016	In Web Directory
WellCare	Spec	1972599405	VEMULA, VASUNDHARA-DEVI	210 W 17TH ST		HOPKINSVILLE	KY	42240	(270) 886-1919	7/11/2016	Not Found in Web Directory

[1]Some fields that appear in all uppercase letters in databases have been modified in letter case to better fit the page; content or spelling has not been altered.

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

2016 External Quality Review Technical Report

Final (6/10/2016) Revised 7/21/16

Review of MCO Contract Year(s) 2013–2015

Report Date: June 2016

Table of Contents

Executive Summary....5

Background....22

External Quality Review Activities....25

Findings, Strengths and Recommendations Related to Health Care Quality, Timeliness and Access....26

- Introduction....26
- Compliance Monitoring....26
- Validation of Performance Measures....37
- NCQA HEDIS 2015 Compliance Audit....87
- Consumer Satisfaction Measures – Reporting Year 2015....98
- Validation of Performance Improvement Projects....100

Additional EQR Activities in Progress....160

- Managed Care Program Progress Report....160
- MCO Performance Dashboard....160
- MCO Performance Annual Health Plan Report Card....160
- Quality Companion Guide....160
- Comprehensive Evaluation Summary....160
- Validation of Patient-Level Claims....160
- Quality of Care Focus Studies....162
- Access and Availability Surveys....164
- Pharmacy Program Reviews....165
- Individual Case Review....165

MCO Responses to Prior Recommendations....166

Appendix A – Medicaid Managed Care Compliance Monitoring....214

Appendix B – Validation of Performance Improvement Projects....217

Appendix C – Validation of Performance Measures....219

List of Tables

Table 1: Domains of Quality and Access/Timeliness 6
Table 2: Kentucky Medicaid MCOs – CY 2015 22
Table 3: Annual Compliance Review 2016 – Domains by Plan 27
Table 4: Overall Compliance Determination by Review Domain – 2016 30
Table 5: Elements Requiring Corrective Action by Review Area – 2016 32
Table 6: 2016 Medicaid Managed Care Compliance Review Findings by Domain – All MCOs 33
Table 7: Kentucky Medicaid Managed Care HEDIS Performance Measures – RY 2015 38
Table 8: Kentucky-Specific Medicaid Managed Care Performance Measures – RY 2015 39
Table 9: Healthy Kentuckians Performance Measure Rates – RY 2015 41
Table 10: Anthem Blue Cross and Blue Shield Medicaid – RY 2015 Performance Measure Rates 52
Table 11: CoventryCares of Kentucky – RY 2013–2015 Performance Measure Rates 58
Table 12: Humana-CareSource – RY 2013–2015 Performance Measure Rates 66
Table 13: Passport Health Plan – RY 2013–2015 Performance Measure Rates 73
Table 14: WellCare of Kentucky – RY 2013–2015 Performance Measure Rates 81
Table 15: HEDIS 2015 Board Certification Measures 89
Table 16: HEDIS 2015 Effectiveness of Care Measures 91
Table 17: HEDIS 2015 Access and Availability Measures 95
Table 18: HEDIS 2015 Use of Services 96
Table 19: CAHPS 5.0H Adult Version – RY 2015 98
Table 20: CAHPS 5.0H Child Version – RY 2015 99
Table 21: Anthem Blue Cross and Blue Shield Medicaid 2015 PIP: Use of Antipsychotics in Children and Adolescents – Baseline Results 101
Table 22: Anthem Blue Cross and Blue Shield Medicaid 2015 PIP: Emergency Department Utilization – Baseline Results 103
Table 23: CoventryCares of Kentucky 2013 PIP: Decreasing Non-emergent/Inappropriate ED Utilization - Final Results 107
Table 24: CoventryCares of Kentucky: 2013 Decreasing Non-emergent/Inappropriate ED Utilization PIP – Final Score 108
Table 25: CoventryCares of Kentucky 2013 PIP: Antidepressant Medication Management and Compliance – Final Results 110
Table 26: CoventryCares of Kentucky 2013 PIP: Antidepressant Medication Management and Compliance – Final Score 111
Table 27: CoventryCares of Kentucky 2014 PIP: Follow-Up Care for Children Prescribed ADHD Medication – Interim Results 112
Table 28: CoventryCares of Kentucky 2014 PIP: Supporting Families of Children with ADHD – Interim Score 113
Table 29: CoventryCares of Kentucky 2014 PIP: Decreasing Avoidable Hospital Readmissions – Interim Results 114
Table 30: CoventryCares of Kentucky 2014 PIP: Decreasing Avoidable Hospital Readmissions – Interim Score 115
Table 31: CoventryCares of Kentucky 2015 PIP: Use of Antipsychotics in Children and Adolescents – Baseline Results 116
Table 32: CoventryCares of Kentucky 2015 PIP: Increasing Comprehensive Diabetes Testing and Screening – Baseline Results 118
Table 33: Humana-CareSource 2014 PIP: Untreated Depression – Interim Results 121
Table 34: Humana-CareSource 2014 PIP: Untreated Depression – Interim Score 122
Table 35: Humana-CareSource 2014 PIP: Emergency Department Use Management – Interim Results 123
Table 36: Humana-CareSource 2014 PIP: Emergency Department Use Management – Interim Score 124
Table 37: Humana-CareSource 2015 PIP: Use of Antipsychotics in Children and Adolescents – Baseline Results 127
Table 38: Humana-CareSource 2015 PIP: Postpartum Care – Baseline Results 129
Table 39: Passport Health Plan 2014 PIP: Psychotropic Drug Intervention Program – Interim Results 134
Table 40: Passport Health Plan 2014 PIP: Psychotropic Drug Intervention Program – Interim Score 135
Table 41: Passport Health Plan 2014 PIP: Development and Implementation of an Asthma Action Plan – Baseline #2 Results 137
Table 42: Passport Health Plan 2014 PIP: Development and Implementation of an Asthma Action Plan – Interim Score 138
Table 43: Passport Health Plan 2015 PIP: Use of Antipsychotics in Children and Adolescents - Baseline Results 140
Table 44: Passport Health Plan 2015 PIP: Reducing Readmission Rates of Postpartum Members - Baseline Results 141
Table 45: WellCare of Kentucky 2013 PIP: Utilization of Behavioral Health Medication in Children – Final Results 146
Table 46: WellCare of Kentucky 2013 PIP: Utilization of Behavioral Health Medication in Children – Final Score 146
Table 47: WellCare of Kentucky 2013 PIP: Inappropriate Emergency Department Utilization – Final Results 148
Table 48: WellCare of Kentucky 2013 PIP: Inappropriate Emergency Department Utilization – Final Score 149
Table 49: WellCare of Kentucky 2013 PIP: Management of Chronic Obstructive Pulmonary Disease – Interim Results 150
Table 50: WellCare of Kentucky 2014 PIP: Management of Chronic Obstructive Pulmonary Disease – Interim Score 151
Table 51: WellCare of Kentucky 2014 PIP: Follow-up After Hospitalization for Mental Illness – Interim Results 152
Table 52: WellCare of Kentucky 2014 PIP: Follow-up After Hospitalization for Mental Illness Interim Score 153
Table 53: WellCare of Kentucky 2015 PIP: Use of Antipsychotics in Children and Adolescents – Baseline Results 154
Table 54: WellCare of Kentucky 2015 PIP: Postpartum Care – Baseline Results 156
Table 55: Anthem Blue Cross and Blue Shield Response to Recommendations Issued in 2015 Technical Report 166
Table 56: CoventryCares of Kentucky Response to Recommendations Issued in 2015 Technical Report 186

Table 57: Humana-CareSource Response to Recommendations Issued in 2015 Technical Report....191
Table 58: Passport Health Plan Response to Recommendations Issued in 2015 Technical Report....197
Table 59: WellCare of Kentucky Response to Recommendations Issued in 2015 Technical Report....203
Table 60: Medicaid Managed Care Compliance Monitoring Standard Designations....215

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Executive Summary

Purpose of Report

The Balanced Budget Act of 1997 established that state agencies contracting with Medicaid managed care organizations (MCOs) provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the State agency and the MCO. Subpart E – External Quality Review of 42 Code of Federal Regulations (CFR) sets forth the requirements for annual external quality review (EQR) of contracted MCOs. CFR 438.350 requires states to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCO. The states must further ensure that the EQRO has sufficient information to carry out the EQR; that the information be obtained from EQR-related activities, and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services (CMS). Quality, as it pertains to EQR, is defined in 42 CFR 438.320 as "the degree to which an MCO increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge."

These same federal regulations require that the annual EQR be summarized in a detailed technical report that aggregates, analyzes and evaluates information on the quality, timeliness and access to health care services that MCOs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the plans regarding health care quality, timeliness and access, and make recommendations for improvement. Finally, the report must assess the degree to which any previous recommendations were addressed by the MCOs.

To meet these federal requirements, the Department for Medicaid Services (DMS) has contracted with Island Peer Review Organization (IPRO), an EQRO, to conduct the annual EQR of Kentucky's Medicaid managed care (MMC) plans.

Scope of EQR Activities Conducted

This EQR technical report focuses on the three federally mandated EQR activities that were conducted. As set forth in 42 CFR 438.358, these activities were:

Compliance Review

This review determines MCO compliance with its contract and with state and federal regulations in accordance with the requirements of 42 CFR 438.204 (g) (Standards for Access, Structure and Operation, and Measurement and Improvement).

Validation of Performance Measures

Each MCO is required to report annual performance measures (PMs) aligned with the Healthy Kentuckians (HK) 2020 goals. Healthy Kentuckians 2020 (HK 2020) is designed to mirror the national Healthy People 2020 initiative, align with statewide initiatives and priorities, and serve as a foundation for moving the health of Kentucky forward. Like Healthy People 2020, HK provides a framework for health promotion and disease prevention by including science-based goals and objectives, baseline data and targets based on established benchmarks to measure progress. HK 2020's goals and objectives are intended to guide efforts to improve the health and safety of people in Kentucky through prevention, promotion, and protection and focuses on state-level goals for promoting health, preventing disease and disability, eliminating disparities, and improving health-related quality of life.

Annually, the measures that are not one of the Healthcare Effectiveness Data and Information Set (HEDIS®) are validated by the EQRO. IPRO addresses the reliability and validity of the reported PM rates as required by both the health plan contract and the Federal MMC regulations and requirements.

Validation of Performance Improvement Projects

Performance improvement projects (PIPs) for the subject time period were reviewed for each MCO to ensure that the projects were designed, conducted and reported in a methodologically sound manner, allowing real improvements in care and services and giving confidence in the reported improvements.

The results of these three EQR activities performed by IPRO are detailed in the Findings, Strengths and Recommendations section of the report.

Overall Conclusions and Recommendations

The following is a high-level summary of the conclusions drawn from the findings of the EQR activities regarding the Kentucky MMC health plans' strengths and IPRO's recommendations with respect to quality of care and access to/timeliness of care. Specific findings, strengths and recommendations are described in detail in the Findings, Strengths and Recommendations section of this report. For the purposes of this section, the domains of quality and access/timelines domains are listed in Table 1.

Table 1: Domains of Quality and Access/Timeliness

Quality	Access/Timeliness
Compliance	
Quality Measurement and Improvement	Health Risk Assessment (HRA)
Grievances	Access
Credentialing/Recredentialing	Utilization Management (UM)
Program Integrity	EPSDT
Delegation	Care Management
Medical Records	Enrollee Rights
	Member Outreach
	Behavioral Health Services
	Pharmacy Services
HEDIS	
Effectiveness of Care Measure	Access and Availability
	Use of Services
Healthy Kentuckians Performance Measures (PMs)	
Preventive Care	Children with Special Health Care Needs (CSHCN)
Perinatal Care	Access to Care

Anthem Blue Cross and Blue Shield Medicaid

Anthem Blue Cross and Blue Shield Medicaid entered the Kentucky Medicaid program in 2014 and 2015 was the first year the MCO reported HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS®), and HK PMs. Due to the limited time in operation, the MCO was not able to report the full set of measures. Therefore, this review is based on data and information collected during the annual compliance review, PIP validations, and the HEDIS and HK measures that were reported. It is also important to note that the prior review consisted only of information obtained from the annual compliance review. As such, this is the only area for which there is a past assessment for comparison.

Quality of Care

In the domain of quality, Anthem Blue Cross and Blue Shield Medicaid demonstrated the following strengths:

- Anthem Blue Cross and Blue Shield Medicaid performed well, earning full compliance with requirements for Delegation, and earning substantial compliance, in the following compliance domains related to quality: Quality Measurement and Improvement (2.47 of 3.0 points), Grievances (2.43 of 3.0 points), Credentialing/Recredentialing (2.60 of 3.0 points), and Program Integrity (2.08 of 3.0 points).
- Anthem Blue Cross and Blue Shield performance exceeded the weighted average of all MCOs for the following Healthy Kentuckian metrics pertinent to quality: Screening for Prenatal Tobacco Use, Screening for Prenatal Alcohol Use, Screening for Prenatal Substance/Drug Use, Prenatal Assessment, Education and/or Counseling for Nutrition, Prenatal Education and/or Counseling for OTC Medications, Prenatal Screening for Domestic Violence, Prenatal Screening for Depression and Postpartum Screening for Depression. The MCO could not report any of the measures in the Preventive Care domain due to enrollment criteria.

- MCO performance was above the NCQA national average for the following HEDIS metrics: Antidepressant Medication Management (both for Acute and Continuation Phase), Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medication, and Medication Management for ACE Inhibitors or ARBs, Digoxin and Diuretics.
- The MCO submitted the following PIP focused on quality of care: Use of Antipsychotics in Children and Adolescents (baseline). Strengths of the proposal included a rationale supported with national statistics and inclusion of process measures to track the interventions. Direct outreach to providers prescribing antipsychotics but not compliant with metabolic testing is a robust intervention. Collection of medical records for members in APC, APM and APP measures for further evaluation of care can identify barriers and root-causes and lead to effective interventions that target PCPs and psychiatrists.
- The MCO submitted the following PIP proposal on quality of care: Preventive Care for Members with Serious Mental Illness (SMI) (Statewide Collaborative), which aims to improve receipt of screening and interventions for physical and behavioral health among members with serious mental illness, i.e., schizophrenia or bipolar disorder. Key strengths include: the MCO developed its own content for the topic and rationale, in addition to what was provided by DMS and IPRO; the MCO identified both member and provider barriers.

In the domain of quality, the plan demonstrated the following opportunities for improvement:

- Anthem Blue Cross and Blue Shield earned only minimal compliance with requirements for Medical Records. In addition, there were 31 elements requiring corrective action across six (6) domains. The quality domain with the greatest number of elements requiring corrective action was Quality Measurement and Improvement (15).
- Anthem Blue Cross and Blue Shield Medicaid underperformed the statewide average for the following Healthy Kentuckian measures pertinent to quality: Prenatal receipt of intervention for tobacco use, prenatal receipt of interventions for alcohol use, and prenatal receipt of interventions for drug/substance use.
- MCO performance was below the NCQA national average for the following HEDIS metrics: Cervical Cancer Screening, Chlamydia Screening in Women, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, Pharmacotherapy Management of COPD Exacerbation (both Systemic Corticosteroid and Bronchodilator numerators), Controlling High Blood Pressure, Persistence of Beta-Blocker After a Heart Attack, Comprehensive Diabetes measures other than HbA1cTesting and Medical Attention for Nephropathy, Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis, Use of Imaging Studies for Low Back Pain, Follow-up 30 and 7 days after Hospitalization for Mental Illness, and Adherence to Medications for Individuals with Schizophrenia.

In the domain of quality, IPRO recommends that Anthem Blue Cross and Blue Shield Medicaid:

- Address areas with less than full compliance for all review domains, particularly Medical Records and Quality Measurement and Improvement.
- Develop and implement quality improvement interventions to address HEDIS and Healthy Kentuckian measures that underperformed the NCQA national average and the Kentucky statewide average, respectively.
- For the PIP to improve appropriate antipsychotic use in children and adolescents, pending baseline data, the MCO can analyze claims data, e.g., members receiving multiple, concurrent antipsychotics; most common provider type among prescribers; geographic patterns; as well as provider network data to determine if there are access and availability issues for behavioral health services.

<u>Access to Care/Timeliness of Care</u>

In the domain of access to/timeliness of care, Anthem Blue Cross and Blue Shield Medicaid demonstrated the following strengths:

- The MCO earned full compliance with the requirements for Member Outreach, and earned substantial compliance for the following compliance domains related to access and timeliness: Access (2.17 of 3.0 points), UM (2.90 of 3.0 points), EPSDT (2.14 of 3.0 points), Enrollee Rights (2.83 of 3.0 points), and Pharmacy (2.86 of 3.0 points).
- The MCO underperformed relative to the weighted average of all MCOs for the Healthy Kentuckian metric for utilization of dental services.
- The MCO submitted a baseline PIP report focusing on access, “Emergency Department Utilization.” Strengths included a strong rationale supported by data and national statistics and inclusion of process measures to track the interventions that are robust. For example, high frequency ED members are targeted for case management and ED lock-in; the post-ED visit follow-up calls have the potential to identify causes for ED use; barriers to PCPs use and are

an opportunity to educate members; and PCPs with high numbers of panel members who utilize the ED are targeted for education and improvement.

- The MCO submitted a PIP proposal to "Increase Annual Dental Visits in EPSDT Population" that based their barrier analysis on data, including member and provider feedback, and developed an intervention strategy that addresses members, providers, the dental vendor, and collaboration with public health agencies.

In the domain of access to/timeliness of care, the plan demonstrated the following opportunities for improvement:

- Anthem Blue Cross and Blue Shield Medicaid was minimally compliant in the compliance domains Health Risk Assessment, Care Management, and Behavioral Health Services.
- The access domain with the greatest number of elements requiring corrective actions was Behavioral Health (16), followed by Care Management (4).

In the domain of access to/timeliness of care, IPRO recommends that Anthem Blue Cross and Blue Shield Medicaid:

- Address areas of less than full compliance for all review domains, particularly for Health Risk Assessment, Care Management, and Behavioral Health Services, which scored minimal compliance.

CoventryCares of Kentucky

Quality of Care

In the domain of quality, the plan demonstrated the following strengths:

- As in the prior year, CoventryCares of Kentucky demonstrated strong performance and earned substantial compliance for the following compliance domains related to quality: Credentialing/Recredentialing (2.92 of 3.0 points), Medical Records (2.95 of 3.0 points), and Quality Measurement and Improvement (2.74 of 3.0 points).
- CoventryCares of Kentucky improved compared to the prior year from minimal or non-compliance to substantial compliance in the following domains related to quality: Grievances (increased from 1.40 to 2.68 of 3.0 points), Delegation (from 1.0 to 2.92 of 3.0 points) and Program Integrity (from 0.67 to 2.74 of 3.0 points).
- Overall, the plan required corrective action for 23 of 414 elements (5.6%) across six (6) domains related to quality, compared to 37 in the prior year. For each of the domains, the number of elements requiring corrective action was equal to or less than ten (≤ 10).
- Few of the rates for the following HEDIS measures for prevention and screening ranked above national Medicaid averages: Adult BMI Assessment (ABA), Childhood Immunization Status: Combo 3 (CIS); Immunizations for Adolescents (IMA) – both antigens and Combo 1, an improvement from 2014.
- Among the HEDIS measures related to respiratory conditions, rates for asthma medication management remained a strength. Rates for the following ranked above the National Committee for Quality Assurance (NCQA) national averages for Medicaid:[3] Use of Appropriate Medications for People with Asthma (AMA), Medication Management for People with Asthma (MMA) – both 50% and 75% Compliance, and Asthma Medication Ratio (AMR).
- Related to diabetes care, CoventryCares of Kentucky performed very well on the HEDIS Comprehensive Diabetes Care (CDC) numerators for HbA1c testing and control with the following exceeding the Quality Compass® national Medicaid averages: HbA1c Testing, HbA1c Control (< 8.0%), HbA1c Control (< 7.0%), and HbA1c Poor Control (> 9.0%).[4]
- The plan performed well on measures related to management of behavioral health medications as demonstrated by HEDIS rates above the NCQA Medicaid national average for: Antidepressant Medication Management (AMM) – both acute and continuation phase, Follow-up Care for Children Prescribed ADHD Medication (ADD) - both initiation and continuation/maintenance phase, Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA). Performance for the new metrics, Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC) and Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) could not be assessed, since there were no Quality Compass benchmarks for these first-year measures.
- Related to management of medications for chronic conditions, the plan surpassed the Quality Compass® Medicaid national averages for the aforementioned metrics for asthma medication management as well as HEDIS Annual Monitoring for Patients on Persistent Medications (MPM) for two of three (2 of 3) medication numerators and the total rate. Additionally, although the rate for Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) fell

[3] The national average is the NCQA Quality Compass™ 2015 HEDIS average for all Medicaid MCOs reporting to NCQA.

[4] For the numerator, HbA1c Poor Control (> 9.0%), a lower rate is better performance and a rate below the average is desirable.

below the national Medicaid average, performance for Controlling High Blood Pressure (CBP) improved in 2015 and surpassed the NCQA national average.

- Related to the HK PMs, CoventryCares of Kentucky's reported rates exceeded the statewide aggregate rate for the following quality measures: Prenatal Screening/Counseling: screening for tobacco use and intervention for tobacco use; screening for alcohol use and intervention for alcohol use; screening for substance/drug use and intervention for substance/drug use; assessment or education/counseling for nutrition; screening for domestic violence; and prenatal screening for depression. The remaining rates for the quality measures fell below the statewide aggregate rates, including: Adult Height and Weight Documented, Adult Counseling for Nutrition and Physical Activity, Cholesterol Screening for Adults, Children and Adolescents Ages 3-17 Years with Height and Weight Documented, Adolescent Screening/Counseling (all 4 numerators) and Postpartum Screening for Depression. For the quality measures overall, rates improved for twenty-two (22) numerators (between nearly 5 to over 50 percentage points); declined for seven (7) numerators (between about 3 to over 30 percentage points), and all rates were found to be reportable. This was a substantial improvement over prior performance.
- CoventryCares of Kentucky submitted the baseline measurement for the following PIP focused on quality of care: "Increasing Comprehensive Diabetes Testing and Screening." Strengths included: a strong rationale supported by data, clearly defined indicators derived from HEDIS, ongoing barrier analysis, and a robust intervention strategy that includes gap reports, collaboration with community health centers. Improvement cannot be assessed since only baseline data are available. No numeric score is assigned at the baseline phase.
- CoventryCares of Kentucky submitted a proposal for the following PIP focused on quality of care: "Management of Physical Health Risks for People with Serious Mental Illness." Strengths included: early identification of the target population, incorporating a process measure related to engagement in care management, identifying barriers and planning interventions related to members, providers, and the plan, and developing process measures to evaluate the success of the interventions. Improvement cannot be assessed as baseline data are not yet reported. No numeric score is assigned at the proposal phase.

In the domain of quality, the plan demonstrated the following opportunities for improvement:

- As in 2014, the majority of HEDIS measures for prevention and screening ranked below the NCQA Medicaid national averages, including: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) - all 3 numerators, Lead Screening in Children, as well as the following women's preventive services: Human Papillomavirus Vaccine for Female Adolescents (HPV), Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS), and Chlamydia Screening in Women (CHL). The new measure, Non-recommended Cervical Cancer Screening in Adolescent Females (NCS) could not be evaluated, as no benchmarks were available for this new measure.
- Despite strong performance on the measures related to asthma medication management, once again, CoventryCares of Kentucky's overall performance related to care for respiratory conditions is in need of improvement. As was noted in both 2013 and 2014, the following HEDIS rates were below the NCQA national averages for Medicaid: Appropriate Testing for Children with Pharyngitis (CWP), Appropriate Treatment for Children with URI (URI), Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB), Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR). Additionally, for both 2014 and 2015, performance for Pharmacotherapy Management for COPD Exacerbation (PCE) (both numerators) was below average.
- Although CoventryCares of Kentucky performed well for the HEDIS Comprehensive Diabetes Care (CDC) numerators related to HbA1c testing and control, the rates for each of the three (3) remaining numerators, Eye Exam Performed, Medical Attention for Nephropathy, and Blood Pressure Control (< 140/90 mmHg) each ranked below the national Medicaid averages. It should be noted that in 2013, the rates for all numerators were below the averages and in 2014, so some improvement has been shown since then.
- Despite strong performance for HEDIS measures related to management of behavioral health medications in 2015 and above average performance in measures of behavioral health care in 2014, CoventryCares of Kentucky's rates the following measures fell below national averages in 2015: Follow-up After Hospitalization for Mental Illness (FUH) – both 7-day and 30-day follow-up, Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medication (SSD) and Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD).
- As in 2014, the rates for HEDIS Board Certification continue to present an opportunity for improvement, though some improvement was seen. Rates for two for six (2 of 6) provider categories exceeded the Quality Compass Medicaid averages in 2015 (Internal Medicine and Other Physician Specialties) while in 2014, the rates for all

provider types fell below average. It should be noted, however, that CoventryCares of Kentucky's performance surpassed the other MCOs in that all of its rates were above the statewide average rates.

- Reporting Year (RY) 2015 Adult CAHPS 5.0H metrics for member satisfaction with network providers was similar to RY 2014, with two of three (2 of 3) rates below NCQA national averages. In 2014, How Well Doctors Communicate and Rating of Specialist Seen Most Often ranked below average, while in RY 2015, Rating of Personal Doctor and Rating of Specialist Seen Most Often were below average.
- Performance for the Child CAHPS 5.0H survey items: How Well Doctors Communicate, Rating of Personal Doctor and Rating of Specialist Seen Most Often continued to decline from reporting year (RY) 2013, when all three (3) exceeded the national Medicaid averages. In RY 2014, rates for two of three (2 of 3) survey items exceeded the NCQA national averages and in the current period (RY 2015) the rate for only one of three (1 of 3) surpassed the national average.
- Member satisfaction with the plan did not improve in RY 2015. Adult CAHPS 5.0H rates for Customer Service, Rating of Health Plan, and Rating of all Health Care all ranked below the Medicaid national averages as was the case in RY 2014. Likewise, for the Child CAHPS 5.0, rates for Rating of Health Plan and Rating of all Health Care were below the NCQA national averages in both RY 2014 and RY 2015.
- CoventryCares of Kentucky submitted the final measurement report for the following PIP focused on quality of care: "Major Depression: Antidepressant Medication Management and Compliance." The MCO achieved improvement and exceeded its goals for the three (3) indicators at both interim and final remeasurement. The plan provided a strong rationale supported by literature citations and MCO-specific data. Opportunities for improvement included clarifying the Medication Possession Ratio (MPR) indicators, i.e., member-specific MPR ≥ 80% versus the proportion of members with MPR ≥ 80%. Additionally, the interim rates exceeded the targets so the plan should have revised its goals upward for the final measurement. Also, the interventions were somewhat passive in nature and should been more specifically targeted to the indicator topic. Although the MCO implemented a CAP for this PIP, and improvements were made, it was not possible to improve the interim PIP score from "Not Met" (47.5 of 80 points) to "Met". The overall score achieved at final remeasurement was "Not Met" (57.5 of 100 points) as well.
- CoventryCares of Kentucky submitted the interim measurement for the following PIP focused on quality of care, "Follow-up Care for Children Prescribed ADHD Medication" (formerly "Supporting Families of Children with ADHD"). As part of its corrective actions, the plan changed its PIP indicator to the HEDIS measure for ADHD and revised the timeline for this PIP, changing the baseline year from CY 2013/HEDIS 2014 to CY 2014/HEDIS 2015. However, the plan did not seek DMS approval for the change. As a result of the change in timeline, the MCO reported only baseline results (CY 2014). No interim results were provided; therefore, achievement of improvement could not be evaluated. Additionally, interventions would have been active during the baseline period (CY 2014), possibly impacting the performance. Despite the errors, other aspects of the PIP were strong, and the interim phase PIP score was "Met" (52.5 of 80 points) for the interim phase.
- CoventryCares of Kentucky submitted the baseline measurement for the following PIP focused on quality of care: "Use of Antipsychotics in Children and Adolescents." The MCO failed to include three of six (3 of 6) DMS-required indicators in the methodology. Additionally, the plan did not report the baseline rates for the three (3) HEDIS indicators and the three (3) DMS-directed proposed HEDIS indicators. The MCO reported descriptive data related to its population receiving antipsychotic medications. Additionally, the MCO needs to state its performance goals relative to the baseline rates. Strengths included a strong rationale supported by literature and data and a database tool developed by the plan to identify members receiving antipsychotics and in need of intervention. At the baseline phase, no numeric score is provided.

In the domain of quality, IPRO recommends that CoventryCares of Kentucky:

- maintain the substantial and full compliance that was achieved in the current annual review, strive to achieve full compliance for all domains and address all elements that were found less than fully compliant, focusing on elements with minimal or non-compliance designations and requiring corrective action;
- work to improve the rates for HEDIS measures which fell below the NCQA national averages and the HK PM rates that fell below the statewide aggregate rate, particularly those that have ranked below average for more than one reporting period;
- evaluate the root causes and initiate improvement strategies for member satisfaction with network providers and the health plan, as demonstrated by continued performance below national averages for Adult and Child CAHPS 5.0H; and

- implement corrective actions to improve the methodological soundness and success of each of the current PIPs.

Access to Care/Timeliness of Care

In the domain of access to/timeliness of care, CoventryCares of Kentucky demonstrated the following strengths:

- Compliance domains related to access were an area of strength for CoventryCares of Kentucky. The following domains achieved Full Compliance (3.0 of 3.0 total points): Utilization Management (UM), EPSDT, and Member Outreach. While these other domains earned substantial compliance: Health Risk Assessment (2.71 of 3.0 points0, Access (2.82 of 3.0 points), Care Management (2.79 of 3 points), Enrollee Rights (2.87 of 3.0 points), Behavioral Health Services (2.94 of 3.0 total points), and Pharmacy Services (2.72 of 3.0 points). It should be noted that performance in several areas improved from minimal or non-compliance to substantial compliance, including: Health Risk Assessment, Care Management, and Pharmacy Services. In fact, across the nine (9) domains related to access and timeliness, only 10 of 345 elements (2.9%) required corrective action
- Similar to RY 2014, in RY 2015, CoventryCares of Kentucky reported rates above national averages for the following access and availability-related HEDIS measures: Adults' Access to Preventive/Ambulatory Health Services (AAP) (2 of 3 age groups and total), Children and Adolescents' Access to Primary Care Practitioners (PCPs; CAP; all 4 age groups), Annual Dental Visit (ADV), and Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care.
- Related to HEDIS Use of Services measures, the plan performed above the national Medicaid averages for the following: Frequency of Ongoing Prenatal Care: 81%+ Expected Visits (FPC) and Ambulatory Care: Total Outpatient Visits (AMBA). Additionally, the plan had more than average maternity discharges when compared with Medicaid plans nationally.
- As seen in RY 2014, CoventryCares of Kentucky's RY 2015 rates were above the national average for both the CAHPS 5.0H Adult and Child survey metrics: Getting Needed Care and Getting Care Quickly.
- CoventryCares of Kentucky exhibited strong performance for the following HK PMs for children with special health care needs' (CSHCN) access to care, with rates above the statewide rate: Well-Child Visits in the First 15 Months of Life: 6+ Visits, Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life, Adolescent Well-Care Visits, and Children and Adolescents' Access to Primary Care Practitioners (ages 25 months – 6 years, 7-11 years and 12–19 years cohorts). Performance improved, as the plan exceeded the average for 6 of 7 measures in RY 2015, compared to 4 of 7 in RY 2014.
- In RY 2015, the CMS-416 EPSDT Dental Services measures were added to the HK PMs. CoventryCares of Kentucky's rates for 6 of 7 measures exceeded the statewide averages. It is important to note however, that substantial opportunity for improvement exists.
- CoventryCares of Kentucky submitted the final measurement for the following PIP focused on access to and timeliness of care: "Decreasing Non-emergent/Inappropriate Emergency Room Utilization." The MCO achieved improvement and exceeded its performance goals for both indicators. Additionally, as directed by DMS, the plan implemented a corrective action plan (CAP) for this PIP and this resulted in the PIP score improving from "Not Met" to "Met" (37.5 to 57.5 of 80-points) and "Met" (67.5 of 100 points) at the final phase.
- CoventryCares of Kentucky submitted the interim measurement for the following PIP related to access to and timeliness of care: "Decreasing Avoidable Hospital Re-admissions." In the report, the plan was able to address the recommendations, including providing definitions for key indicator terms, more detailed descriptions of the interventions, and the current status of intervention implementation. The plan achieved improvement and exceeded its goal for the MCO-defined 30-day re-admission rate. As a result, the performance targeted was revised. Other strengths included a strongly supported rationale and intervention strategy that actively engaged members. However, the plan included the HEDIS Plan All-Cause Re-admissions (PCR) measure in the aim statement, but did not address it in the methodology or results. Overall, the PIP score at the interim phase was "Met" (50 of 80 points).
- CoventryCares of Kentucky submitted a proposal for the following PIP focused on access to and timeliness of care: "Postpartum Care." The plan strengthened the PIP by working with DMS and IPRO. Strengths of the final proposal included: focus on physical health (postpartum visits) and mental health (postpartum depression) and use of the Healthy Kentuckian (HK) performance measures (PMs) as PIP indicators, and implementing a member incentive for completing a postpartum visit. Opportunities included: clarifying and refining the aims, objectives, and indicators, conducting barrier analyses, and developing process measures Improvement cannot be assessed as baseline data are not yet reported. No numeric score is assigned at the proposal phase.

In the domain of access to/timeliness of care, the plan demonstrated the following opportunities for improvement:

- Despite strong performance on the HEDIS measures Timeliness of Prenatal Care (PPC) and Frequency of Prenatal Care (FPC), the rate of Postpartum Care visits (PPC) was below the NCQA national average, as was also seen in RY 2014.
- Once again, despite strong performance on HEDIS Children and Adolescents' Access to Primary Care Practitioners (CAP); access to well-care services for children and adolescents is in need of improvement as seen in rates below national averages for the HEDIS measures: Well-Child Visits in the First 15 Months of Life: 6+ Visits (W15), Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) and Adolescent Well-Care Visits (AWC).
- As in RY 2014, improvement is needed in access to behavioral health and addiction services as demonstrated by performance below the NCQA national Medicaid averages for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET; both numerators), Identification of Alcohol and Other Drug Services (IAD), and Follow-up After Hospitalization for Mental Illness (FUH; both 7-day and 30-day follow up).

In the domain of access to/timeliness of care, IPRO recommends that CoventryCares of Kentucky:

- maintain the substantial and full compliance that was achieved in the current annual review, strive to achieve full compliance for all domains and address all elements that were found less than fully compliant, focusing on elements with minimal or non-compliance designations and requiring corrective action;
- work to improve the rates for HEDIS measures which fell below the NCQA national averages and HK PM rates that fell below the statewide aggregate rate, particularly those that have ranked below average for more than one reporting period or declined from the prior reporting period, with a particular focus on HEDIS measures for postpartum care, well-care visits for children and adolescents, and behavioral health/addiction services; and
- implement corrective actions to improve the methodological soundness and success of each of the current PIPs.

Humana-CareSource

It is important to note that RY 2015 was Humana-CareSource's second year for reporting HEDIS, CAHPS, and the HK PMs and first year reporting data for the state-wide service area. Therefore, trended performance should be viewed with caution.

Quality of Care

In the domain of quality, Humana-CareSource demonstrated the following strengths:

- Humana-CareSource's performance for the compliance review was similar to the CY 2015 review. The plan achieved full compliance (3.0 of 3.0 points) for the following compliance domains related to quality: Credentialing/Recredentialing and Program Integrity and substantial compliance in the following domains: Quality Measurement and Improvement (2.99 of 3.0 points), and Grievances (2.75 of 3.0 points). The following domains were deemed due to full compliance in the prior review: Delegation and Medical Records. It should be noted that no elements across these quality-related domains required corrective action, i.e., no elements were found minimally or non-compliant.
- Overall, Humana-CareSource's rates exceeded the national Medicaid averages for few of the HEDIS Effectiveness of Care measures. As stated prior, it is important to note that caution should be observed when comparing performance between RY 2014 and RY 2015, as HEDIS 2015 was the first year the plan reported data for the statewide service area (versus only Region 3). Additionally, the number of HEDIS measures the plan could calculate and report was limited due to enrollment limitations.
    - For Prevention and Screening, only Chlamydia Screening in Women (CHL) surpassed the average.
    - In the Respiratory Conditions domain, Appropriate Testing for Children with Pharyngitis (CWP), Use of Appropriate Medications for Asthma (ASM), Medication Management for People with Asthma (MMA – both 50% and 75% compliance) and Asthma Medication Ratio (AMR) exceeded national averages.
    - Rates for three (3) numerators of the Comprehensive Diabetes Care (CDC) measure: HbA1c Testing, HbA1c Poor Control (≥ 9%)[5] and Medical Attention for Nephropathy were above the Quality Compass™ Medicaid averages. This is an improvement from RY 2014, when only two (2) measure rates exceeded NCQA national average.
    - Regarding behavioral health, the plan surpassed the national Medicaid averages for Antidepressant Medication Management (AMM; both acute phase and continuation phase treatment), Follow-up Care for Children

[5] For the numerator, HbA1c Poor Control (> 9.0%), a lower rate is better performance and a rate below the average is desirable.

Prescribed ADHD Medication (ADD; both initiation and continuation/maintenance phase), and Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medication (SSD).
  - Lastly, the plan reported a rate that exceeded the national average for Annual Monitoring for Patients on Persistent Medications (MPM; 2 of 3 medications and total rate).
- Humana-CareSource saw substantial improvement in member satisfaction for adult members with providers and the MCO as reflected in the Adult CAHPS 5.0H results for How Well Doctors Communicate, Rating of Personal Doctor, Rating of Specialist Seen Most Often and Customer Service, Rating of All Health Care, and Rating of Health Plan, all of which ranked above national Medicaid averages.
- The following HK PMs performed above the statewide average in RY 2015: Cholesterol Screening for Adults, and Adolescent Screening/Counseling rates for alcohol/substance use, sexual activity, and depression. The rate for postpartum depression screening was 10 percentage points above the statewide average. As in the prior reporting period, it is difficult to interpret year-to-year performance as a limited number of HK PMs were reported in 2014 and the plan's service area and population changed significantly between RY 2014 and RY 2015.
- Humana-CareSource submitted the interim measurement for the following PIP focused on quality of care: "Untreated Depression." The MCO met and exceeded its goals for improvement for both PIP indicators and achieved a score of "Met" (80 of 80 points) on the interim evaluation.
- Humana-CareSource reported the baseline measurement for the following PIP focused on quality of care: "Use of Antipsychotics for Children and Adolescents." Strengths included: a well-developed rationale supported by data and clinical practice guidelines, working with external collaborators, and a creative intervention strategy. At the baseline phase, no numeric score is provided.
- Humana-CareSource submitted a proposal for the following PIP focused on quality of care: "HbA1c Control." Strengths included: a project topic selected with provider input, a well-developed rationale supported by data and literature, analysis of current data by age, gender, eligibility category, and region, using member and provider interviews to conduct barrier analyses, and piloting interventions in both urban and rural areas.
- Humana-CareSource submitted a proposal for the following PIP focused on quality of care: "Effectiveness of Coordinated Care Management on Physical Health Risk Screenings in the Seriously Mentally Ill." Strengths include using member and provider interviews to conduct barrier analyses, development of a member profile report for ongoing risk monitoring, follow-up and care coordination, and a multifaceted, evidence-based intervention strategy.

In the domain of quality, the plan demonstrated the following opportunities for improvement:

- Performance for HEDIS Effectiveness of Care measures continues to present ample opportunity for improvement.
  - For Prevention and Screening, the plan exceeded the NCQA national Medicaid average for only one (1) measure, Chlamydia Screening in Women (CHL). Rates for all of the following ranked below the NCQA national averages: Adult BMI Assessment (ABA), Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC), Childhood Immunization Status (CIS): Combo 3, Immunizations for Adolescents (IMA); (both individual antigens and Combo #1), Human Papillomavirus Vaccine for Female Adolescents (HPV), Lead Screening in Children (LSC), and Cervical Cancer Screening (CCS).
  - Regarding care for Respiratory Conditions, the four of nine (4 of 9) rates fell below national Medicaid averages, including: Appropriate Treatment for Children with URI (URI), Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB), and Pharmacotherapy Management of COPD Exacerbation (PCE; both numerators). Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) was not applicable/not reported.
  - Both measures of cardiovascular care ranked below national averages, Controlling High Blood Pressure (CBP) and Persistence of Beta-Blocker Treatment After a Heart Attack (PBH).
  - Rates for the four of seven (4 of 7) HEDIS Comprehensive Diabetes Care (CDC) numerators fell below average, including: HbA1c Control (< 8%), HbA1c Control (< 7%), Eye Exam Performed, and Blood Pressure Control (< 140/90).
  - For HEDIS measures related to behavioral health care, improvement is needed for the following four (4) measures, which fell below the national Medicaid averages as well as the statewide averages: Follow-up After Hospitalization for Mental Illness (FUH; both 7-day and 30-day follow-up), Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD), and Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA).
- Regarding board certification of network providers, rates for the HEDIS Board Certification (BCR) measure for all specialties fell below national averages, as was the case in the prior reporting period (RY 2014). However, some

improvement was seen as the plan's rates were above the statewide average for four of six (4 of 6) specialties, compared to three of six (3 of 6) in RY 2014.

- Despite strong performance related to member satisfaction with providers and the MCO on the Adult CAHPS 5.0H, results for the Child CAHPS 5.0H continue offer substantial room for improvement, although there was slight improvement seen compared to RY 2014. Satisfaction with providers and MCO continued to fall below the NCQA national averages: Rating of Personal Doctor, Rating of All Health Care and Rating of Health Plan, while the following improved and exceeded national averages: How Well Doctors Communicate and Customer Service. As was the case in RY 2014, for the Child CAHPS 5.0 H, Rating of Specialist Seen Most Often was reported as "N/A". An "N/A" was reported due to the denominator being less than 100.
- Substantial opportunity for improvement exists among the quality-related HK PMs. Humana-CareSource reported rates below the statewide average for the following measures: Adult Height and Weight Documented, Adult Counseling for Nutrition and Physical Activity, Child and Adolescent Height and Weight Documented. Although rates improved substantially since RY 2014, the rates for measures for Prenatal Screening/Counseling continue to present an opportunity for improvement. Rates for the following numerators fell below the statewide average: tobacco screening and intervention for positive tobacco use, alcohol screening and intervention[6] for alcohol use, screening for substance use, nutrition assessment/counseling, counseling for OTC and prescription medications, screening for domestic violence, and prenatal depression screening.

In the domain of quality, IPRO recommends that Humana-CareSource:

- maintain current level of performance for compliance domains that achieved full compliance, strive for full compliance for the remaining domains;
- work to improve rates for HEDIS Effectiveness of Care measures that were below the NCQA national averages, with particular attention to the metrics for preventive and screening and care for diabetes;
- based on the Child CAHPS 5.0H results, conduct a root-cause analysis to determine the reasons for lack of member/parent satisfaction and initiate interventions directed toward improvement; and
- continue to conduct interventions directed at improving HK measure rates, for the Prenatal Screening/Counseling measures in particular.

Access to Care/Timeliness of Care

In the domain of access to/timeliness of care, the plan demonstrated the following strengths:

- The plan demonstrated excellent performance on the compliance domains related to access and timeliness, achieving full compliance (3.0 of 3.0 points) for the following: Health Risk Assessment, Utilization Management, EPSDT Services, and Care Management and substantial compliance for the remaining domains: Access (2.33 of 3.0 points), Enrollee Rights (2.67 of 3.0 points), Behavioral Health Services (2.83 of 3.0 points), and Pharmacy Services (2.60 of 3.0 points). Additionally, Member Outreach was deemed, due to prior full compliance. It is also important to note that only two (2) elements across these eight (8) domains required corrective action.
- Adult CAHPS 5.0H results revealed strong member satisfaction with Getting Needed Care and Getting Care Quickly, an improvement from RY 2014. Likewise, the rate for HEDIS Call Answer Timeliness exceeded the NCQA national average.
- Humana-CareSource submitted the interim measurement for following PIP focused on access to/timeliness of care: "Emergency Department (ED) Use Management." The MCO did not achieve its goal for improvement for either PIP indicator, and in fact, the rates increased (a lower rate is better performance in this case). It should be noted that the plan is measuring performance for MY 2013 – MY 2015 for the Region 3 service area and for MY 2014 – MY 2015 for the expanded, statewide service area. Strengths of this PIP include collaboration with provider groups and Emergency Medical Services (EMS) and well-defined interventions that target members, providers, and the health plan, as well as use of process measures to track the interventions.
- Humana-CareSource submitted the baseline measurement for the following PIP focused on access to/timeliness of care: "Postpartum Care." Strengths include: strong rationale supported by data and clinical practice guidelines, measureable objectives and clearly stated goals, and a well-defined and broad intervention strategy that targets members, providers, and the health plan. At the baseline phase, no numeric score is provided.

[6] Caution should be used in interpreting this rate, due to a denominator < 30.

In the domain of access to/timeliness of care, the plan demonstrated the following opportunities for improvement:

- As was the case for HEDIS 2014, performance for the following Access and Availability measures is in need of improvement as evidenced by rates below the NCQA national averages for Medicaid: Adults' Access to Ambulatory and Preventive Health Care Services (AAP; all 3 age groups and total), Children and Adolescents' Access to Primary Care Practitioners (CAP; all 4 age groups)[7] as well as Well-Child Visits in the First 15 Months of Life – 6+ Visits[8] (WC15), Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (WC34), Adolescent Well-Care Visits (AWC). It should be noted, however, that Ambulatory Care: Total Outpatient Visits (AMBA) ranked above the national Medicaid average.
- In RY 2015, the CMS-416 Dental Services measure set was added to the HK PMs. Humana-CareSource's rates were below the statewide average for all 7 numerators. This is consistent with the rate for HEDIS Annual Dental Visits (ADV, which ranked below the Medicaid national average.
- Although rates for HEDIS Timeliness of Prenatal Care and Frequency of Prenatal Care: 81%+ Expected Visits were above average in RY 2014, rates for all access to prenatal and postpartum care metrics fell below the national averages in RY 2015, including: Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care and Postpartum Care and Frequency of Prenatal Care: 81%+ Expected Visits.
- In RY 2014, Humana-CareSource was not able to report rates for all of the measures of access to behavioral health services. In RY 2015, the rates for Follow-up After Hospitalization for Mental Illness (FUH; both 7-day and 3—day follow-up visits) were again below the NCQA national Medicaid averages, as were rates for the newly reported Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET; both the initiation and engagement numerators). However, performance was above average for Identification of Alcohol and Other Drug Services (IAD).
- Despite above average performance among adults for the CAHPS 5.0H composites Getting Needed Care and Getting Care Quickly, results for the child survey were below average for these two metrics of member satisfaction with access to care.
- Similar to access to care for the overall child membership, performance on HK PMs for access to care for CSHCN was below average. The following rates fell below the statewide average: Annual Dental Care, Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (WC34), and Adolescent Well-Care Visits (AWC) Children and Adolescents' Access to Primary Care Practitioners (25 months–6 years age, 7-11 years, and 12-19 years cohorts).[9]

In the domain of access to/timeliness of care, IPRO recommends that Humana-CareSource:

- address any areas of less than full compliance with special attention to few elements that require corrective action;
- work to improve rates for HEDIS and HK measures that were below the NCQA national averages or the statewide aggregate rate, with particular attention on metrics for children and adolescent's access to PCPs, well-care visits, and dental care for both the general population and CSHCN as well as child member satisfaction with access to care; and
- address performance in the areas of prenatal and postpartum care.

[7] For HEDIS 2014, Humana-CareSource was only able to report rates for Children and Adolescents' Access to Primary Care Practitioners for the 12–24 months and 25 months–6 years cohorts. For HEDIS 2015, the plan reported all 4 rates.

[8] HEDIS 2015 was the first year Humana-CareSource was able to report a rate for Well-Child Visits in the First 15 Months of Life.

[9] Humana-CareSource was not able to report rates for the following measures of access for CSHCNs: Well-Child Visits in the First 15 Months of Life and Children's and Adolescents' Access to Primary Care Practitioners (12-24 months).

Passport Health Plan

Quality of Care

In the domain of quality, the plan demonstrated the following strengths:

- Passport Health Plan demonstrated strong performance for each quality-related compliance domain reviewed in 2015, with compliance review determinations of either substantial or full, and no elements requiring corrective action.
- The plan performed strongly with respect to the HEDIS measures/submeasures for Preventive Care. Passport Health Plan's rates exceeded the NCQA national average for eleven of thirteen (11 of 13) measures. The exceptions were Breast Cancer Screening and Cervical Cancer Screening, however; the rates did surpass the corresponding statewide averages.
- The MCO's rates for HEDIS measures related to care for chronic respiratory conditions were very good. Rates were above the NCQA national averages for all of the following: Use of Spirometry Testing in the Assessment and Diagnosis of COPD, Pharmacotherapy Management of COPD Exacerbation (both numerators), Use of Appropriate Medications for People with Asthma, Medication Management for People with Asthma: 50% and 75% Compliance, Children with Pharyngitis and Asthma Medication Ratio.
- In relation to HEDIS measures for cardiovascular care, the plan's results were mixed. The rate for Persistence of Beta-Blocker Treatment After a Heart Attack exceeded the NCQA national average, but the rate for Controlling High Blood Pressure exceeded neither the NCQA national average nor the weighted statewide average.
- Care for diabetes was once again an area of high performance for Passport Health Plan, with rates for six of seven (6 of 7) Comprehensive Diabetes Care numerators: HbA1c testing, HbA1c > 9 mg/dL, HbA1c < 8 mg/dL, HbA1c < 7 mg/dL, Medical Attention for Nephropathy, and Blood Pressure Control < 140/90 that outperformed the NCQA national average. Eye Exam Performed was the single comprehensive diabetes measure that did not outperform the NCQA national average, as well as the weighted statewide average.
- Plan performance on measures related to behavioral health was mixed, with plan rates outperforming NCQA national averages for Antidepressant Medication Management, Follow-up Care for Children Prescribed ADHD Medication, and Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication, but not for Follow-up After Hospitalization for Mental Illness, Diabetes Monitoring for People with Diabetes and Schizophrenia, or Adherence to Antipsychotic Medications for Individuals with Schizophrenia. There was no NCQA comparison data available for the measures of Use of Multiple Concurrent Antipsychotics in Children and Adolescents nor for Metabolic Monitoring for Children and Adolescents on Antipsychotics; however, compared to the weighted statewide average, the former did not outperform the weighted statewide average, but the latter did.
- All metrics related to Annual Monitoring for Patient on Persistent Medications exceeded NCQA national averages. Passport Health Plan performed below the NCQA national average for the HEDIS Board Certification metric across all specialties, i.e., Family Medicine, Internal Medicine, Obstetrician/Gynecologist, Pediatricians, Geriatricians, Other Physician Specialists.
- Passport Health Plan performance on the HK PMs for perinatal care was mixed, with rates above the statewide average for screening for tobacco use and screening for substance use, but rates below the statewide average for interventions for women screened positive for each of these metrics. Screening rates for depression during one of the first two prenatal visits and screening for depression during a postpartum visit were higher than the statewide average; however, the prenatal depression screening rate of 39.47% was considerably lower than the postpartum depression screening rate of 60.52%, indicating opportunity for improvement. Passport Health Plan performance on many of the preventive care measures for the CSHCN cohort exceeded the statewide average, and for those that did not, rates were close and exceeded 90%. Performance on the 7 metrics for child access to dental services was less than 50%, and rates for the following metrics fell below the statewide average: Any Dental Services, Dental Treatment Services, Sealant on a Permanent Molar Tooth, and Any Dental or Oral Health Service. Child CAHPS 5.0 results remained strong this reporting period, with five of six (5 of 6) measures of satisfaction with the health plan and providers ranking above the NCQA national average, including: How Well Doctors Communicate and Rating of Specialist Seen Most Often. Satisfaction with the MCO was better than average as well, with rates for Customer Service, Rating of All Health Care, and Rating of Health Plan exceeding NCQA national averages.
- Adult CAHPS 5.0 results were mixed, with four of eight (4 of 8) measures of satisfaction ranking above the NCQA national average, including: Getting Needed Care, Getting Care Quickly, Customer Service, and Rating of Health Plan.

- Passport Health Plan conducted PIPs on the following topics: "Psychotropic Drug Intervention Program (PDIP)" (interim remeasurement) and "Use of Antipsychotics in Children and Adolescents" (baseline). Strengths included strong rationales supported by data for both PIPs. For the PIP focusing on the PDIP, the rates improved at interim remeasurement for both study indicators, but did not exceed the improvement targets. Additionally, for this PIP assessment, the MCO scored 80 points out of 80 total points. For the PIP focusing on use of antipsychotics, specific strengths included a barrier analysis based on data and input from providers and members, as well as a robust intervention strategy that targets providers, members, and health plan systems, and incorporates multiple collaborators, e.g., clinic and school-based liaisons.
- The MCO also submitted a baseline PIP on the topic of "Development and Implementation of an Asthma Action Plan" that reported baseline 2014 data on HEDIS asthma medication measures (AMM, MMA, AMR), as well as baseline 2014 data on asthma ER visits, 23 hour observation stays, inpatient admissions, PCP and specialist visits.
- Two additional baseline PIPs were submitted: the Statewide Collaborative PIP on Use of Antipsychotics in Children and Adolescents, which included baseline rates for HEDIS APC, APP and APM measures, and a baseline PIP on "Reducing Readmission Rates of Postpartum Members"; however, the latter PIP did not report baseline results. Both PIPs included robust interventions for members, providers and the health plan.

In the domain of quality, the plan demonstrated the following opportunities for improvement:

- There were relatively few HEDIS measures that ranked below the NCQA national average. Metrics that did not outperform the NCQA national averages indicate opportunities for improvement and include: Controlling High Blood Pressure, Follow-up After Hospitalization for Mental Illness, Diabetes Monitoring for People with Diabetes and Schizophrenia, Adherence to Antipsychotic Medications for Individuals with Schizophrenia, and HEDIS Board Certification across all provider metrics. Despite performance that was generally above the statewide aggregate rates for the HK PMs, there is room for improvement related to: prenatal depression screening, Any Dental Services, Dental Treatment Services, Sealant on a Permanent Molar Tooth, and Any Dental or Oral Health Service. Adult CAHPS 5.0 results that fell below the NCQA national average include: How Well Doctors Communicate, Rating of Personal Doctor and Rating of Specialist Seen Most Often, as well as Rating of All Health Care.
- Passport Health Plan conducted PIPs on the following topics: "Use of Antipsychotics in Children and Adolescents" (baseline measurement) and "You Can Control Your Asthma! Development and Implementation of an Asthma Action Plan" (baseline measurement). Both these PIPs present substantial opportunities for improvement, as the MCO was not able to report baseline rates.
- Passport Health Plan submitted one quality related proposal in 2015. They submitted the statewide collaborative PIP "Management of Physical Health Risks in the Seriously Mentally Ill Population". The MCO plans to conduct onsite interviews with providers to identify perceived barriers. The MCO plans to implement a pilot program for physical and behavioral care integration at one or more sites.

In the domain of quality, IPRO recommends that Passport Health Plan:

- focus efforts on rates for HEDIS measures that perform below the NCQA national average;
- conduct barrier analyses and implement strategies to improve member satisfaction for adults; and
- review and implement the EQRO recommendations for each of the PIPs, particularly those related to indicators for the antipsychotics in children/adolescents, asthma and postpartum re-admissions PIPs, where the plan was not able to report baseline rates.

Access to Care/Timeliness of Care

In the domain of access to/timeliness of care, the plan demonstrated the following strengths:

- Regarding compliance with standards, Passport Health Plan demonstrated noteworthy performance related to these domains, achieving full compliance (3.0 of 3.0 points): Grievances, Health Risk Assessment, UM, Pharmacy Benefits, Care Management/Care Coordination, Enrollee Rights, Medical Records and Behavioral Health Services; and earned substantial compliance for QI/MI (2.98 of 3.0 points), Credentialing (2.71 of 3.0 points), Access (2.5 of 3.0 points), and EPSDT (2.5 of 3.0 points), and was deemed for Member Education and Outreach.
- The plan exceeded the NCQA national average for eleven of fourteen (11 of 14) HEDIS Access and Availability measures, including Adults' Access to Preventive/Ambulatory Health Services (all age groups and total), Children's and Adolescents' Access to Primary Care (all age groups), Prenatal and Postpartum Care, and Annual Dental Visit.

- The HEDIS Use of Services also showed strong performance, four of four (4 of 4) measure rates exceeding the national average, including: Well-Child Visits in the First 15 Months of Life: 6+ Visits, Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life, Adolescent Well-Care Visits, and Frequency of Ongoing Prenatal Care: ≥ 81% Expected Visits.
- The plan exceeded the NCQA national averages for the CAHPS 5.0 Adult and Child survey items Getting Needed Care and Getting Care Quickly.
- Passport Health Plan's rates for the HK PMs related to access to care for CSHCNs exceeded the statewide aggregate rate for five of eight (5 of 8) measures. A notable high performing metric was Access to PCPs for children aged 12-24 months.
- Passport Health Plan conducted a PIP focused on appropriate use of antipsychotics in children and adolescents (baseline). A key strength pertinent to access is that Passport is conducting a pilot program to address access to psychiatric services in rural areas via tele-health and placing behavioral health practitioners in rural primary care settings.
- Passport Health Plan submitted one access related proposal in 2015 called "Promoting Healthy Smiles through Increased Utilization of Preventative Dental Care". The MCO has recruited multiple partners in conducting this PIP. The project topic selection is supported by national statistics, health services literature, state statistics, and MCO-specific data.

In the domain of access to/timeliness of care, the plan demonstrated the following opportunities for improvement:

- There is room for improvement related to access to behavioral health services, as rates for both Follow-up After Hospitalization for Mental Illness (both numerators) and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (both numerators) ranked below the NCQA national averages.
- There is an opportunity to improve Call Answer Timeliness.
- The plan should also improve performance on prenatal depression screening and access to dental care.

In the domain of access to/timeliness of care, IPRO recommends that Passport Health Plan:

- continue working to improve rates for HEDIS measures that perform below the NCQA national average; and
- develop strategies and implement interventions to improve access to behavioral health services.

WellCare of Kentucky

Quality of Care

In the domain of quality, the plan demonstrated the following strengths:

- WellCare of Kentucky showed strong performance for the following quality-related compliance domains out of a possible score of 3.0: Quality Measurement and Improvement (3.0) Credentialing/Recredentialing (2.99), Program Integrity (2.89), and Delegation (2.79). Health Information Systems domain was deemed due to prior scores of full compliance. It should be noted that only one (1) element across all domains required corrective action.
- WellCare of Kentucky rated above the NCQA Medicaid National Mean for the following HEDIS measures of quality of care: Adult BMI Assessment, Immunization for Adolescents, Medication Management for People with Asthma, Comprehensive Diabetes Care numerators, including: HbA1c Testing, HbA1c Control < 8 mg/dL, HbA1c Control < 7 mg/dL, HbA1c Poor Control (> 9.0%), and Monitoring for Nephropathy.
- WellCare of Kentucky's performance related to quality of care for members with behavioral health conditions was fairly good. While some measure rates were above the NCAA national averages: Antidepressant Medication Management (Effective Continuation Phase Treatment), Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medication, Diabetes Monitoring for People with Diabetes and Schizophrenia, Follow-up Care for Children Prescribed ADHD Medications (both numerators), and Adherence to Antipsychotic Medications for Individuals with Schizophrenia; others were below average, including: Antidepressant Medication Management (Acute Phase) and Follow-up After Hospitalization for Mental Illness.
- The plan performed well in regard to consumer satisfaction with providers and the MCO, as demonstrated by rates above NCQA national average for both the Adult and Child CAHPS survey questions, Rating of Health Plan and Rating of All Health Care.
- WellCare of Kentucky reported a final rate for 2 PIPs, one in the area of quality on "Use of Behavioral Health Medication in Children" which received a Met compliance with a score of 82.5/100, interim rates for two (2) PIPs,

baseline rates for two (2) PIPs and submitted proposals for two (2) PIPs. Quality of care topics include: "Use of Behavioral Health Medication in Children" (final measurement), "Management of Chronic Obstructive Pulmonary Disease" (interim measurement), and Use of Antipsychotics in Children and Adolescents" (baseline), and proposals on Effectiveness of Coordinated Care Management on Physical Health Risk Screenings in the Seriously Mentally Ill (SMI) Population and Improving Pediatric Oral Health. The MCO's PIPs incorporate strong rationales, clearly defined indicators, sound methodologies, and include broad intervention strategies that target members, providers, and health plan systems and processes.

In the domain of quality, the plan demonstrated the following opportunities for improvement:

- HK PMs related to quality of care continue to present an opportunity for improvement. Rates that fell below the statewide average were: Child and Adolescent members with evidence of both a height and weight; Child and Adolescent members with evidence a healthy weight for height; Adolescent Screening/Counseling: Adolescent Screening for Alcohol/Substance Use, and Adolescent Screening/Counseling for Sexual Activity; as well as Perinatal Screening/Counseling: Screening for Tobacco Use, Screening for Alcohol Use, Screening for Substance Use, Counseling for Nutrition, Counseling for OTC/Prescription Drugs, Screening for Domestic Violence and Prenatal and Postpartum Screening for Depression. Most of these measures were also below the statewide average in RY 2014.
- The MCO as in RY 2014 continues to report all rates below the NCQA national average for all provider types of the HEDIS Board Certification measure, as did most of the Kentucky Medicaid MCOs.
- Opportunity for improvement continues in the HEDIS prevention and screening domain, with rates below the NCQA national average for these measures: Childhood Immunization: Combo3; Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents; Human Papillomavirus Vaccine for Female Adolescents; Lead, Breast and Cervical Screening and Chlamydia Screening.
- HEDIS Effectiveness of Care metrics for cardiovascular risk continue to rank below the NCQA national average: Controlling High Blood Pressure, and Persistent Beta-Blocker Treatment After a Heart Attack.
- For HEDIS measures of acute respiratory care, the plan's rates fell below the NCQA national average for measures: Appropriate Testing for Children with Pharyngitis, Appropriate Treatment for Children with URI, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, Use of Spirometry Testing in the Assessment and Diagnosis of COPD and Pharmacotherapy Management of COPD Exacerbation (Systemic Corticosteroid).

In the domain of quality, IPRO recommends that WellCare of Kentucky:

- continue to work on improving rates for HEDIS and HK measures related to preventive and screening services;
- take action to increase risk screening and counseling for adolescents and pregnant women;
- work to improve HEDIS measure rates that fall below the NCQA national averages, particularly for measures related to cardiovascular care, appropriate testing and antibiotic use for children with acute respiratory illnesses, and some behavioral health care measures;
- address all areas that were found less than fully compliant, with special attention to the domains Health Risk Assessment even though a change to WellCare of Kentucky's process was put into place at the beginning of 2016; and
- as recommended in RY 2014, consider working with DMS and the other MCOs to examine the reasons for low rates for board-certification to determine if this issue is specific to WellCare of Kentucky or is a regional/statewide norm.

Access to Care/Timeliness of Care

In the domain of access to/timeliness of care, WellCare of Kentucky demonstrated the following strengths:

- WellCare of Kentucky achieved full compliance (3.0 of 3.0 total points) for the compliance domains UM, EPSDT, Enrollee Rights, Member Outreach and Medical Records. They received substantial compliance for the domains Health Risk Assessment, Care Management, Behavioral Health Services, and Pharmacy Services. It should be noted that only two (2) elements across all Access/Timeliness of Care domains required corrective action.
- The MCO exceeded the NCQA national average for the following HEDIS Access and Availability of Care measures: Adults' Access to Preventive/Ambulatory Health Services (all age groups and total), Children and Adolescents' Access to Primary Care Practitioners (all age groups: 12–24 months, 25 months–6 years, 7–11 years, and 12–19 years), and Annual Dental Visit.
- The MCO demonstrated strong performance in regard to prenatal care as demonstrated by rates above the NCQA national average for Timeliness of Prenatal Care and Frequency of Ongoing Prenatal Care: 81% + Expected Visits.

- The MCO exceeded the NCQA national averages for both the Adult and Child CAHPS 5.0 items Getting Needed Care and Getting Care Quickly.
- Related to the HK PMs, WellCare of Kentucky was above the Kentucky State Average in measures related to access to care and services for CSHCNs, including: Annual Dental Visits, and Children and Adolescents' Access to Primary Care Practitioners for the age groups 25 months to 6 years, 7 to 11 years, 12 to 19 years and CMS-416 Dental for 5 of the 7 sub measures.
- WellCare of Kentucky submitted a final PIP focused on "Inappropriate Emergency Department Utilization and it received a Met compliance finding with a score of 70/100., "Follow-up After Hospitalization for Mental Illness" (interim measurement), and "Postpartum Care" (baseline). The PIPs incorporate strong rationales, clearly defined indicators, sound methodologies, and include broad intervention strategies that target members, providers, and health plan systems and processes.

In the domain of access to/timeliness of care, the plan demonstrated the following opportunities for improvement:

- Despite an overall score of substantial compliance, there is opportunity for improvement related to the compliance domain HRA and Pharmacy Services, with corrective action required for elements in both of these areas.
- access to behavioral health care services continues to be an area needing improvement. The plan's performance for HEDIS Follow-up After Hospitalization for Mental Illness for both the 7 and 30-day follow-up ranked below the NCQA national average. The Effective Acute Phase Treatment sub measure of the Antidepressant Medication Management measure was below the NCQA national average. Additionally, rates were below the NCQA national average for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (both numerators).
- As reported last year despite strong performance on measures of access the plan's rate for Postpartum Care fell below the NCQA national average once again.
- Also, despite strong performance on measures of access to primary care for children and adolescents, rates for both Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life and Adolescent Well-Care Visits as they were last year, were below the NCQA national averages.

In the domain of access to/timeliness of care, IPRO recommends that WellCare of Kentucky:

- work to improve HEDIS measure rates which fall below the NCQA national averages, particularly related to access/timeliness of behavioral health service;
- Implement the planned PIP focusing on Pediatric Oral Health, evaluating and modifying the intervention strategy where necessary as the PIP progresses;
- address all compliance areas found less than fully compliant; and
- as recommended previously, consider initiating a PIP focused on improving rates for well-care visits for children and adolescents.

Department for Medicaid Services

The primary goals of the Kentucky MMC program are to improve health status of Medicaid enrollees and lower morbidity among enrollees with serious mental illness. DMS has established the following objectives in order to effectively accomplish this goal:

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

DMS has identified six health care conditions and utilization trends which present statewide issues and, as such, have been selected as targets for improvement:

- diabetes,
- coronary artery disease screenings,
- colon cancer screenings,
- cervical/breast cancer screenings,
- mental illness, and
- reduction in ED usage/management of ED services.

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

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

[10] Note that the Cholesterol Screening for People with Cardiovascular Disease measure and the LDL-C numerators for the Comprehensive Diabetes Care measure have been discontinued as of HEDIS 2015.

Background

Kentucky Medicaid Managed Care Program

History of Kentucky Medicaid Managed Care Program

In December 1995, the Commonwealth of Kentucky was granted approval for an amendment to the Medicaid Access and Cost Containment Demonstration Project. The approved amendment permitted the establishment of eight regional managed care networks consisting of public and private providers to deliver health care services to Medicaid beneficiaries. Each region would have one managed care entity or Partnership, subject to state-specified guidelines. Medicaid beneficiaries would be enrolled into the Partnership designated for their area. The Partnership demonstration was implemented on November 1, 1997. Two (2) partnerships were developed and implemented in Region 3 (Louisville/Jefferson County and 15 surrounding counties) and Region 5 (Lexington/Fayette County and 20 surrounding counties). In 1999, the Region 5 Partnership notified DMS that it could no longer maintain its provider community. In 1999 and 2000, CMS approved amendments to the Commonwealth's waiver program that allowed for a move from a statewide to a sub-state model in order to continue to operate the one remaining partnership plan.

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

However in 2011, as a result of an increased demand for cost-effective health care, the Kentucky Cabinet for Health and Family Services (CHFS) and DMS initiated an expansion of the MMC program in order to offer quality health care statewide. In September 2011, CHFS received approval from CMS to operate a Medicaid MCO waiver program for the period of October 1, 2011 through September 30, 2013. The waiver allowed Kentucky to implement a mandatory managed care program statewide. In November 2011, three MCOs, CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky, joined Passport Health Plan in offering Medicaid services including those related to behavioral health. With this expansion, Medicaid services in Kentucky were made available statewide, allowing all eligible Kentuckians to enroll in a managed care plan. For the reporting year 2012, Kentucky MCOs operated regionally, as follows: CoventryCares of Kentucky in all regions; Kentucky Spirit Health Plan in all regions, except Region 3; Passport Health Plan in Region 3; and WellCare of Kentucky in all regions. As of July 2013, Kentucky Spirit Health Plan withdrew from the Kentucky MMC program. However, in January 2013 Humana-CareSource began serving beneficiaries in Region 3 and in 2014, began serving beneficiaries statewide. Also in 2014, Passport Health Plan expanded its service area from Region 3 only to statewide. Anthem Blue Cross and Blue Shield Medicaid joined the program and began enrolling members in January 2014. Anthem Blue Cross and Blue Shield Medicaid served beneficiaries statewide except for Region 3. As of July 1, 2015, each of the five (5) MCOs operates statewide.

In calendar year 2015, the Kentucky MMC program was comprised of the MCOs and service areas listed in Table 2.

Table 2: Kentucky Medicaid MCOs – CY 2015

MCO Name	Medicaid Service Area
Anthem Blue Cross and Blue Shield Medicaid	Statewide[1]
CoventryCares of Kentucky	Statewide
Humana-CareSource	Statewide
Passport Health Plan	Statewide
WellCare of Kentucky	Statewide

[1]Anthem Blue Cross and Blue Shield Medicaid served counties statewide except Region 3 through June 30, 2015 and expanded to the statewide service area as of July 1, 2015.

Kentucky Managed Care Quality Strategy

In September 2012, DMS issued the *Commonwealth of Kentucky Strategy for Assessing and Improving the Quality of Managed Care Services* (the *Quality Strategy*) to outline the goals, objectives and expectations of the expanded Managed Care program.

As part of this *Quality Strategy*, in keeping with federal regulations at 42 CFR 438 Subpart D, DMS established, in collaboration with the Departments for Public Health (DPH) and Behavioral Health, Developmental and Intellectual Disabilities (BHDID), a set of Medicaid Managed Care Performance Measures which the Medicaid plans would be required to report. The measure set was originally designed to align with the *Healthy Kentuckians 2010 Goals* and demonstrate the state's commitment to the national initiative, *Healthy People 2010*. At that time, Healthy Kentuckians (HK) included ten leading health indicators with related goals and objectives. Other measures were derived from HEDIS and included in the PM set to allow for comparison to national benchmarks. Together, these PMs address timeliness of, quality of and access to care provided to individuals enrolled in managed care.

The primary goals of the Kentucky MMC program are to improve health status of Medicaid enrollees and lower morbidity among enrollees with serious mental illness. DMS has established the following objectives in order to effectively accomplish this goal:

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

DMS has identified six health care conditions and utilization trends which present statewide issues and, as such, have been selected as targets for improvement:

- diabetes,
- coronary artery disease screenings,
- colon cancer screenings,
- cervical/breast cancer screenings,
- mental illness, and
- reduction in ED usage/management of ED services.

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

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

As part of Kentucky's *Quality Strategy*, annual reviews of the effectiveness of the quality plan will be used to update the strategy. Updates will be influenced by the findings of the following annual activities:

1. the EQR Technical Report which summarizes the results of regulatory compliance reviews, PMs, PIPs and optional EQR activities,
2. participant input, which includes results of annual surveys of members' and providers' satisfaction with quality and accessibility of services, enrollee grievances and public forum,
3. public input, which is facilitated by the following groups:
    a. MCO-maintained Quality and Member Access Committee (QMAC), comprised of individuals who represent the interests of the member population;
    b. Medicaid Advisory Council; and
    c. Medicaid Technical Advisory Committee(s).

Annual EQR Technical Report

Kentucky DMS contracted IPRO to conduct the EQR of the health plans participating in the Medicaid Program during 2013–2015 as set forth in 42 CFR §438.356(a)(1). After completing the EQR process, IPRO prepared this *2016 External Quality Review Technical Report for Kentucky Medicaid Managed Care,* in accordance with 42 CFR §438.364. The report describes the manner in which data from activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed and how conclusions were drawn as to the *quality, timeliness* and *access* of the care furnished to Kentucky's Medicaid recipients by the MCOs.

This report provides a description of the mandatory EQR activities conducted:

- monitoring of the compliance with standards,
- validation of PMs, and
- validation of PIPs.

This report presents the findings for all health plans participating in Kentucky's MMC program during calendar year 2015: Anthem Blue Cross and Blue Shield Medicaid, CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky.

External Quality Review Activities

During the past year, IPRO conducted a compliance monitoring site visit, validation of PMs and validation of PIPs for Kentucky MCOs. Each activity was conducted in accordance with CMS protocols for determining compliance with MMC regulations. Details of how these activities were conducted are described in Appendices A–C, and address:

- objectives for conducting the activity;
- technical methods of data collection;
- descriptions of data obtained; and
- data aggregation and analysis.

Conclusions drawn from the data and recommendations related to *access, timeliness* and *quality* are presented in the Executive Summary of this report.

Findings, Strengths and Recommendations Related to Health Care Quality, Timeliness and Access

Introduction

This section of the report addresses the findings from the assessment of the Medicaid MCOs' strengths and areas for improvement related to *quality, timeliness* and *access*. The findings are detailed in each subpart of this section (i.e., Compliance Monitoring, Validation of PMs and Validation of PIPs).

This report includes results for each of the five health plans. The results include the MCOs' responses to the recommendations in the previous technical report. Since 2014 was the MCO's first year participating in the Kentucky Medicaid program, the responses to the prior year's report for Anthem Blue Cross and Blue Shield Medicaid are limited to the annual compliance review.

Compliance Monitoring

Review of Medicaid Managed Care Organization Compliance with Regulatory Requirements

This section of the report presents the final results of reviews by IPRO of the compliance of Anthem Blue Cross and Blue Shield Medicaid, CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan, and WellCare of Kentucky with regulatory standards and contract requirements for calendar year 2015.[11] The information is derived from the annual compliance reviews conducted by IPRO in January 2016.

A review, within the previous three-year period, to determine the MCOs' compliance with federal MMC regulations, state regulations and State contract requirements is a mandatory EQR activity as established in the Federal regulations at 42 CFR §438.358(b)(3).

Requirements contained within 42 CFR Subparts C: Enrollee Rights, D: Quality Assessment and Performance Improvement, F: Grievance System and H: Certifications and Program Integrity were reviewed.

For the compliance review process, one of two types of review is conducted for each plan:[12]

1. a "full review" consists of an evaluation under all available domains and file review types, or
2. a "partial review" evaluates only those domains for which the plan previously lacked full compliance.

In 2016, two MCOs (CoventryCares of Kentucky, and WellCare of Kentucky) underwent a full review. Anthem Blue Cross Blue Shield Medicaid, Passport Health Plan and Humana-CareSource received a partial review, based on the findings of the previous review.

Table 3 displays the domains that were reviewed for each plan for the 2016 Annual Compliance Review.

[11] The 2016 Compliance Review assessed MCO performance for the time period of CY 2015.

[12] The Quality Assessment and Performance Improvement: Measurement and Improvement domain is reviewed annually for all MCOs, as required by CMS.

Table 3: Annual Compliance Review 2016 – Domains by Plan

Topic/Tool	Anthem BCBS Medicaid	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky
Behavioral Health Services	a	a	a	a	a
Case Management/Care Coordination	a	a	a	a	a
Enrollee Rights: Enrollee Rights and Protection	a	a	a	a	a
Enrollee Rights: Member Education and Outreach	a	a	N/A	N/A	a
EPSDT	a	a	a	a	a
Grievance System	a	a	a	a	a
Health Risk Assessment	a	a	a	a	a
Medical Records	a	a	N/A	a	a
Pharmacy Benefits	a	a	a	a	a
Program Integrity	a	a	a	a	a
QAPI: Access	a	a	a	a	a
QAPI: Access – Utilization Management	a	a	a	a	a
QAPI: Measurement and Improvement	a	a	a	a	a
QAPI: Measurement and Improvement – Health Information Systems	N/A	N/A	N/A	N/A	N/A
QAPI: Structure and Operations – Credentialing	a	a	a	a	a
QAPI: Structure and Operations – Delegated Services	a	a	N/A	N/A	a

BCBS: Blue Cross and Blue Shield; N/A: not applicable, this requirement was deemed for 2016; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment; QAPI: Quality Assurance and Performance Improvement

A description of the content evaluated under each domain is as follows:

- Behavioral Health Services – The evaluation in this area included, but was not limited to, review of policies and procedures related to behavioral health services and coordination of physical and behavioral health services. In addition, file review was conducted to assess coordination of behavioral health and physical health services by the MCO case management program.
- Case Management/Care Coordination – The evaluation in this area included, but was not limited to, review of policies, procedures, and processes for case management and care coordination for clients of the Department of Community Based Services (DCBS) and the Department for Aging and Independent Living (DAIL); dissemination of information to members and providers; and monitoring, analysis, reporting and interventions. In addition, file review was conducted to assess service plans and care coordination for DCBS/DAIL clients and complex case management for those with chronic conditions and complex needs. It is important to note that, as was done in 2015, for the 2016 review, DMS determined that the MCOs would not be held responsible for the certain contract requirements related to service plans since the service plans are the responsibility of the DCBS and DAIL. The MCOs were only evaluated on attempts to obtain service plans. Therefore, related elements in the file review and the review tool (e.g., MCO signature on the service plan) were scored not applicable (N/A) and were not counted in the overall compliance determination.
- Enrollee Rights: Enrollee Rights and Protection – The evaluation in this area included, but was not limited to, review of policies and procedures for member rights and responsibilities, PCP changes and member services functions.
- Enrollee Rights: Member Education and Outreach – The evaluation in this area included, but was not limited to, a review of the Member and Community Outreach Plan, member informational materials, and outreach activities.
- Early Periodic Screening, Diagnostic, and Treatment (EPSDT) – The evaluation in this area included, but was not limited to, a review of policies and procedures for: EPSDT services, identification of members requiring EPSDT special services, education/information program for health professionals, EPSDT provider requirements and coordination of

services. The assessment also included a file review of UM decisions and appeals related to EPSDT services and review of the annual CMS-416 EPSDT reports.

- Grievance System – The evaluation of the Grievance System included, but was not limited to, review of policies and procedures for grievances and appeals, file review of member and provider grievances and appeals, review of MCO program reports on appeals and grievances and Quality Improvement (QI) committee minutes.
- Health Risk Assessment – The evaluation in this area included, but was not limited to, a review of initial health screenings and plan-initiated contact.
- Health Information Systems – The evaluation in this area included, but was not limited to, a review of policies and procedures for claims processing, claims payment and encounter data reporting, timeliness and accuracy of encounter data; timeliness of claims payments and methods for meeting Kentucky Health Information Exchange (KHIE) requirements.
- Medical Records – The evaluation in this area included, but was not limited to, a review of policies and procedures related to confidentiality, access to medical records, advance medical directives and medical records and documentation standards.
- Pharmacy Benefits – The evaluation in this area included, but was not limited to, a review of policies and procedures for pharmacy benefit requirements; structure of pharmacy program; pharmacy claims and rebate administrations; drug utilization review; and pharmacy lock-in program. In addition, this review included evaluation of the Preferred Drug List and authorization requirements.
- Program Integrity – The evaluation in this area included, but was not limited to, review of MCOs' policies and procedures, training programs, reporting and analysis; compliance with Annual Disclosure of Ownership (ADO) and financial interest provisions; and file review of program integrity cases.
- Quality Assessment and Performance Improvement (QAPI) – Access – The evaluation of this area included, but was not limited to review of policies and procedures for direct access services; provider access requirements; program capacity reporting; evidence of monitoring program capacity and provider compliance with hours of operation and availability.
- QAPI – Measurement and Improvement (MI) – The evaluation in this area included, but was not limited to, review of: QI Program Description, Annual QI Evaluation, QI Work Plan; QI Committee structure and function including meeting minutes; PIPs; PM reporting and clinical practice guidelines.
- QAPI – Structure and Operations: Credentialing – The evaluation in this area included, but was not limited to, review of the policies and procedures related to the credentialing and recredentialing of network providers and enrollment of out-of-network providers. Additionally, file review of credentialing and recredentialing for PCPs and specialists was conducted.
- QAPI – Structure and Operations: Delegated Services – The evaluation in this area included, but was not limited to, review of subcontractor contracts and subcontractor oversight, including subcontractor reporting requirements and conduct of pre-delegation evaluations and annual, formal evaluations.
- QAPI – Access: Utilization Management (UM) – The evaluation in this area included, but was not limited to, review of UM policies and procedures; UM committee minutes; and UM files.

The MCOs' responses to prior year recommendations are evaluated during the compliance review. IPRO evaluated the MCOs' progress related to the 2015 review recommendations and corrective action plans (CAPs).

In order to make an overall compliance determination for each of the domains, an average score is calculated. This is determined by assigning a point value to each element based on the designation assigned by the reviewer. Each element is scored as follows:

Full Compliance = 3 points;
Substantial Compliance = 2 points;
Minimal Compliance = 1 point;
Non-compliance = 0 points; and
Not Applicable = N/A.

The numerical score for each domain is then calculated by adding the points achieved for each element and dividing the total by the number of elements. The overall compliance determination is assigned as follows:

Full Compliance – point range of 3.0;
Substantial Compliance – point range of 2.0–2.99;
Minimal Compliance – point range of 1.0–1.99;
Non-compliance – point range of 0–0.99; and
Not Applicable – N/A.

It is important to note that, at the time of the (prior) two compliance reviews (2014 and 2015), the MCOs were advised that failure to correct prior areas of non-compliance could have a negative impact on the findings. In 2014, 2015 and 2016, each tool contained the following notice: "*As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement and result in possible sanctions by DMS."* Additionally, for the 2016 compliance review, DMS directed that any elements that were found less than compliant in the year prior (2015) and the current review (2016) should be scored "Minimal Compliance" and any elements that were found less than compliant for the two prior years (2014 and 2015) and the current review (2016) should be scored "Non-compliant."

Table 4 displays the numerical score and associated overall compliance determination for each domain reviewed for each of the MCOs.

Table 4: Overall Compliance Determination by Review Domain – 2016

Tool #/ Review Area[1]	Anthem BCBS Medicaid		CoventryCares of Kentucky		Humana-CareSource		Passport Health Plan		WellCare of Kentucky	
	Point Average	Compliance Deter-mination	Point Average	Compliance Deter-mination	Point Average	Compliance Deter-mination	Point Average	Compliance Deter-mination	Point Average	Compliance Deter-mination
1. QI/MI	2.47	Substantial	2.74	Substantial	2.99	Substantial	2.98	Substantial	3.00	Full
2. Grievances	2.43	Substantial	2.68	Substantial	2.75	Substantial	3.00	Full	2.93	Substantial
3. HRA	1.83	Minimal	2.71	Substantial	3.00	Full	3.00	Full	2.57	Substantial
4. Credentialing	2.60	Substantial	2.92	Substantial	3.00	Full	2.71	Substantial	2.99	Substantial
5. Access	2.17	Substantial	2.82	Substantial	2.33	Substantial	2.50	Substantial	2.91	Substantial
5a. UM	2.90	Substantial	3.0	Full	3.00	Full	3.00	Full	3.00	Full
6. Program Integrity	2.08	Substantial	2.74	Substantial	3.00	Full	3.00	Full	2.89	Substantial
7. EPSDT	2.14	Substantial	3.00	Full	3.00	Full	2.50	Substantial	3.00	Full
8. Delegation	3.00	Full	2.92	Substantial	N/A	N/A	N/A	N/A	2.79	Substantial
9. Health Information Systems	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
10. Care Management	1.67	Minimal	2.79	Substantial	3.00	Full	3.00	Full	2.91	Substantial
12a. Enrollee Rights	2.83	Substantial	2.87	Substantial	2.67	Substantial	3.00	Full	3.00	Full
12b. Member Outreach	3.00	Full	3.00	Full	N/A	N/A	N/A	N/A	3.00	Full
13. Medical Records	1.92	Minimal	2.95	Substantial	N/A	N/A	3.00	Full	3.00	Full
15. Behavioral Health Services	1.29	Minimal	2.94	Substantial	2.83	Substantial	3.00	Full	2.92	Substantial
16. Pharmacy Benefits	2.86	Substantial	2.72	Substantial	2.60	Substantial	3.00	Full	2.85	Substantial

[1]Detailed results for each review domain for all MCOs are available in the final Compliance Review Tools, available on the DMS Managed Care Oversight Quality Branch Reports web page at: http://chfs.ky.gov/dms/pqomcoqbreports.htm.

BCBS: Blue Cross and Blue Shield; N/A: not applicable, the domain was deemed for the 2016 review; QI: Quality Improvement; MI: Measurement and Improvement; HRA: Health Risk Assessment; UM: Utilization Management; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment.

As described previously, each element in each domain received a compliance designation: Full Compliance, Substantial Compliance, Minimal Compliance, Non-compliance, or Not Applicable. The final findings are sent to the MCOs and also to DMS's Corrective Action Plan (CAP) and Letter of Concern (LOC) Committee. Two DMS divisions, the Managed Care Oversight Quality Branch and the Managed Care Oversight Contract Management Branch, work together to review the findings and determine if a LOC and/or CAP request are required. The CAP/LOC Committee issues the LOCs and CAP requests to the MCOs. In general, the MCOs must provide a CAP for all elements deemed Minimal Compliance or Non-compliance.

Table 5 displays the number of elements for each domain that required a corrective action plan by MCO.

Table 5: Elements Requiring Corrective Action by Review Area – 2016

Tool #/ Review Area[1]	Anthem BCBS Medicaid		CoventryCares of Kentucky		Humana-CareSource		Passport Health Plan		WellCare of Kentucky	
	# of Elements Requiring Corrective Action	Total # of Elements Reviewed	# of Elements Requiring Corrective Action	Total # of Elements Reviewed	# of Elements Requiring Corrective Action	Total # of Elements Reviewed	# of Elements Requiring Corrective Action	Total # of Elements Reviewed	# of Elements Requiring Corrective Action	Total # of Elements Reviewed
1. QI/MI	15	83	9	99	0	90	0	90	0	102
2. Grievances	3	14	1	44	0	4	0	5	0	43
3. HRA	1	6	1	7	0	2	0	3	1	7
4. Credentialing/ Recredentialing	1	10	2	88	0	6	0	7	0	74
5. Access	1	6	4	67	0	3	0	2	0	66
5a. UM	0	10	0	53	0	5	0	4	0	53
6. Program Integrity	6	13	10	117	0	2	0	1	0	117
7. EPSDT	1	7	0	19	0	1	0	4	0	19
8. Delegation	0	1	1	26	N/A	N/A	N/A	N/A	1	34
9. Health Information Systems	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
10. Care Management	4	9	1	24	0	2	0	4	0	23
12a. Enrollee Rights	0	36	3	89	1	6	0	4	0	89
12b. Member Outreach	0	1	0	18	N/A	N/A	N/A	N/A	0	6
13. Medical Records	6	13	0	40	N/A	N/A	0	1	0	33
15. Behavioral Health Services	16	24	0	50	0	6	0	7	0	47
16. Pharmacy Services	0	7	1	18	1	5	0	4	1	13
Total Elements # (%)	54 (22.5%)	240	33 (4.3%)	759	2 (1.5%)	131	0 (0%)	136	3 (0.4%)	726

[1]The number (#) of elements reviewed for each domain and in total varies by MCO since the # of elements deemed and/or designated Not Applicable (N/A) varied.
BCBS: Blue Cross and Blue Shield; N/A: not applicable, the domain was deemed for the 2016 review; QI: Quality Improvement; MI: Measurement and Improvement; HRA: Health Risk Assessment; UM: Utilization Management; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment.

2016 Medicaid Compliance Review Findings for Calendar Year 2015: All MCOs

This section contains a summary of the current year findings. For each domain, findings across the five MCOs are described along with a description of the file review results (Table 6).

Table 6: 2016 Medicaid Managed Care Compliance Review Findings by Domain – All MCOs

2016 Medicaid Managed Care Compliance Review Findings (Review Year 2015)	
Review Domain	Summary of Review Findings
Behavioral Health Services	The Behavioral Health Services Domain was reviewed for each of the five (5) MCOs. · One (1) MCO achieved Full Compliance (3.0 of 3.0 points); three (3) MCOs achieved Substantial Compliance with scores ranging from 2.83 to 2.94 of 3.0 points; and one (1) MCO earned Minimal Compliance, with a score of 1.29 of 3.0 points. · Four (4) of the MCOs had no elements requiring corrective action. The fifth MCO had 16 elements that required a CAP (rated minimal or non-compliant) of 24 total elements (80%). · A file review was conducted to assess the MCOs' physical health and behavioral health care coordination for four (4) MCOs. One (1) MCO was deemed. Performance varied across the MCOs. Identification of physical and behavioral health needs and coordination of care was a relative strength among the MCOs.
Case Management/ Care Coordination	The Care Management/Care Coordination Domain was reviewed for each of the five (5) MCOs. · Two (2) MCOs earned 3.0 of 3.0 points (Full Compliance); two (2) MCOs achieved Substantial Compliance (2.79 and 2.91 of 3.0 points); and one (1) MCO scored Minimal Compliance with a score of 1.67 of 3.0 points. · The number of elements requiring corrective action was zero (0) for three (3) MCOs. The other MCOs had one (1) and four (4) elements requiring corrective action. · The Care Coordination File Review assessed overall coordination of care efforts, including assessment, care plan development, and facilitation and coordination of services. File review was conducted for two (2) MCOs and both were fully compliant with the requirements reviewed. · The Complex Care Management File Review assessed overall coordination of care efforts for members with complex needs. File review was conducted for two (2) MCOs. One (1) MCO was fully compliant with the requirements reviewed. One (1) MCO was lacking in the area of coordination of care. · As in the prior annual review (2015), the requirements related to service plans were designated not applicable as the service plan is under the domain of DCBS and DAIL, although all MCOs were responsible for requesting a copy of the service plan for each enrolled DCBS and DAIL client. As noted in prior years, each of the MCOs faces challenges in obtaining complete service plans, though all demonstrate efforts to obtain service plans and all meet with DCBS regularly. · The Case Management for DCBS/DAIL clients assessed assessment, care plan development, and facilitation and coordination of services for those members. File review was conducted for three (3) MCOs. Two (2) MCOs performed well on this review, while one (1) MCO presented only four (4) applicable files that did not demonstrate evidence of coordination of care. · The Claims/EPSDT File Review assessed the extent to which enrolled DCBS clients received EPSDT services and if not, whether outreach was conducted and the extent of coordination between physical and behavioral health, when applicable. File review was conducted for two (2) MCOs. One (1) MCO was fully compliant with the requirements reviewed, while the other MCOs was fully compliant with standards for coordination and substantially compliant with requirements for provision of well care and EPSDT services.
Enrollee Rights and	The Enrollee Rights and Protections: Enrollee Rights Domain was reviewed for each of the five (5) MCOs.

2016 Medicaid Managed Care Compliance Review Findings (Review Year 2015)	
Review Domain	Summary of Review Findings
Protections – Enrollee Rights	· Two (2) MCOs achieved Full Compliance; the three (3) remaining MCOs achieved Substantial Compliance with scores ranging from 2.67 to 2.87 of 3.0 points. · Three (3) of the MCOs had no (0) elements requiring corrective action, while the remaining two (2) MCOs had one (1) and three (3) elements rated minimally or non-compliant and requiring a CAP. · There was no file review conducted for this domain.
Enrollee Rights and Protections - Member Outreach	The Enrollee Rights and Protections: Member Outreach Domain was reviewed for three of five (3 of 5) MCOs. · Two (2) MCOs were deemed for this domain based on prior Full Compliance. · Three (3) MCOs underwent review and all achieved Full Compliance with scores of 3.0 of 3.0 points. · There was no file review conducted for this domain.
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	The EPSDT Domain was reviewed for each of the five (5) MCOs. · Three (3) MCOs achieved Full Compliance (3.0 of 3.0 points); two (2) MCOs earned Substantial Compliance with scores of 2.14 and 2.50 of 3.0 points. · Four (4) MCOs had no (0) elements requiring corrective action, while the fifth MCO had only one (1) element requiring a CAP. · The EPSDT UM File Review assessed the extent to which the MCOs were compliant with standards for UM denials related to prior authorization requests for EPSDT services. File review was conducted for all five (5) MCOs. The MCOs were fully compliant with the requirements with the exception of one (1) MCO lacking clear language in member notices of action in several cases. · The EPSDT Appeals File Review assessed the extent to which the MCOs were compliant with standards for processing for appeals related to EPSDT. File review was conducted for four (4) MCOs. The MCOs were compliant with the requirements for EDPST appeals with two exceptions. One (1) MCO was not compliant with the requirements for member notice of action related to the right to continue benefits and possible member liability for the cost of those continued benefits. Another MCO was not compliant with documentation of at oral notice for expedited appeals.
Grievance System	The Grievance Domain was reviewed for each of the five (5) MCOs. · One (1) MCO achieved Full Compliance and the remaining four (4) MCOs earned Substantial Compliance with scores ranging from 2.43 to 2.93 of 3.0 points. · Three (3) MCOs had no (0) elements requiring corrective action. The other two (2) MCOs had one (1) and three (3) elements requiring corrective action. · The Member Grievance File Review assessed the extent to which the MCOs were compliant with the standards for member grievance processing. Samples of member grievances were selected for both quality and random issues. File review was conducted for three (3) MCOs. MCOs were generally compliant with the requirements for member grievance processing. General areas of non-compliance included: timeliness, timely acknowledgment, documentation of complete investigation, and the requirements for member resolution notices. It should be noted that in some cases, files identified in the quality of care grievance samples were found not to relate to quality of care when reviewed. · The Provider Grievance File Review assessed the extent to which the MCOs were compliant with the standards for provider grievance processing. File review was conducted for two (2) MCOs. One (1) MCO was fully compliant with the requirements for provider grievance processing. One (1) MCO was not able to provide a case listing for provider grievance file sample

2016 Medicaid Managed Care Compliance Review Findings (Review Year 2015)	
Review Domain	Summary of Review Findings
	selection. · The Member Appeals File Review assessed the extent to which the MCOs were compliant with the standards for member appeals processing. File review was conducted for three (3) MCOs. One (1) MCO was fully compliant with the standards for member appeals. The other two (2) MCOs were generally compliance but there were some deficiencies related to timely acknowledgement, documentation of oral notification for expedited appeals, and member notification of the right to continue benefits and possible liability for those continued benefits. · The Provider Appeals File Review assessed the extent to which the MCOs were compliant with the standard for provider appeals processing. File review was conducted for one (1) MCO. The MCO was fully compliant with the requirements for provider appeal processing with the exception of several appeals that were not resolved timely.
Health Information Systems	The Health Information Systems Domain was deemed and was reviewed for none of the MCOs.
Health Risk Assessment	The Health Risk Assessment Domain was reviewed for each of the five (5) MCOs. · Two (2) MCOs achieved Full Compliance, while two (2) earned Substantial Compliance and the other MCO earned Minimal Compliance. Scores ranged from 1.83 to 3.0 of 3.0 total points. · Two (2) of the MCOs had no elements requiring corrective action, while the remaining three (3) MCOs had one (1)) element requiring corrective action. · The Health Risk Assessment (HRA) File Review assessed the extent to which the MCOs were compliant with the requirements for health risk assessment of newly enrolled members. File review was conducted for all five (5) MCOs. All MCOs faced challenges in obtaining completed health risk assessments from the members. All MCOs provided documentation for most or all of the members in the sample. The number of completed HRAs ranged from zero to seven (0 to 7). Most MCOs were able describe current or planned improvement initiatives.
Medical Records	The Medical Records Domain was reviewed for four of the five (4 of 5) MCOs. · Two (2) MCOs achieved Full Compliance, one (1) Substantial Compliance and one (1) Minimal Compliance. Scores ranged from 1.92 to 3.0 of 3.0 total points. · Three (3) of the MCOs had no elements requiring corrective action, and the fourth had six (6) elements in need of corrective action. · There was no file review conducted for this domain.
Pharmacy Benefits	The Pharmacy Benefits Domain was reviewed for each of the five (5) MCOs. · One (1) MCO achieved Full Compliance and four (4) MCOs earned Substantial Compliance. Scores ranged from 2.60 to 3.0 of 3.0 total points. · The number of elements requiring corrective action was one (1) for three (3) MCOs and zero (0) for the remaining two MCOs. · There was no file review conducted for this domain.
Program Integrity	The Program Integrity Domain was reviewed for each of the five (5) MCOs. · Two (2) MCOs achieved Full Compliance; three (3) MCOs scored Substantial Compliance. Scores ranged from 2.08 to 3.0 of 3.0 total points. · The number of elements requiring corrective action was zero (0) for three MCOs and 6 and 10 for the other two.

2016 Medicaid Managed Care Compliance Review Findings (Review Year 2015)	
Review Domain	Summary of Review Findings
	· The Program Integrity File Review assessed the extent to which the MCOs were compliant with the standards for identifying and investigating cases of potential fraud. File review was conducted for two (2) MCOs. The MCOs achieved Substantial Compliance with all standards reviewed.
Quality Assessment and Performance Improvement (QAPI) – Access	The QAPI – Access Domain was reviewed for each of the five (5) MCOs. · All five (5) MCOs earned Substantial Compliance. Scores ranged from 2.17 to 2.91 of 3.0 total points. · The number of elements requiring corrective action was zero (0) for three (3) of the MCOs and one (1) and four (4) for the remaining two (2) MCOs. · There was no file review conducted for this domain.
QAPI – Structure and Operations: Credentialing	The QAPI – Structure and Operations: Credentialing Domain was reviewed for each of the five (5) MCOs. · One (1) MCO achieved Full Compliance and the remaining four (4) MCOs achieved Substantial Compliance. Scores ranged from 2.60 to 3.0 of 3.0 total points. · The number of elements requiring corrective action was zero for three (3) of the MCOs and the other two had 1 and 2 each. · The Credentialing File Review assessed extent to which the MCOs were compliant with the requirements for provider credentialing. File review was conducted for two (2) MCOs and one was fully compliant and the other had Substantial Compliance with all requirements for credentialing. · The Recredentialing File Review assessed extent to which the MCOs were compliant with the requirements for provider recredentialing. File review was conducted for two (2) MCOs and one was fully compliant and the other had Substantial Compliance with all requirements for recredentialing.
QAPI – Structure and Operations: Delegated Services	The QAPI – Structure and Operations: Delegated Services Domain was reviewed for three of the five (3 of 5) MCOs. · One (1) MCO achieved Full Compliance, and two (2) earned Substantial. · Two (2) of the MCOs each had one (1) element requiring corrective action. · There was no file review conducted for this domain.
QAPI – Measurement and Improvement	The QAPI – Measurement and Improvement Domain was reviewed for each of the five (5) MCOs. · One (1) MCO achieved Full Compliance and four (4) MCOs earned Substantial Compliance. Scores ranged from 2.47 to 3.0 of 3.0 total points. · The number of elements requiring corrective action was 9 and 15 for the MCOs that did not achieve Full Compliance. · There was no file review conducted for this domain.
QAPI – Access: Utilization Management	The QAPI – Access: Utilization Management (UM) Domain was reviewed for each of the five (5) MCOs. · Four (4) MCOs achieved Full Compliance and the remaining MCO scored Substantial Compliance. · None of the MCOs required corrective action based on their scores. · The Utilization Management File Review assessed the extent to which the MCOs were compliant with the requirements for UM denials. File review was conducted for five (5) MCOs. Four (4) MCOs were fully compliant with all requirements for UM denials. The other MCO received a Substantial Compliance.

Validation of Performance Measures

This section of the report summarizes the Medicaid MCOs' reporting of select PMs followed by results of the HEDIS 2015 audit.

Kentucky DMS Requirements for Performance Measure Reporting

The 42 CFR §438.358(b)(2) establishes that one of the mandatory EQR activities for the MMC health plans is the validation of PMs reported (as required by DMS) during the preceding 12 months. These are defined in §438.240(b)(2) as any national PMs and levels that may be identified and developed by CMS in consultation with the states and other relevant stakeholders.

In 2015, DMS required plans to report a total of 33 measures in the HK measure set: 9 HEDIS measures and 24 HK measures. These PMs are listed in Table 7 and Table 8. Additionally, the MCOs are required by contract to report HEDIS measures data annually to NCQA and the state.

As required by DMS through the MCOs' contracts, all non-HEDIS measures must be validated by an EQRO. All five MCOs reported PMs for reporting year 2015, Anthem Blue Cross and Blue Shield Medicaid, CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan, and WellCare of Kentucky. This was the first reporting year for Anthem Blue Cross and Blue Shield Medicaid. IPRO reviewed all data and documentation used to calculate the PMs to ensure the validity and reliability of the reported measures.

IPRO's Objectives for Validation of Performance Measures

IPRO conducted the mandatory validation of the Kentucky Medicaid MCOs 2015 HK measure rates and reviewed the HEDIS 2015 data submitted by each of the MCOs. The MCOs' reported HEDIS rates are presented with weighted statewide averages[13] calculated by IPRO and are compared to national Medicaid benchmarks calculated using HEDIS data from all Medicaid MCOs that reported to NCQA. For the HK measures, this report presents the results of the validation and presents the MCOs' rates along with a weighted statewide average[14] calculated by IPRO.

Healthy Kentuckians Performance Measures – Reporting Year 2015

As described above, health plans are required by DMS to calculate and report PMs aligned with HK goals on an annual basis. HK represents Kentucky's goals and objectives in the areas of clinical preventive services and health services. IPRO, the EQRO, validates these measures to determine the extent to which the MCOs followed the specifications established by DMS in calculating rates for the Kentucky Medicaid-specific PMs. The information presented here summarizes the validation activities and findings for the HK PM rates for measurement year (MY) 2014 (RY 2015).

[13] A weighted average is an average in which some values count more than others. In this case, the MCOs with greater eligible populations were counted more toward the statewide average.

[14] A weighted average is an average in which some values count more than others. In this case, the MCOs with greater eligible populations were counted more toward the statewide average.

Table 7: Kentucky Medicaid Managed Care HEDIS Performance Measures – RY 2015

HEDIS Performance Measures
HEDIS *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*[1] The percentage of members 2–17 years of age who had an outpatient visit with a primary care practitioner (PCP) or obstetrician/gynecologist (ob/gyn) and who had evidence of body mass index (BMI) percentile documentation, assessment/counseling for nutrition and assessment/counseling for physical activity during the measurement year.
HEDIS *Adult BMI Assessment* The percentage of members 18–74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year.[2]
HEDIS *Controlling High Blood Pressure* The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (< 140/90) during the measurement year.
HEDIS *Annual Dental Visit* The percentage of members 2–21 years of age who had at least one dental visit during the measurement year.
HEDIS *Lead Screening in Children* 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.
HEDIS *Well-Child Visits in the First 15 Months of Life* 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.
HEDIS *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.
HEDIS *Adolescent Well-Care Visits* 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.
HEDIS *Children's and Adolescents' Access to Primary Care Practitioners* The percentage of members 12 months–19 years of age who had a visit with a 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.

[1]See the related Kentucky-specific measure: Height and Weight Documented; Appropriate Weight for Height.
[2]See the related Kentucky-specific measures: Counseling for Nutrition and Physical Activity for Adults and Height and Weight Documented; Appropriate Weight for Height.

Table 8: Kentucky-Specific Medicaid Managed Care Performance Measures – RY 2015

Kentucky-Specific Performance Measures[1]
Prenatal and Postpartum Risk Assessment and Education/Counseling The percentage of pregnant members who delivered between November 6th of the year prior to the measurement year and November 5th of the measurement year who had a prenatal/postpartum visit and received the following prenatal/postpartum services: · 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 over-the-counter (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. (Note these are reported as fourteen separate numerators.)
Cholesterol Screening for Adults 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 low-density lipoprotein (LDL)-C/cholesterol screening documented during the measurement year or the four years prior.
Height and Weight Documented; Appropriate Weight for Height for Adults 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.)
Counseling for Nutrition and Physical Activity for Adults 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.)
Height and Weight Documented and Appropriate Weight for Height for Children and Adolescents The percentage of members 2–17 years of age who had an outpatient visit with a primary care practitioner (PCP) or obstetrician/gynecologist (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.)
Adolescent Preventive Screening/Counseling 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.)
Individuals with Special Health Care Needs' (ISHCNs) Access to Preventive Care The percentage of child and adolescent members, ages 12 months through 19 years, in the Supplemental Security Income (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. <u>Access to Care:</u> · Children's and Adolescents' Access to Primary Care Practitioners <u>Preventive Care Visits:</u> · 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)

[1]Copies of the full specifications for each of the Kentucky-specific performance measures are available by request.

Table 9 shows the rates for each of the five (5) MCOs and the statewide rate for reporting year 2015 for each of the Kentucky-specific HK PMs.[15] The rates for the MCO specific PMs are reported later in this section of the Technical Report in Table 10 through Table 14. If a measure was determined "not reportable" an "NR" appears in the rate cell. If a measure was not reported because of a denominator of less than 30 or because the MCO had no eligible members, "N/A" appears in the cell. The statewide rates represent weighted averages.[16] If one (1) or more MCOs were not able to report a rate due to lack of eligible members, the data for the remaining MCOs were used. If only one MCO reported a rate, no statewide rate was calculated.

It is important to note that caution should be used when comparing the MCOs' performance for the 2015 reporting year as the MCOs had varying market experience. This applies particularly to Anthem Blue Cross and Blue Shield Medicaid since 2015 was the first reporting year since entry into the Kentucky Medicaid program.

[15] The complete results for all MCOs, including all performance measure denominators, numerators, and rates as well as validation results are available in the full report and its appendices, "Validation of Reporting Year 2015 Kentucky Medicaid Managed Care Performance Measures", available on the DMS Managed Care Oversight – Quality Branch Reports website at: http://chfs.ky.gov/dms/pqomcoqbreports.htm.

[16] A weighted average is an average in which some values count more than others. In this case, the MCOs with greater eligible populations were counted more toward the statewide average.

Table 9: Healthy Kentuckians Performance Measure Rates – RY 2015

Performance Measure Domain	Age Group	Admin/ Hybrid	Measure Name	Measure Description	Anthem BCBS Medicaid	Passport Health Plan Rate	CoventryCares of Kentucky Rate	Humana-CareSource Rate	WellCare of Kentucky Rate	Weighted 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 height and weight documented during the measurement year or the year prior to the measurement year.	N/A	90.05%	68.61%	66.42%	83.56%	79.51%
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had a healthy weight for height documented during the measurement year or the year prior to the measurement year (as identified by appropriate BMI).	N/A	22.62%	23.53%	25.17%	25.50%	24.41%
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had counseling for nutrition documented during the measurement year or the year prior to the measurement year.	N/A	40.28%	20.68%	27.01%	33.79%	30.57%
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had counseling for physical activity documented during the measurement year or the year prior to the measurement year.	N/A	41.67%	20.44%	25.55%	32.42%	30.00%

Performance Measure Domain	Age Group	Admin/ Hybrid	Measure Name	Measure Description	Anthem BCBS Medicaid	Passport Health Plan Rate	CoventryCares of Kentucky Rate	Humana-CareSource Rate	WellCare of Kentucky Rate	Weighted Average All MCOs
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 LDL-C/cholesterol screening in the measurement year or during the four years prior.	N/A	59.62%	44.70%	59.60%	72.56%	58.71%
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 both a height and weight on the same date of service during the measurement year.	N/A	93.47%	79.69%	73.23%	68.50%	77.46%
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 both a height and weight on the same date of service during the measurement year.	N/A	96.91%	70.97%	70.42%	72.46%	76.39%
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 both a height and weight on the same date of service during the measurement year.	N/A	94.70%	76.40%	72.26%	69.83%	76.98%

Performance Measure Domain	Age Group	Admin/ Hybrid	Measure Name	Measure Description	Anthem BCBS Medicaid	Passport Health Plan Rate	CoventryCares of Kentucky Rate	Humana-CareSource Rate	WellCare of Kentucky Rate	Weighted Average All MCOs
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 healthy weight for height during the measurement year.	N/A	58.46%	29.13%	47.32%	32.64%	39.50%
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 healthy weight for height during the measurement year.	N/A	53.50%	33.04%	38.61%	27.72%	38.94%
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 healthy weight for height during the measurement year.	N/A	56.64%	30.50%	44.44%	30.95%	39.29%
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 screening/counseling for tobacco.	N/A	85.19%	47.74%	59.86%	62.33%	61.35%

Performance Measure Domain	Age Group	Admin/ Hybrid	Measure Name	Measure Description	Anthem BCBS Medicaid	Passport Health Plan Rate	CoventryCares of Kentucky Rate	Humana-CareSource Rate	WellCare of Kentucky Rate	Weighted Average All MCOs
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 screening/counseling for alcohol/substances.	N/A	72.84%	36.13%	52.11%	38.36%	44.54%
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 screening/counseling for sexual activity.	N/A	61.73%	27.10%	50.70%	26.71%	34.32%
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 who had screening for depression documented.	N/A	44.44%	27.10%	47.18%	40.41%	36.76%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for tobacco use during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	79.05%	75.39%	59.89%	44.91%	39.16%	55.58%

Performance Measure Domain	Age Group	Admin/ Hybrid	Measure Name	Measure Description	Anthem BCBS Medicaid	Passport Health Plan Rate	CoventryCares of Kentucky Rate	Humana-CareSource Rate	WellCare of Kentucky Rate	Weighted Average All MCOs
				The percentage of pregnant members who had positive screening for tobacco use.	46.99%	33.53%	34.93%	33.59%	35.54%	34.40%
				The percentage of pregnant members who had positive screening for tobacco use and received intervention for tobacco use.	51.28%	54.39%	67.12%	51.16%	55.81%	61.25%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for alcohol use during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	72.38%	72.51%	55.01%	40.00%	36.57%	51.88%
				The percentage of pregnant members who had positive screening for alcohol use.	6.58%	8.56%	8.33%	5.26%	3.54%	8.06%
				The percentage of pregnant members who were found positive for alcohol use and received intervention for alcohol use.	20.00%*	25.00%*	25.00%*	0.00%*	0.00%*	22.43%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for substance/drug use during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	76.19%	70.95%	53.30%	38.60%	32.69%	49.54%

Performance Measure Domain	Age Group	Admin/ Hybrid	Measure Name	Measure Description	Anthem BCBS Medicaid	Passport Health Plan Rate	CoventryCares of Kentucky Rate	Humana-CareSource Rate	WellCare of Kentucky Rate	Weighted Average All MCOs
				The percentage of pregnant members who had positive screening for substance/drug use.	21.25%	9.06%	11.29%	11.82%	12.87%	10.68%
				The percentage of pregnant members who were found positive for substance/drug use and received intervention for drug/substance use.	23.53%*	51.72%*	66.67%*	69.23%*	7.69%*	61.92%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of assessment of and/or education/counseling for nutrition during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	35.24%	39.69%	35.53%	29.12%	21.36%	31.37%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of assessment of and/or education/ counseling for OTC/ prescription medication during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	77.14%	88.47%	46.42%	33.68%	34.30%	50.98%

Performance Measure Domain	Age Group	Admin/ Hybrid	Measure Name	Measure Description	Anthem BCBS Medicaid	Passport Health Plan Rate	CoventryCares of Kentucky Rate	Humana-CareSource Rate	WellCare of Kentucky Rate	Weighted Average All MCOs
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for domestic violence during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	58.10%	25.28%	32.38%	17.89%	17.80%	25.16%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for depression during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	60.95%	39.47%	40.69%	23.86%	24.27%	33.98%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for depression during a postpartum visit.	40.00%	60.52%	26.23%	49.53%	36.81%	39.42%
Children with Special Health Care Needs: Access to Care and Preventive Care Services										
Preventive Care	Child CSHCN Cohort	A	Annual Dental Visit	The percentage of members 2–21 years of age who had at least one dental visit during the measurement year.						
				SSI Total (B, BP, D, DP, K, M)	0.00%*	57.27%	47.84%	41.40%	53.35%	52.84%
				SSI Blind (B, BP, K)	N/A	68.42%*	42.86%*	N/A	48.08%	50.51%
				SSI Disabled (D, DP, M)	N/A	57.23%	47.87%	41.40%	53.37%	52.85%
				Foster (P,S, X)	N/A	73.24%	67.94%	51.72%	71.77%	70.85%
				CCSHCN (provider type 22 and 23)	0.00%	66.37%	62.50%	N/A	69.64%	67.51%
				Total ADV (2–21 years)	0.00%	62.72%	54.97%	43.68%	60.09%	59.22%
Preventive Care	Child CSHCN	A	HEDIS Well-Child	The percentage of members who turned 15 months old during the measurement year and who had 6 or more well-child visits with a PCP during their first 15 months of life.						

Performance Measure Domain	Age Group	Admin/ Hybrid	Measure Name	Measure Description	Anthem BCBS Medicaid	Passport Health Plan Rate	CoventryCares of Kentucky Rate	Humana-CareSource Rate	WellCare of Kentucky Rate	Weighted Average All MCOs
				SSI Total (B, BP, D, DP, K, M)	N/A	38.64%	40.00%*	N/A	38.35%	38.62%
				SSI Blind (B, BP, K)	N/A	N/A	N/A	N/A	0.00%*	N/A
				SSI Disabled (D, DP, M)	N/A	38.64%	40.00%*	N/A	38.64%	38.78%
				Foster (P, S, X)	N/A	59.76%	60.00%	N/A	44.51%	53.03%
				CCSHCN (provider type 22 and 23)	N/A	80.00%*	100.00%*	N/A	46.77%	51.20%
				Total WC15mo	N/A	51.35%	70.59%	N/A	43.69%	47.57%
Preventive Care	Child CSHCN Cohort	A	HEDIS Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life	The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.						
				SSI Total (B, BP, D, DP, K, M)	N/A	76.87%	88.22%	58.97%	61.05%	69.33%
				SSI Blind (B, BP, K)	N/A	100.00%*	75.00%*	N/A	50.00%*	72.22%
				SSI Disabled (D, DP, M)	N/A	76.69%	88.37%	58.97%	61.11%	69.31%
				Foster (P, S, X)	N/A	73.69%	92.54%	81.82%	67.11%	74.04%
				CCSHCN (provider type 22 and 23)	N/A	72.65%	100.00%*	N/A	68.59%	70.23%
				Total WC34	N/A	75.28%	90.69%	65.77%	64.51%	71.17%
Preventive Care	Child CSHCN Cohort	A	HEDIS Adolescent Well-Care	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.						
				SSI Total (B, BP, D, DP, K, M)	0.00%*	51.24%	48.59%	37.28%	31.41%	40.26%
				SSI Blind (B, BP, K)	N/A	40.00%*	52.63%*	N/A	25.81%	36.67%
				SSI Disabled (D, DP, M)	N/A	51.28%	48.57%	37.28%	31.43%	40.28%
				Foster (P, S, X)	N/A	59.98%	69.68%	42.20%	51.78%	58.06%
				CCSHCN (provider type 22 and 23)	2.63%	56.72%	100.00%	N/A	44.22%	50.33%
				Total AWC	2.50%	53.88%	55.30%	38.34%	37.07%	45.24%
Preventive Care	Child CSHCN 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 CSHCN Cohort	A	HEDIS Children's Access to PCPs	The percentage of members 12–24 months of age who had a visit with a primary care practitioner (PCP) during the measurement year.						
				SSI Total (B, BP, D, DP, K, M)	N/A	98.18%	100.00%*	N/A	96.62%	97.24%
				SSI Blind (B, BP, K)	N/A	N/A	N/A	N/A	100.00%*	N/A
				SSI Disabled (D, DP, M)	N/A	98.18%	100.00%*	N/A	96.60%	97.23%

Performance Measure Domain	Age Group	Admin/ Hybrid	Measure Name	Measure Description	Anthem BCBS Medicaid	Passport Health Plan Rate	CoventryCares of Kentucky Rate	Humana-CareSource Rate	WellCare of Kentucky Rate	Weighted Average All MCOs
				Foster (P, S, X)	N/A	99.08%	92.31%*	N/A	99.52%	99.09%
				CCSHCN (provider type 22 and 23)	N/A	100.00%*	100.00%*	N/A	97.55%	97.73%
				Total CAP 12–24 months	N/A	98.73%	95.65%*	N/A	97.88%	98.04%
Preventive Care	Child CSHCN Cohort	A	HEDIS Children's Access to PCPs	The percentage of members 25 months–6 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)	N/A	92.79%	91.92%	83.87%	94.54%	93.34%
				SSI Blind (B, BP, K)	N/A	100.00%*	80.00%*	N/A	91.67%*	91.30%
				SSI Disabled (D, DP, M)	N/A	92.75%	92.06%	83.87%	94.56%	93.35%
				Foster (P, S, X)	N/A	88.77%	94.87%	91.30%	91.49%	91.29%
				CCSHCN (provider type 22 and 23)	N/A	94.74%	96.00%*	N/A	95.99%	95.83%
				Total CAP 25 months–6 years	N/A	91.29%	93.49%	86.33%	93.92%	92.98%
Preventive Care	Child CSHCN 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	93.78%	97.09%	85.26%	96.18%	95.27%
				SSI Blind (B, BP, K)	N/A	50.00%*	100.00%*	N/A	100.00%*	92.86%
				SSI Disabled (D, DP, M)	N/A	93.85%	97.07%	85.26%	96.16%	95.28%
				Foster (P, S, X)	N/A	92.34%	93.53%	80.00%	93.33%	92.91%
				CCSHCN (provider type 22 and 23)	N/A	95.30%	100.00%*	N/A	98.68%	97.80%
				Total CAP 7–11 years	N/A	93.46%	95.65%	84.35%	95.66%	94.72%
Preventive Care	Child CSHCN 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	90.64%	95.04%	80.31%	93.98%	92.70%
				SSI Blind (B, BP, K)	N/A	75.00%*	75.00%*	N/A	95.00%*	86.11%
				SSI Disabled (D, DP, M)	N/A	90.69%	95.13%	80.31%	93.98%	92.72%
				Foster (P, S, X)	N/A	91.70%	90.79%	70.79%	92.20%	91.14%
				CCSHCN (provider type 22 and 23)	N/A	92.78%	100.00%	N/A	96.41%	95.66%
				Total CAP 12–19 years	N/A	91.04%	93.78%	78.26%	93.73%	92.44%
Utilization of Dental	Child	A	CMS-416 Dental	This performance measure assesses the percentage of members ages <21 years, 6-9 years and 10-14 years of age who received the specified dental services.						

Performance Measure Domain	Age Group	Admin/ Hybrid	Measure Name	Measure Description	Anthem BCBS Medicaid	Passport Health Plan Rate	CoventryCares of Kentucky Rate	Humana-CareSource Rate	WellCare of Kentucky Rate	Weighted Average All MCOs
				Any Dental Services	39.74%	45.72%	49.46%	32.03%	47.50%	47.29%
				Preventive Dental Services	5.53%	41.70%	38.90%	29.32%	42.08%	40.13%
				Dental Treatment Services	3.56%	17.50%	23.08%	12.14%	21.09%	20.72%
				Sealant on a Permanent Molar Tooth	1.80%	4.11%	5.12%	3.73%	5.49%	5.02%
				Diagnostic Dental Services	7.07%	47.16%	46.41%	30.47%	45.10%	45.22%
				Oral Health Services Provided by a Non-Dentist Provider	0.24%	N/A	4.71%	1.29%	1.97%	2.59%
				Any Dental or Oral Health Service	39.74%	46.66%	50.67%	39.26%	49.18%	48.84%

BCBS: Blue Cross and Blue Shield; N/A: not applicable (plan did not have any eligible members for this rate); H: hybrid measure; A: administrative measure; RY: reporting year; NR: MCO did not report a rate; *: caution should be used when interpreting these rates as the denominator is <30.

For the development of the RY 2016 PMs, each of the measures was reviewed, incorporating MCO experiences and lessons learned from calculating the measures, the results of the PM validation activities, and DMS priorities.

Refinement of Current Measures for RY 2015

- Clarifying specifications based on medical record review validation findings and MCO input
- Updating all measures that are/are based on HEDIS measures to reflect changes in HEDIS specifications
- Evaluating all measures and refining or retiring them where necessary/desired

Development of New Measures for RY 2015

- Added a measure based on the CMS-416 EPSDT indicators for dental service(s).
- Considered adding measures from the Adult and/or Child Children's Health Insurance Program Reauthorization Act (CHIPRA) core for future reporting.

Anthem Blue Cross and Blue Shield Medicaid – RY 2015 Performance Measure Rates

Performance Trends RY 2014 to RY 2015

No trends can be evaluated as this is the first reporting year for Anthem Blue Cross and Blue Shield Medicaid. Since 2014 was the MCO's first year in operation, Anthem Blue Cross and Blue Shield Medicaid was able to report a very limited number of measures. Anthem Blue Cross and Blue Shield Medicaid's performance for RY 2015 is presented in Table 10.

Overall observations regarding Anthem Blue Cross and Blue Shield Medicaid's performance include:
Anthem Blue Cross and Blue Shield Medicaid did not report the *Adult BMI Assessment and Counseling for Nutrition and Physical Activity* in 2015 due to lack of an adequate eligible member population, since 2014 was the MCO's first year in operation.

Table 10: Anthem Blue Cross and Blue Shield Medicaid – RY 2015 Performance Measure Rates

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2015 Rate
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had their height and weight 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 healthy weight for height 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 counseling for nutrition 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 counseling for physical activity 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 ≥ 35 years and female enrollees age ≥ 45 years who had an outpatient visit and had LDL-C/cholesterol screening in the measurement year or during the four years prior.	N/A
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 both a height and weight on the same date of service during the measurement year.	N/A
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 both a height and weight on the same date of service during the measurement year.	N/A
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 both a height and weight on the same date of service during the measurement year.	N/A

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2015 Rate
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 healthy weight for height during the measurement year.	N/A
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 healthy weight for height during the measurement year.	N/A
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 healthy weight for height during the measurement year.	N/A
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 screening/counseling for tobacco.	N/A
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 screening/counseling for alcohol/substances.	N/A
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 screening/counseling for sexual activity.	N/A
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 screening for depression documented.	N/A
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for tobacco use during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	79.05%
				The percentage of pregnant members who had positive screening for tobacco use.	46.99%
				The percentage of pregnant members who had positive screening for tobacco use and received intervention for tobacco use.	51.28%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for alcohol use during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	72.38%
				The percentage of pregnant members who had positive screening for alcohol use.	6.58%
				The percentage of pregnant members who were found positive for alcohol use and received intervention for alcohol use.	20.00%*

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2015 Rate
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for substance/drug use during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	76.19%
				The percentage of pregnant members who had positive screening for substance/drug use.	21.25%
				The percentage of pregnant members who were found positive for substance/drug use and were provided intervention for drug/substance use.	23.53%*
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of assessment of and/or education/counseling for nutrition during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	35.24%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of assessment of and/or education/counseling for OTC/prescription medication during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	77.14%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for domestic violence during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	58.10%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members year who had evidence of screening for depression during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO.	60.95%
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for depression during a postpartum visit.	40.00%
Children with Special Health Care 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 at least one dental visit during the measurement year.	
				SSI Total (B, BP, D, DP, K, M)	0.00%*
				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)	0.00%
				Total ADV (2–21 years)	0.00%
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 at least 6 well-child visits with a PCP during their first 15 months of life.	
				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

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2015 Rate
Preventive Care	Child - CSHCN Cohort	A	HEDIS Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	
				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 WC34	N/A
Preventive Care	Child - CSHCN Cohort	A	HEDIS Adolescent Well-Care Visits	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.	
				SSI Total (B, BP, D, DP, K, M)	0.00%*
				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)	2.63%
				Total AWC	2.50%
Preventive Care	Child - CSHCN 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 - CSHCN Cohort	A	HEDIS Children's Access to PCPs	The percentage of members 12–24 months of age who had a visit with a primary care practitioner (PCP) during the measurement year.	
				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	N/A
Preventive Care	Child - CSHCN Cohort	A	HEDIS Children's Access to PCPs	The percentage of members 25 months–6 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)	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 25 months–6 years	N/A
Preventive Care	Child - CSHCN 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)	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

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2015 Rate
Preventive Care	Child - CSHCN 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
Utilization of Dental Services	Child	A	CMS-416 Dental Services[1]	This performance measure assesses the percentage of members ages <21 years, 6-9 years and 10-14 years of age who received the specified dental services.	
				Any Dental Services	39.74%
				Preventive Dental Services	5.53%
				Dental Treatment Services	3.56%
				Sealant on a Permanent Molar Tooth	1.80%
				Diagnostic Dental Services	7.07%
				Oral Health Services Provided by a Non-Dentist Provider	0.24%
				Any Dental or Oral Health Service	39.74%

N/A: not applicable (plan did not have any eligible members for this rate); H: hybrid measure; A: administrative measure; RY: reporting year; NR: MCO did not report a rate; *: caution should be used when interpreting these rates as the denominator is <30.
[1] The CMS-416 Dental Services measure is a new measure for RY 2015; therefore, there are no rates reported for prior years.

CoventryCares of Kentucky – RY 2013–2015 Performance Measure Rates

Performance Trends RY 2014 to RY 2015

CoventryCares of Kentucky performance for RYs 2014 and 2015 is presented in Table 11, along with the change in rate (increase or decrease) from year to year.

Overall observations regarding CoventryCares of Kentucky's performance include:

- Performance improved for documentation of adult height and weight (+12.82 percentage points) to nearly 69% and declined for healthy weight for height (-3.03 percentage points) to 24%. Recall that the healthy weight for height measure is currently for reporting purposes only; MCOs are not held accountable for improvement.
- The rate for the related measure, counseling for nutrition for adults, declined by 1.31 percentage points and remained quite low at almost 21%. The rate for counseling for physical activity for adults increased 4.93 percentage points to 20.44%.
- The rate for cholesterol screening for adults was substandard, at 44.70%, declining over 30 percentage points from 77.56% in RY 2014.
- For children and adolescents 3 – 17 years of age, documentation of height and weight increased by almost 16 percentage points, from 60.65% to 76.40%,and those with a healthy weight for height, while still quite low, improved over 11 percentage points to 30.50%.
- Related to adolescent screening and counseling, all four (4) rates improved substantially from RY 2014 to RY 2015; for tobacco from 30.37% to 47.74% (+17.37); for alcohol/substances from 17.04% to 36.13% (+19.09); for sexual activity from 14.07% to 27.10% (+13.03); and for depression from 11.85% to 27.10% (+15.25).
- For screening during the perinatal period, screening for tobacco use was most often found (59.89%), while rates for the other screening numerators in RY 2015 were 55.01% for alcohol use and 53.30% for drug/substance use. The rates for each of these improved, with increases ranging from 31.33 to 33.41 percentage points. For those with positive screenings, the percentage who had intervention ranged from ~ 67% for both tobacco and substance use to a low of 25% for alcohol use.

- Other observations regarding CoventryCares of Kentucky's performance in this area:
  - Rates for assessment/counseling for OTC/prescription medication (46.42%) and nutrition (35.53%) also improved substantially.
  - Screening for prenatal depression increased 29.42 percentage points between RY 2014 and RY 2015 to 40.69%, while screening for domestic violence (32.38%) improved 23.08 percentage points.
  - The rate for postpartum depression screening declined markedly (-14.58) from 40.81% to 26.23%.
- Regarding access to PCPs for CSHCN, performance ranged between ~ 93% (ages 25 months – 6 years and 12-19 years groups) and 97.01% (7–11 years of age).
- Other observations for this set of measures include:
  - The rates *Well-Child Visits* for CSHCN ages 15 months (50.91%) and for adolescents (54.33%) were lower than for those 3-6 years of age (90.37%).
  - Annual Dental Visits for CSHCNs ages 2-21 years declined (-8.59) to a rate of 54.89%.
- The CMS-416 EPSDT measures for dental services for children were reported for the first time in RY 2015. The rate for any dental service was 49.46%, for preventive services, 38.90%, and for sealants on a permanent molar, 5.12%.

Table 11: CoventryCares of Kentucky – RY 2013–2015 Performance Measure Rates

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had their height and weight documented during the measurement year or the year prior to the measurement year.	52.80%	55.79%	68.61%	12.82
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had a healthy weight for height documented during the measurement year or the year prior to the measurement year (as identified by appropriate BMI).	26.42%	26.56%	23.53%	-3.03
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had counseling for nutrition documented during the measurement year or the year prior to the measurement year.	17.52%	21.99%	20.68%	-1.31
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had counseling for physical activity documented during the measurement year or the year prior to the measurement year.	15.19%	15.51%	20.44%	4.93
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 LDL-C/cholesterol screening in the measurement year or during the four years prior.	73.89%	77.56%	44.70%	-32.86
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 both a height and weight on the same date of service during the measurement year.	67.15%	62.29%	79.69%	17.40
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 both a height and weight on the same date of service during the measurement year.	68.39%	57.04%	70.97%	13.93

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
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 both a height and weight on the same date of service during the measurement year.	67.59%	60.65%	76.40%	15.75
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 healthy weight for height during the measurement year.	10.70%	17.84%	29.13%	11.29
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 healthy weight for height during the measurement year.	15.09%	20.25%	33.04%	12.79
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 healthy weight for height during the measurement year.	12.29%	18.56%	30.50%	11.94
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 screening/counseling for tobacco.	36.36%	30.37%	47.74%	17.37
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 screening/counseling for alcohol/substances.	28.57%	17.04%	36.13%	19.09
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 screening/counseling for sexual activity.	18.83%	14.07%	27.10%	13.03
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 screening for depression documented.	NR	11.85%	27.10%	15.25

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for tobacco use 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%	59.89%	33.41
				The percentage of pregnant members who had a screening for tobacco use and were found positive for tobacco use.	NR	54.26%	34.93%	-19.33
				The percentage of pregnant members who were found positive for tobacco use and received intervention for tobacco use.	NR	43.14%	67.12%	23.98
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for alcohol use 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%	55.01%	32.47
				The percentage of pregnant members who had a screening for alcohol use and were found positive for alcohol use.	NR	33.75%	8.33%	-25.42
				The percentage of pregnant members who were found positive for alcohol use and received intervention for alcohol use.	NR	3.70%*	25.00%*	21.30
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for substance/drug use 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%	53.30%	31.33
				The percentage of pregnant members who had a screening for substance/drug use and were found positive for substance/drug use.	NR	34.62%	11.29%	-23.33
				The percentage of pregnant members who were found positive for substance/drug use and were provided intervention for drug/substance use.	NR	7.41%*	66.67%*	59.26

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of assessment of and/or education/counseling for nutrition 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%	35.53%	24.54
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of assessment of and/or education/ counseling for OTC/ prescription medication 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%	46.42%	34.31
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for domestic violence 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%	32.38%	23.08
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for depression 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%	40.69%	29.42
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for depression during a postpartum visit.	0.00%	40.81%	26.23%	-14.58
Children with Special Health Care 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 at least one dental visit during the measurement year.				
				SSI Total (B, BP, D, DP, K, M)	54.32%	55.33%	47.84%	-7.49
				SSI Blind (B, BP, K)	66.67%	40.00%*	42.86%*	2.86
				SSI Disabled (D, DP, M)	54.25%	55.37%	47.87%	-7.50
				Foster (P,S, X)	73.10%	68.98%	67.94%	-1.04
				CCSHCN (provider type 22 and 23)	67.27%	66.67%	62.50%	-4.17
				Total ADV (2–21 years)	60.76%	63.48%	54.97%	-8.51
Preventive Care	Child - CSHCN	A	HEDIS Well-Child	The percentage of members who turned 15 months old during the measurement year and who had at least 6 well-child visits with a PCP during their first 15 months of life.				

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
				SSI Total (B, BP, D, DP, K, M)	N/A	N/A	40.00%*	N/A
				SSI Blind (B, BP, K)	N/A	N/A	N/A	N/A
				SSI Disabled (D, DP, M)	N/A	N/A	40.00%*	N/A
				Foster (P,S, X)	N/A	N/A	60.00%	N/A
				CCSHCN (provider type 22 and 23)	N/A	N/A	100.00%*	N/A
				Total WC15mo	N/A	N/A	70.59%	N/A
Preventive Care	Child - CSHCN Cohort	A	HEDIS Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life	The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.				
				SSI Total (B, BP, D, DP, K, M)	57.01%	55.25%	88.22%	32.97
				SSI Blind (B, BP, K)	N/A	N/A	75.00%*	N/A
				SSI Disabled (D, DP, M)	57.10%	55.25%	88.37%	33.12
				Foster (P,S, X)	69.69%	67.51%	92.54%	25.03
				CCSHCN (provider type 22 and 23)	75.00%	82.61%	100.00%*	-17.39
				Total WC34	63.18%	65.88%	90.69%	24.81
Preventive Care	Child - CSHCN Cohort	A	HEDIS Adolescent Well-Care Visits	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.				
				SSI Total (B, BP, D, DP, K, M)	35.46%	28.28%	48.59%	20.31
				SSI Blind (B, BP, K)	N/A	33.33%*	52.63%*	19.30
				SSI Disabled (D, DP, M)	35.45%	28.26%	48.57%	20.31
				Foster (P,S, X)	54.20%	48.76%	69.68%	20.92
				CCSHCN (provider type 22 and 23)	44.36%	43.75%	100.00%	56.25
				Total AWC	41.17%	38.81%	55.30%	16.49
Preventive Care	Child - CSHCN 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 - CSHCN	A	HEDIS Children's	The percentage of members 12–24 months of age who had a visit with a primary care practitioner (PCP) during the measurement year.				

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
				SSI Total (B, BP, D, DP, K, M)	96.67%	89.74%	100.00%*	10.26
				SSI Blind (B, BP, K)	N/A	N/A	N/A	N/A
				SSI Disabled (D, DP, M)	96.63%	89.74%	100.00%*	10.26
				Foster (P,S, X)	99.13%	98.31%	92.31%*	-6.00
				CCSHCN (provider type 22 and 23)	100.00%*	100.00%*	100.00%*	0
				Total CAP 12–24 months	98.26%	95.76%	95.65%*	-0.11
Preventive Care	Child - CSHCN Cohort	A	HEDIS Children's Access to PCPs	The percentage of members 25 months–6 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)	95.60%	27.94%	91.92%	63.98
				SSI Blind (B, BP, K)	N/A	N/A	80.00%*	N/A
				SSI Disabled (D, DP, M)	95.58%	27.94%	92.06%	64.12
				Foster (P,S, X)	94.28%	91.54%	94.87%	3.33
				CCSHCN (provider type 22 and 23)	100.00%	100.00%	96.00*	-4.00
				Total CAP 25 months–6 years	95.45%	76.78%	93.49%	16.71
Preventive Care	Child - CSHCN 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%	97.09%	45.95
				SSI Blind (B, BP, K)	N/A	50.00%*	100.00%*	50.00
				SSI Disabled (D, DP, M)	N/A	51.15%	97.07%	45.92
				Foster (P,S, X)	N/A	95.83%	93.53%	-2.30
				CCSHCN (provider type 22 and 23)	N/A	100.00%*	100.00%*	0
				Total CAP 7 -11 years	N/A	84.42%	95.65%	11.23
Preventive Care	Child - CSHCN 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%	95.04%	-0.14
				SSI Blind (B, BP, K)	N/A	96.02%	75.00%*	-21.02
				SSI Disabled (D, DP, M)	N/A	94.79%	95.13%	0.34
				Foster (P,S, X)	N/A	94.39%	90.79%	-3.60
				CCSHCN (provider type 22 and 23)	N/A	100.00%	100.00%	0
				Total CAP 12 -19 years	N/A	94.85%	93.78%	-1.07

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
Utilization of Dental Services	Child	A	CMS-416 Dental Services[1]	This performance measure assesses the percentage of members ages <21 years, 6-9 years and 10-14 years of age who received the specified dental services.				
				Any Dental Services			49.46%	N/A
				Preventive Dental Services			38.90%	N/A
				Dental Treatment Services			23.08%	N/A
				Sealant on a Permanent Molar Tooth			5.12%	N/A
				Diagnostic Dental Services			46.41%	N/A
				Oral Health Services Provided by a Non-Dentist Provider			4.71%	N/A
				Any Dental or Oral Health Service			50.67%	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; NR: MCO did not report a rate;
*: caution should be used when interpreting these rates as the denominator is <30.
[1] The CMS-416 Dental Services measure is a new measure for RY 2015; therefore, there are no rates reported for prior years.

Humana-CareSource – RY 2013–2015 Performance Measure Rates

Performance Trends RY 2014 to RY 2015

Humana-CareSource's performance for RYs 2014 and 2015 is presented in Table 12, along with the change in rate (increase or decrease) from year to year.

Overall observations regarding Humana-CareSource's performance include:

- For children and adolescents 3 – 17 years of age, documentation of height and weight increased slightly from 69.83% to 72.26%, while those with a healthy weight for height, while still quite low, improved over 14 percentage points to 44.44%.
- Documentation of height and weight for adults was reported for the first time on RY 2015. The rate was 66.42%. The other numerator rates for this measure were very low: 25.17% for healthy weight for height; 27.01% for counseling for nutrition, and 25.55% for counseling for physical activity.
- The rate for cholesterol screening for adults was subpar, at 59.60%, and declined substantially (-17.30) from 76.90% in RY 2014 to 59.60%.
- Related to adolescent screening and counseling, all four (4) rates increased; for tobacco from 58.04% to 59.86%; for alcohol/substances from 47.32% to 52.11%; for sexual activity from 41.07% to 50.70%; and for screening for depression from 31.25% to 47.18%.
- Related to screening during the perinatal period, rates ranged from 38.60% (for drug/substance use) to 44.91% (for tobacco use). Note that each of the rates improved by over 30 percentage points. Intervention for positive use was most often found for substance use (69.23%), then tobacco use (51.16%) and lastly, for alcohol use (0%).
- Other observations regarding Humana-CareSource's performance in this area:
  - Rates for assessment/counseling for nutrition (29.12%), assessment/counseling for OTC/prescription medication (33.68%), screening for domestic violence (17.89%), and prenatal screening for depression (23.86%) improved between 13.64-35.43 percentage points.
  - Screening for depression during a postpartum visit improved substantially (+35.43) from 14.10% in RY 2014 to 49.53% in RY 2015.

§ Regarding well-child visits for CSHCN, two (2) rates were reported. The rate for 3-6 year olds was 65.77% (+6.01) and for adolescents, the rate improved 4.95 percentage points to 38.34%.

§ Related to access to PCPs for CSHCNs, the three (3) rates that were reported ranged from 78.26% (12-19 year olds) to 86.33% (ages 25 months – 6 years).

§ Annual dental visits for CSHCNs improved slightly to 43.68% (+2.39).

§ The CMS-416 EPSDT dental services for children measures were reported for the first time in RY 2015. Rates were 32.03% for any dental service, 29.32% for preventive services, and only 3.73% for sealants.

Table 12: Humana-CareSource – RY 2013–2015 Performance Measure Rates

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had their height and weight documented during the measurement year or the year prior to the measurement year.	N/A	66.42%	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 healthy weight for height documented during the measurement year or the year prior to the measurement year (as identified by appropriate BMI).	N/A	25.17%	N/A
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had counseling for nutrition documented during the measurement year or the year prior to the measurement year.	N/A	27.01%	N/A
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had counseling for physical activity documented during the measurement year or the year prior to the measurement year.	N/A	25.55%	N/A
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 LDL-C/cholesterol screening in the measurement year or during the four years prior.	76.90%	59.60%	-17.30
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 both a height and weight on the same date of service during the measurement year.	70.23%	73.23%	3.00
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 both a height and weight on the same date of service during the measurement year.	68.75%	70.42%	1.67
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 both a height and weight on the same date of service during the measurement year.	69.83%	72.26%	2.43

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
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 healthy weight for height during the measurement year.	29.28%	47.32%	18.04
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 healthy weight for height during the measurement year.	32.56%	38.61%	6.05
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 healthy weight for height during the measurement year.	30.19%	44.44%	14.25
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 screening/counseling for tobacco.	58.04%	59.86%	1.82
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 screening/counseling for alcohol/substances.	47.32%	52.11%	4.79
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 screening/counseling for sexual activity.	41.07%	50.70%	9.63
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 screening for depression documented.	31.25%	47.18%	15.93
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for tobacco use 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%	44.91%	36.41
				The percentage of pregnant members who had positive screening for tobacco use.	42.31%*	33.59%	-8.72
				The percentage of pregnant members who had positive screening for tobacco use and received intervention for tobacco use.	36.36%*	51.16%	14.80

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for alcohol use 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%	40.00%	35.42
				The percentage of pregnant members who had positive screening for alcohol use.	0.00%*	5.26%	5.26
				The percentage of pregnant members who were found positive for alcohol use and received intervention for alcohol use.	N/A	0.00%*	N/A
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for substance/drug use 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%	38.60%	33.70
				The percentage of pregnant members who had positive screening for substance/drug use.	0.00%*	11.82%	11.82
				The percentage of pregnant members who were found positive for substance/drug use and were provided intervention for drug/substance use.	N/A	69.23%*	N/A
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of assessment of and/or education/ counseling for nutrition 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%	29.12%	24.22
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of assessment of and/or education/ counseling for OTC/ prescription medication 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%	33.68%	30.41
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for domestic violence 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%	17.89%	13.64

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for depression 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%	23.86%	21.25
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for depression during a postpartum visit.	14.10%	49.53%	35.43
Children with Special Health Care 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 at least one dental visit during the measurement year.			
				SSI Total (B, BP, D, DP, K, M)	40.03%	41.40%	1.37
				SSI Blind (B, BP, K)	N/A	N/A	N/A
				SSI Disabled (D, DP, M)	40.20%	41.40%	1.20
				Foster (P,S, X)	44.33%	51.72%	7.39
				CCSHCN (provider type 22 and 23)	43.11%	N/A	N/A
				Total ADV (2–21 years)	41.29%	43.68%	2.39
Preventive Care	Child - CSHCN 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 at least 6 well-child visits 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
				CCSHCN (provider type 22 and 23)	N/A	N/A	N/A
				Total WC15mo	N/A	N/A	N/A
Preventive Care	Child - CSHCN Cohort	A	HEDIS Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life	The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.			
				SSI Total (B, BP, D, DP, K, M)	53.85%	58.97%	5.12
				SSI Blind (B, BP, K)	N/A	N/A	N/A
				SSI Disabled (D, DP, M)	53.33%	58.97%	5.64
				Foster (P,S, X)	67.74%	81.82%	14.08
				CCSHCN (provider type 22 and 23)	66.67%	N/A	N/A
				Total WC34	59.76%	65.77%	6.01

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
Preventive Care	Child - CSHCN Cohort	A	HEDIS Adolescent Well-Care Visits	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.			
				SSI Total (B, BP, D, DP, K, M)	32.55%	37.28%	4.73
				SSI Blind (B, BP, K)	N/A	N/A	N/A
				SSI Disabled (D, DP, M)	32.72%	37.28%	4.56
				Foster (P,S, X)	32.41%	42.20%	9.79
				CCSHCN (provider type 22 and 23)	40.68%	N/A	N/A
				Total AWC	33.39%	38.34%	4.95
Preventive Care	Child - CSHCN 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 - CSHCN Cohort	A	HEDIS Children's Access to PCPs	The percentage of members 12–24 months of age who had a visit with a primary care practitioner (PCP) during the measurement year.			
				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
				CCSHCN (provider type 22 and 23)	N/A	N/A	N/A
				Total CAP 12–24 months	93.33%	N/A	N/A
Preventive Care	Child - CSHCN Cohort	A	HEDIS Children's Access to PCPs	The percentage of members 25 months–6 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)	79.59%	83.87%	4.28
				SSI Blind (B, BP, K)	N/A	N/A	N/A
				SSI Disabled (D, DP, M)	79.38%	83.87%	4.49
				Foster (P,S, X)	77.50%	91.30%	13.80
				CCSHCN (provider type 22 and 23)	91.80%	N/A	N/A
				Total CAP 25 months–6 years	82.91%	86.33%	3.42
Preventive Care	Child - CSHCN 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	85.26%	N/A
				SSI Blind (B, BP, K)	N/A	N/A	N/A
				SSI Disabled (D, DP, M)	N/A	85.26%	N/A

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
				Foster (P,S, X)	N/A	80.00%	N/A
				CCSHCN (provider type 22 and 23)	N/A	N/A	N/A
				Total CAP 7 -11 years	N/A	84.35%	N/A
Preventive Care	Child - CSHCN 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	80.31%	N/A
				SSI Blind (B, BP, K)	N/A	N/A	N/A
				SSI Disabled (D, DP, M)	N/A	80.31%	N/A
				Foster (P,S, X)	N/A	70.79%	N/A
				CCSHCN (provider type 22 and 23)	N/A	N/A	N/A
				Total CAP 12 -19 years	N/A	78.26%	N/A
Utilization of Dental Services	Child	A	CMS-416 Dental Services[1]	This performance measure assesses the percentage of members ages <21 years, 6-9 years and 10-14 years of age who received the specified dental services.			
				Any Dental Services		32.03%	N/A
				Preventive Dental Services		29.32%	N/A
				Dental Treatment Services		12.14%	N/A
				Sealant on a Permanent Molar Tooth		3.73%	N/A
				Diagnostic Dental Services		30.47%	N/A
				Oral Health Services Provided by a Non-Dentist Provider		1.29%	N/A
				Any Dental or Oral Health Service		39.26%	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; NR: MCO did not report a rate;
*: caution should be used when interpreting these rates as the denominator is <30.
[1] The CMS-416 Dental Services measure is a new measure for RY 2015; therefore, there are no rates reported for prior years.

Passport Health Plan – RY 2013–2015 Performance Measure Rates

Performance Trends RY 2014 to RY 2015

Passport Health Plan's performance for RYs 2014 and 2015 is presented in Table 13, along with the change in rate (increase or decrease) from year to year.

Overall observations regarding Passport Health Plan's performance include:

- There were marginal improvements for the adult measures documentation of height and weight (89.85%-90.05%) and counseling for physical activity (40.40%-41.67%) from RY 2014 to RY 2015. Conversely, rates for the other two (2) numerators declined; healthy weight for height at 22.62% (-0.97) and counseling for nutrition at 40.28% (-2.77).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.
- The rate for cholesterol screening for adults decreased markedly from 87.79% to 59.62% (-28.17).
- For children and adolescents 3 – 17 years of age, documentation of height and weight (94.70%) and those with a healthy weight for height (56.64%) each rose slightly.
- Related to adolescent screening and counseling, all rates increased; for tobacco from 74.85% to 85.19%, for alcohol/substances from 59.51% to 72.84%, for sexual activity from 53.99% to 61.73% and for screening for depression from 28.83% to 44.44%.
- Rates for screening and counseling during the perinatal period included: screening for tobacco use, 75.39% (+11.29); alcohol use, 72.51% (+ 8.41); and substance use, 70.95% (+6.85). Intervention for positive use ranged from a low of 25% for alcohol use to > 50% for both tobacco use and substance use.
- Assessment/counseling for OTC/prescription medication was most often found (88.47%), screening for domestic violence was infrequently noted (25.28%), while screening for depression during the prenatal period was also relatively low, but remained stable, at 39.47%.
- The percentage of pregnant members who had evidence of screening for depression during a postpartum visit improved greatly (+21.50), increasing from 39.02% to 60.52% between RY 2014 and RY 2015.
- Regarding access to care for CSHCN:
  - Well-care visit rates fluctuated slightly (+/- less than 2 percentage points). Rates were as follows: 51.35% for children aged 15 months; 75.28% for children 3-6 years of age; and 53.88% for adolescents ages 12-21 years.
  - Access to PCPs for CSHCNs also fluctuated slightly (+/- less than 2 percentage points). The rates ranged from ~ 91% for both children ages 25 months to 6 years and adolescents aged 12-19 years to > 98% for children ages 12-24 months.
  - *HEDIS Annual Dental Visits* for CSHCNs remained stable at 62.72%.
- The CMS-416 EPSDT measures for dental services were reported for the first time in RY 2015. Rates included: any dental services – 45.72%; preventive services—41.70%; and sealants on a permanent molar – 4.11%.

Table 13: Passport Health Plan – RY 2013–2015 Performance Measure Rates

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had their height and weight documented during the measurement year or the year prior to the measurement year.	83.89%	89.85%	90.05%	0.20
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had a healthy weight for height documented during the measurement year or the year prior to the measurement year (as identified by appropriate BMI).	22.63%	23.59%	22.62%	-0.97
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had counseling for nutrition documented during the measurement year or the year prior to the measurement year.	38.85%	43.05%	40.28%	-2.77
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had counseling for physical activity documented during the measurement year or the year prior to the measurement year.	30.68%	40.40%	41.67%	1.27
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 LDL-C/cholesterol screening in the measurement year or during the four years prior.	84.23%	87.79%	59.62%	-28.17
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 both a height and weight on the same date of service during the measurement year.	87.95%	92.03%	93.47%	1.44

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
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 both a height and weight on the same date of service during the measurement year.	91.10%	92.11%	96.91%	4.80
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 both a height and weight on the same date of service during the measurement year.	88.96%	92.05%	94.70%	2.65
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 healthy weight for height during the measurement year.	59.63%	59.21%	58.46%	-0.75
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 healthy weight for height during the measurement year.	48.12%	48.57%	53.50%	4.93
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 healthy weight for height during the measurement year.	55.83%	55.64%	56.64%	1.00
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 screening/counseling for tobacco.	71.92%	74.85%	85.19%	10.34

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
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 screening/counseling for alcohol/substances.	63.70%	59.51%	72.84%	13.33
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 screening/counseling for sexual activity.	55.48%	53.99%	61.73%	7.74
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 screening for depression documented.	NR	28.83%	44.44%	15.61
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for tobacco use 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%	75.39%	11.29
				The percentage of pregnant members who had positive screening for tobacco use.	31.75%	28.57%	33.53%	4.96
				The percentage of pregnant members who had positive screening for tobacco use and received intervention for tobacco use.	65.42%	60.53%	54.39%	-6.14
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for alcohol use 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%	72.51%	8.41
				The percentage of pregnant members who had positive screening for alcohol use.	3.92%	4.14%	8.56%	4.42
				The percentage of pregnant members who were found positive for alcohol use and received intervention for alcohol use.	69.23%*	36.36%*	25.00%*	-11.36

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for substance/drug use 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%	70.95%	6.85
				The percentage of pregnant members who had positive screening for substance/drug use.	5.76%	5.64%	9.06%	3.42
				The percentage of pregnant members who were found positive for substance/drug use and were provided intervention for drug/substance use.	52.63%*	40.00%*	51.72%*	11.72
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of assessment of and/or education/ counseling for nutrition 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%	39.69%	9.57
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of assessment of and/or education/ counseling for OTC/ prescription medication 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%	88.47%	24.61
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for domestic violence 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%	25.28%	4.56

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members year who had evidence of screening for depression 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%	39.47%	0.43
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for depression during a postpartum visit.	58.39%	39.02%	60.52%	21.50
Children with Special Health Care 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 at least one dental visit during the measurement year.				
				SSI Total (B, BP, D, DP, K, M)	52.94%	57.02%	57.27%	0.25
				SSI Blind (B, BP, K)	52.94%	60.00%*	68.42%*	8.42
				SSI Disabled (D, DP, M)	52.94%	57.01%	57.23%	0.22
				Foster (P,S, X)	67.60%	76.71%	73.24%	-3.47
				CCSHCN (provider type 22 and 23)	71.43%	64.86%	66.37%	1.51
				Total ADV (2–21 years)	56.76%	63.00%	62.72%	-0.28
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 at least 6 well-child visits with a PCP during their first 15 months of life.				
				SSI Total (B, BP, D, DP, K, M)	35.47%	37.37%	38.64%	1.27
				SSI Blind (B, BP, K)	100.00%*	N/A	N/A	N/A
				SSI Disabled (D, DP, M)	34.32%	37.37%	38.64%	1.27
				Foster (P,S, X)	61.47%	68.75%	59.76%	-8.99
				CCSHCN (provider type 22 and 23)	N/A	N/A	80.00%*	N/A
				Total WC15mo	45.55%	49.69%	51.35%	1.66
Preventive Care	Child - CSHCN Cohort	A	HEDIS Well-Child Visits in the 3rd, 4th, 5th and 6th	The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.				
				SSI Total (B, BP, D, DP, K, M)	70.42%	73.18%	76.87%	3.69
				SSI Blind (B, BP, K)	100.00%*	80.00%*	100.00%*	20.00
				SSI Disabled (D, DP, M)	70.35%	73.13%	76.69%	3.56
				Foster (P,S, X)	77.08%	78.27%	73.69%	-4.58
				CCSHCN (provider type 22 and 23)	N/A	N/A	72.65%	N/A

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
			Years of Life	Total WC34	72.61%	75.19%	75.28%	0.09
Preventive Care	Child - CSHCN Cohort	A	HEDIS Adolescent Well-Care Visits	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.				
				SSI Total (B, BP, D, DP, K, M)	48.86%	52.16%	51.24%	-0.92
				SSI Blind (B, BP, K)	42.86%*	45.45%*	40.00%*	-5.45
				SSI Disabled (D, DP, M)	48.88%	52.19%	51.28%	-0.91
				Foster (P,S, X)	59.34%	62.56%	59.98%	-2.58
				CCSHCN (provider type 22 and 23)	59.65%	56.67%	56.72%	0.05
				Total AWC	51.38%	54.96%	53.88%	-1.08
Preventive Care	Child - CSHCN 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 - CSHCN Cohort	A	HEDIS Children's Access to PCPs	The percentage of members 12–24 months of age who had a visit with a primary care practitioner (PCP) during the measurement year.				
				SSI Total (B, BP, D, DP, K, M)	93.49%	97.25%	98.18%	0.93
				SSI Blind (B, BP, K)	100.00%*	N/A	N/A	N/A
				SSI Disabled (D, DP, M)	93.37%	97.25%	98.18%	0.93
				Foster (P,S, X)	100.00%	98.82%	99.08%	0.26
				CCSHCN (provider type 22 and 23)	N/A	N/A	100.00%*	N/A
				Total CAP 12–24 months	96.19%	97.94%	98.73%	0.79
Preventive Care	Child - CSHCN Cohort	A	HEDIS Children's Access to PCPs	The percentage of members 25 months–6 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)	90.95%	92.58%	92.79%	0.21
				SSI Blind (B, BP, K)	100.00%*	80.00%*	100.00%*	20.00
				SSI Disabled (D, DP, M)	90.92%	92.66%	92.75%	0.09
				Foster (P,S, X)	91.03%	92.15%	88.77%	-3.38
				CCSHCN (provider type 22 and 23)	N/A	N/A	94.74%	N/A
				Total CAP 25 months–6 years	90.98%	92.40%	91.29%	-1.11
Preventive Care	Child - CSHCN 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%	93.78%	-0.84
				SSI Blind (B, BP, K)	100.00%*	100.00%*	50.00%*	-50.00

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change from RY 2014 to RY 2015
				SSI Disabled (D, DP, M)	90.95%	94.60%	93.85%	-0.75
				Foster (P,S, X)	89.06%	96.05%	92.34%	-3.71
				CCSHCN (provider type 22 and 23)	100.00%*	100.00%*	95.30%	-4.70
				Total CAP 7 -11 years	90.56%	94.90%	93.46%	-1.44
Preventive Care	Child - CSHCN 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%	90.64%	-1.74
				SSI Blind (B, BP, K)	83.33%*	100.00%*	75.00%*	-25.00
				SSI Disabled (D, DP, M)	88.78%	92.35%	90.69%	-1.66
				Foster (P,S, X)	86.58%	94.06%	91.70%	-2.36
				CCSHCN (provider type 22 and 23)	94.44%	96.43%*	92.78%	-3.65
				Total CAP 12 -19 years	88.33%	92.68%	91.04%	-1.64
Utilization of Dental Services	Child	A	CMS-416 Dental Services[1]	This performance measure assesses the percentage of members ages <21 years, 6-9 years and 10-14 years of age who received the specified dental services.				
				Any Dental Services			45.72%	N/A
				Preventive Dental Services			41.70%	N/A
				Dental Treatment Services			17.50%	N/A
				Sealant on a Permanent Molar Tooth			4.11%	N/A
				Diagnostic Dental Services			47.16%	N/A
				Oral Health Services Provided by a Non-Dentist Provider			N/A	N/A
				Any Dental or Oral Health Service			46.66%	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; NR: MCO did not report a rate;
*: caution should be used when interpreting these rates as the denominator is <30.
[1] The CMS-416 Dental Services measure is a new measure for RY 2015; therefore, there are no rates reported for prior years.

WellCare of Kentucky – RY 2013–2015 Performance Measure Rates

Performance Trends RY 2014 to RY 2015

WellCare of Kentucky's performance for RYs 2014 and 2015 is presented in Table 14, along with the change in rate (increase or decrease) from year to year.

Overall observations regarding WellCare of Kentucky's performance include:

- The rates for documentation of height and weight for adults and healthy weight for height remained stable at 83.56% and 25.50%, respectively. 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.
- Counseling for physical activity for adults declined slightly from 33.33% to 32.42%, while counseling for nutrition increased (~ 6 percentage points) from 27.78% (RY 2014) to 33.79% (RY 2015).
- The rate for cholesterol screening for adults, although still high, decreased approximately 8 percentage points from 80.86% to 72.56% between RY 2014 and RY 2015.
- For children and adolescents 3 – 17 years of age, documentation of height and weight decreased over 10 percentage points, to 69.83%, while those with a healthy weight for height increased over 11 percentage points to 30.95%.
- Related to adolescent screening and counseling, each of the four rates improved, from almost 19 percentage points for screening for depression to just less than one (1) percentage point for alcohol/substance screening/counseling. Screening/counseling for tobacco use was seen most often, at 62.33%, followed by screening for depression (40.41%), screening/counseling for alcohol/substances (38.36%), and lastly, screening/counseling for sexual activity (26.71%).
- Screening for domestic violence and screening for depression in the prenatal period were seen infrequently, at 17.80% and 24.27%, respectively.
- Rates for screening during the perinatal period were: 39.16% for tobacco use screening; 36.57% for alcohol use screening and 32.69% for substance use screening. Intervention for positive use ranged from 0.00% for alcohol use to 55.81% for tobacco use, with intervention for substance use at 7.69%.
- Rates improved (nearly 4 percentage points) for both assessment/counseling for nutrition (21.36%) and assessment/counseling for OTC/prescription medication (34.30%).
- The rate screening for depression during a postpartum visit was 36.81%.
- Rates for the set of measures for access to PCPs for CSHCNs were very strong, all above 90%. The highest rate was seen for the CSHCNs ages 12 – 24 months at 97.88% and the lowest rates were ~ 93% for both children ages 25 months – 6 years and adolescents ages 12-19 years.
- Regarding well-care for CSHCN, performance remained stable for children ages 3-6 years (62.77% to 64.51%) and for adolescents ages 12-21 years (36.97% to 37.07%) but dropped substantially for infants with 6 more visits in the first 15 months of life (52.27% to 43.69%).
- Access to annual dental visits for CSHCNs dropped negligibly from 61.81% to 60.09%.

Table 14: WellCare of Kentucky – RY 2013–2015 Performance Measure Rates

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change RY 2014 to RY 2015
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had their height and weight documented during the measurement year or the year prior to the measurement year.	0.00%*	84.72%	83.56%	-1.16
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had a healthy weight for height documented during the measurement year or the year prior to the measurement year (as identified by appropriate BMI).	N/A	25.53%	25.50%	-0.03
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had counseling for nutrition documented during the measurement year or the year prior to the measurement year.	0.00%*	27.78%	33.79%	6.01
Preventive Care	Adult	H	BMI	The percentage of members 18–74 years of age who had an outpatient visit and who had counseling for physical activity documented during the measurement year or the year prior to the measurement year.	0.00%*	33.33%	32.42%	-0.91
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 LDL-C/cholesterol screening in the measurement year or during the four years prior.	72.94%	80.86%	72.56%	-8.30
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 both a height and weight on the same date of service during the measurement year.	68.42%	78.49%	68.50%	-9.99
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 both a height and weight on the same date of service during the measurement year.	72.11%	82.35%	72.46%	-9.89

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change RY 2014 to RY 2015
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 both a height and weight on the same date of service during the measurement year.	69.68%	79.86%	69.83%	-10.03
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 healthy weight for height during the measurement year.	10.71%	21.62%	32.64%	11.02
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 healthy weight for height during the measurement year.	17.76%	15.75%	27.72%	11.97
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 healthy weight for height during the measurement year.	13.20%	19.48%	30.95%	11.47
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 screening/counseling for tobacco.	51.02%	54.90%	62.33%	7.43
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 screening/counseling for alcohol/substances.	30.61%	37.91%	38.36%	0.45
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 screening/counseling for sexual activity.	18.37%	24.18%	26.71%	2.53
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 who had screening for depression documented.	15.65%	21.57%	40.41%	18.84

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change RY 2014 to RY 2015
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for tobacco use 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%	39.16%	-1.80
				The percentage of pregnant members who had a screening for tobacco use who were found positive for tobacco use.	43.65%	36.31%	35.54%	-0.77
				The percentage of pregnant members who were found positive for tobacco use and received intervention for tobacco use.	56.36%	59.65%	55.81%	-3.84
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for alcohol use 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%	36.57%	-3.59
				The percentage of pregnant members who had a screening for alcohol use and who were found positive for alcohol use.	4.42%	2.63%	3.54%	0.91
				The percentage of pregnant members who were found positive for alcohol use and received intervention for alcohol use.	20.00%*	25.00%*	0.00%*	-25.00
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for substance/drug use 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%	32.69%	-4.28
				The percentage of pregnant members who had positive screening for substance/drug use.	8.93%	9.29%	12.87%	3.58
				The percentage of pregnant members who were found positive for substance/drug use and received intervention for drug/substance use.	10.00%*	53.85%*	7.69%*	-46.16
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of assessment of and/or education/counseling for nutrition 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%	21.36%	3.54

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change RY 2014 to RY 2015
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of assessment of and/or education/counseling for OTC/ prescription medication 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%	34.30%	3.71
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for domestic violence 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%	17.80%	-2.68
Perinatal Care	N/A	H	Prenatal Screening/ Counseling	The percentage of pregnant members who had evidence of screening for depression 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%	24.27%	-3.66
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 screening for depression during a postpartum visit.	46.72%	44.16%	36.81%	-7.35
Children with Special Health Care 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 at least one dental visit during the measurement year.				
				SSI Total (B, BP, D, DP, K, M)	52.72%	55.60%	53.35%	-2.25
				SSI Blind (B, BP, K)	58.33%*	58.50%	48.08%	-10.42
				SSI Disabled (D, DP, M)	52.70%	55.60%	53.37%	-2.23
				Foster (P,S, X)	70.85%	74.20%	71.77%	-2.43
				CCSHCN (provider type 22 and 23)	65.96%	70.40%	69.64%	-0.76
				Total ADV (2–21 years)	58.48%	61.81%	60.09%	-1.72
Preventive Care	Child - CSHCN 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 at least 6 well-child visits with a PCP during their first 15 months of life.				
				SSI Total (B, BP, D, DP, K, M)	0.09%*	40.00%	38.35%	-1.65
				SSI Blind (B, BP, K)	N/A	100.00%*	0.00%*	-100.00
				SSI Disabled (D, DP, M)	0.09%*	39.20%	38.64%	-0.56
				Foster (P,S, X)	23.07%*	59.10%	44.51%	-14.59
				CCSHCN (provider type 22 and 23)	16.66%*	54.20%	46.77%	-7.43
				Total WC15mo	16.67%*	52.27%	43.69%	-8.58

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change RY 2014 to RY 2015
Preventive Care	Child - CSHCN Cohort	A	HEDIS Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life	The percentage of members 3, 4, 5, and 6 years of age who had one or more well-child visits with a PCP during the measurement year.				
				SSI Total (B, BP, D, DP, K, M)	60.41%	58.00%	61.05%	3.05
				SSI Blind (B, BP, K)	50.00%*	60.00%*	50.00%*	-10.00
				SSI Disabled (D, DP, M)	60.46%	58.00%	61.11%	3.11
				Foster (P,S, X)	67.07%	67.60%	67.11%	-0.49
				CCSHCN (provider type 22 and 23)	65.96%	67.50%	68.59%	1.09
				Total WC34	63.45%	62.77%	64.51%	1.74
Preventive Care	Child - CSHCN Cohort	A	HEDIS Adolescent Well-Care Visits	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.				
				SSI Total (B, BP, D, DP, K, M)	32.33%	31.70%	31.41%	-0.29
				SSI Blind (B, BP, K)	11.76%*	25.90%*	25.81%	-0.09
				SSI Disabled (D, DP, M)	32.43%	31.70%	31.43%	-0.27
				Foster (P,S, X)	54.30%	52.70%	51.78%	-0.92
				CCSHCN (provider type 22 and 23)	41.08%	41.70%	44.22%	2.52
				Total AWC	37.48%	36.97%	37.07%	0.10
Preventive Care	Child - CSHCN 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 - CSHCN Cohort	A	HEDIS Children's Access to PCPs	The percentage of members 12–24 months of age who had a visit with a primary care practitioner (PCP) during the measurement year.				
				SSI Total (B, BP, D, DP, K, M)	96.15%	96.80%	96.62%	-0.18
				SSI Blind (B, BP, K)	100.00%*	100.00%*	100.00%*	0.00
				SSI Disabled (D, DP, M)	96.12%	96.70%	96.60%	-0.10
				Foster (P,S, X)	97.53%	95.70%	99.52%	3.82
				CCSHCN (provider type 22 and 23)	99.17%	95.60%	97.55%	1.95
				Total CAP 12–24 months	97.71%	95.94%	97.88%	1.94
Preventive Care	Child - CSHCN Cohort	A	HEDIS Children's Access to PCPs	The percentage of members 25 months–6 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)	95.45%	94.50%	94.54%	0.04
				SSI Blind (B, BP, K)	75.00%	83.30%*	91.67%*	8.37
				SSI Disabled (D, DP, M)	95.53%	94.50%	94.56%	0.06
				Foster (P,S, X)	91.39%	90.50%	91.49%	0.99
				CCSHCN (provider type 22 and 23)	96.36%	94.30%	95.99%	1.69
				Total CAP 25 months–6 years	94.61%	93.36%	93.92%	0.56

Performance Measure Domain	Age Group	Admin/ Hybrid	Category	Measure Definition	RY 2013 Rate	RY 2014 Rate	RY 2015 Rate	Change RY 2014 to RY 2015
Preventive Care	Child - CSHCN 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	97.90%	96.18%	-1.72
				SSI Blind (B, BP, K)	N/A	100.00%*	100.00%*	0.00
				SSI Disabled (D, DP, M)	N/A	97.90%	96.16%	-1.74
				Foster (P,S, X)	N/A	94.40%	93.33%	-1.07
				CCSHCN (provider type 22 and 23)	N/A	98.60%	98.68%	0.08
				Total CAP 7–11 years	N/A	97.09%	95.66%	-1.43
Preventive Care	Child - CSHCN 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	95.50%	93.98%	-1.52
				SSI Blind (B, BP, K)	N/A	100.00%*	95.00%*	-5.00
				SSI Disabled (D, DP, M)	N/A	95.50%	93.98%	-1.52
				Foster (P,S, X)	N/A	94.00%	92.20%	-1.80
				CCSHCN (provider type 22 and 23)	N/A	97.60%	96.41%	-1.19
				Total CAP 12–19 years	N/A	95.29%	93.73%	-1.56
Utilization of Dental Services	Child	A	CMS-416 Dental Services[1]	This performance measure assesses the percentage of members ages <21 years, 6-9 years and 10-14 years of age who received the specified dental services.				
				Any Dental Services			47.50%	N/A
				Preventive Dental Services			42.08%	N/A
				Dental Treatment Services			21.09%	N/A
				Sealant on a Permanent Molar Tooth			5.49%	N/A
				Diagnostic Dental Services			45.10%	N/A
				Oral Health Services Provided by a Non-Dentist Provider			1.97%	N/A
				Any Dental or Oral Health Service			49.18%	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; NR: MCO did not report a rate;
*: caution should be used when interpreting these rates as the denominator is <30.
[1] The CMS-416 Dental Services measure is a new measure for RY 2015; therefore, there are no rates reported for prior year.

NCQA HEDIS 2015 Compliance Audit

HEDIS reporting is a contract requirement for Kentucky's Medicaid plans. In addition, the plans' HEDIS measure calculations are audited annually by an NCQA-licensed audit organization, in accordance with NCQA's HEDIS Compliance Audit specifications. Note that the MCO's were audited by NCQA licensed auditor individually contracted by each MCO and were not audited by IPRO.

As part of the HEDIS 2015 Compliance Audit, auditors assessed compliance with NCQA standards in the six designated Information Systems (IS) categories, as follows:

- IS 1.0: Medical Services Data – Sound Coding Methods and Data Capture, Transfer and Entry
- IS 2.0: Enrollment Data – Data Capture, Transfer and Entry
- IS 3.0: Practitioner Data – Data Capture, Transfer and Entry
- IS 4.0: Medical Record Review Process – Training, Sampling, Abstraction and Oversight
- IS 5.0: Supplemental Data – Capture, Transfer and Entry
- IS 6.0: Member Call Center Data – Capture, Transfer and Entry
- IS 7.0: Data Integration – Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

In addition, the following HEDIS Measure Determination (HD) standards categories were assessed:

- HD 1.0: Denominator Identification
- HD 2.0: Sampling
- HD 3.0: Numerator Identification
- HD 4.0: Algorithmic Compliance
- HD 5.0: Outsourced or Delegated HEDIS Reporting Functions

HEDIS 2015 Measures

For the 2015 reporting year, five (5) MCOs were able to report HEDIS 2015: Anthem Blue Cross and Blue Shield Medicaid, Humana-CareSource, CoventryCares of Kentucky, Passport Health Plan, and WellCare of Kentucky. This was the first year Anthem Blue Cross and Blue Shield Medicaid reported HEDIS data. The measures required for reporting are listed by domain. MCO rates for all measures are presented in this section.

Health Plan Descriptive Information

Board Certification (BCR)

- Family Medicine
- Internal Medicine
- OB/GYN
- Pediatricians
- Geriatricians
- Other Physicians

Effectiveness of Care: Prevention and Screening

- Adult BMI Assessment (ABA)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)
- Childhood Immunization Status (CIS)
- Immunization for Adolescents (IMA)
- HPV Vaccine for Female Adolescents (HPV)
- Lead Screening in Children (LSC)
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Non-recommended Cervical Cancer Screening in Adolescent Females (NCS)
- Chlamydia Screening in Women (CHL)

Effectiveness of Care: Respiratory Conditions

- Appropriate Testing for Children with Pharyngitis (CWP)
- Appropriate Treatment for Children with URI (URI)
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
- Pharmacotherapy Management of COPD Exacerbation (PCE)
- Use of Appropriate Medications for People With Asthma (ASM)
- Medication Management for People With Asthma (MMA)
- Asthma Medication Ratio (AMR)

Effectiveness of Care: Cardiovascular Conditions[17]

- Controlling High Blood Pressure (CBP)
- Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

Effectiveness of Care: Diabetes

- Comprehensive Diabetes Care (CDC)[18]

Effectiveness of Care: Musculoskeletal

- Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)
- Use of Imaging Studies for Low Back Pain (LBP)

Effectiveness of Care: Behavioral Health

- Antidepressant Medication Management (AMM)
- Follow-up Care for Children Prescribed ADHD Medication (ADD)
- Follow-up After Hospitalization for Mental Illness (FUH)
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)
- Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)
- Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)
- Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

Effectiveness of Care: Medication Management

- Annual Monitoring for Patients on Persistent Medications (MPM)[19]

Access /Availability of Care

- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Children and Adolescents' Access to Primary Care Practitioners (CAP)
- Annual Dental Visit (ADV)
- Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)
- Prenatal and Postpartum Care (PPC)
- Call Answer Timeliness (CAT)
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

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[17] The measure Cholesterol Screening for Patients with Cardiovascular Conditions (CMC) was retired.
[18] The CDC numerators LDL-C Screening, LDL-C control (< 100 mg/dL), and Blood Pressure control (<140/80 mm/Hg) were retired.
[19] The MPM numerator annual monitoring of anticonvulsant medication was retired.

Use of Services

- Frequency of Ongoing Prenatal Care (FPC)
- 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)
- Adolescent Well-Care Visit (AWC)
- Ambulatory Care: Outpatient Visits (AMB)
- Ambulatory Care: Emergency Department Visits (AMB)
- Inpatient Utilization: General Hospital/Acute Care (IPU)
- Identification of Alcohol and Other Drug Services (IAD)
- Mental Health Utilization (MPT)

In Table 15 through Table 18, the MCOs' reported rates and the weighted statewide rate[20] are provided when available. The MCOs' reported rates are compared to the NCQA HEDIS 2015 Quality compass national average for Medicaid HMOs, where possible. An up arrow (↑) means the rate is greater than the NCQA national average for Medicaid. A down arrow (↓) means the rate is lower than the NCQA national average for Medicaid.

HEDIS Compliance Audits result in audited rates or calculations at the measure level and indicate if the measures can be publicly reported. The auditor approves the rate or report status of each measure and survey included in the audit, as shown below:

- Reportable (R) – a rate or numeric result. The organization followed the specifications and produced a reportable rate or result for the measure.
- Small Denominator (N/A) – the organization followed the specifications, but the denominator was too small (< 30) to report a valid rate.
- Benefit Not Offered (NB) – the organization did not offer the health benefit required by the measure.
- Not Reportable (NR) – the organization calculated the measure, but the rate was materially biased, or the organization chose not to report the measure or was not required to report the measure.

HEDIS *Board Certification* rates illustrate the percentage of physicians in the provider network that were board certified as of the last day of the measurement year (MY; December 31, 2014). Table 15 presents the HEDIS Board Certification rates for MY 2014 along with the weighted statewide average and a comparison of the MCO rates to the NCQA national average. An up arrow (↑) means the rate is greater than the NCQA national average. A down arrow (↓) means the rate is lower than the NCQA national average.

Table 15: HEDIS 2015 Board Certification Measures

Measure	Anthem BCBS Medicaid	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	Statewide Average
Family Medicine	NR	67.70%↓	41.18%↓	24.86%↓	45.11%↓	44.71%
Internal Medicine	NR	77.23%↑	65.28%↓	39.86%↓	47.87%↓	57.56%
Obstetrician/Gynecologist	NR	67.95%↓	72.22%↓	30.38%↓	45.77%↓	54.08%
Pediatricians	NR	73.57%↓	78.55%↓	43.29%↓	36.06%↓	57.87%
Geriatricians	NR	58.06%↓	20.00%↓	47.37%↓	63.16%↓	47.15%
Other Physician Specialists	NR	81.84%↑	68.44%↓	16.69%↓	38.37%↓	51.33%

BCBS: Blue Cross and Blue Shield; NR: not reported; ↑: above NCQA national average for Medicaid; ↓: below NCQA national average for Medicaid.

[20] A weighted average is an average in which some values count more than others. In this case, the MCOs with greater eligible populations were counted more toward the statewide average.

In general, all or most of the Board Certification rates for each of the MCOs were below the NCQA national averages, and represent an opportunity for improvement (Table 15). Additionally, the majority of Board Certification rates for all of the MCOs were below the 50th percentile. One notable difference was that CoventryCares of Kentucky was above the NCQA national average for both Internal Medicine and Other Physician Specialists. Moreover, the statewide averages ranked at or below the Quality Compass®[21] 50th percentile for all specialties.

HEDIS 2015 Effectiveness of Care measures evaluate how well a health plan provides preventive screenings and care for members with acute and chronic illnesses, including: respiratory illnesses, cardiovascular illnesses, diabetes, behavioral health conditions and musculoskeletal conditions. In addition, medication management measures are included. Table 16 presents the HEDIS Effectiveness of Care rates for MY 2014 along with the weighted state wide averages and comparison to the NCQA HEDIS 2015 national average for Medicaid. An up arrow (↑) means the rate is greater than the NCQA national average for Medicaid. A down arrow (↓) means the rate is lower than the NCQA national average for Medicaid.

[21] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Table 16: HEDIS 2015 Effectiveness of Care Measures

Measure	Anthem BCBS Medicaid	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	Weighted Statewide Average
Prevention and Screening						
Adult BMI Assessment (ABA)	N/A	86.13%↑	66.91%↓	89.35%↑	91.32%↑	88.73%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)						
BMI Percentile	N/A	45.50%↓	56.69%↓	86.31%↑	43.80%↓	52.97%
Counseling for Nutrition	N/A	51.34%↓	49.64%↓	72.85%↑	41.36%↓	51.26%
Counseling for Physical Activity	N/A	40.88%↓	47.20%↓	63.58%↑	40.39%↓	45.23%
Childhood Immunization Status: Combo 3 (CIS)	N/A	71.05%↑	51.09%↓	80.05%↑	62.04%↓	68.71%
Immunizations for Adolescents (IMA)						
Meningococcal	N/A	83.07%↑	69.83%↓	88.89%↑	80.77%↑	83.03%
Tdap/Td	N/A	90.10%↑	71.78%↓	93.52%↑	88.08%↑	89.53%
Combination #1	N/A	82.11%↑	67.15%↓	88.43%↑	79.23%↑	81.90%
Human Papillomavirus Vaccine for Female Adolescents (HPV)	N/A	15.82%↓	13.25%↓	30.63%↑	20.44%↓	20.65%
Lead Screening in Children (LSC)	N/A	60.58%↓	65.45%↓	77.26%↑	61.11%↓	64.60%
Breast Cancer Screening (BCS)	N/A	51.58%↓	N/A	56.95%↓	51.47%↓	52.86%
Cervical Cancer Screening (CCS)	25.29%↓	49.15%↓	35.52%↓	55.53%↓	48.18%↓	46.95%
Non-recommended Cervical Cancer Screening in Adolescent Females (NCS) [1,2]	13.13%	7.86%	6.37%	6.00%	7.57%	7.38%
Chlamydia Screening in Women (CHL)	51.27%↓	50.43%↓	55.02%↑	63.49%↑	48.69%↓	52.40%
Respiratory Conditions						
Appropriate Testing for Children with Pharyngitis (CWP)	N/A	65.23%↓	78.39%↑	84.46%↑	67.27%↓	69.13%
Appropriate Treatment for Children with URI (URI)	N/A	61.64%↓	80.35%↓	81.16%↓	60.24%↓	63.86%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	27.56%↓	19.38%↓	22.49%↓	19.38%↓	17.59%↓	18.78%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	N/A	23.09%↓	N/A	33.81%↑	23.27%↓	26.06%
Pharmacotherapy Management of COPD Exacerbation (PCE)						
Systemic Corticosteroid	63.73%↓	64.20%↓	57.78%↓	72.04%↑	65.07%↓	65.27%
Bronchodilator	71.48%↓	76.11%↓	69.05%↓	86.02%↑	79.61%↑	78.55%
Use of Appropriate Medications for People with Asthma (ASM)	N/A	85.82%↑	90.35%↑	88.48%↑	85.67%↑	86.51%
Medication Management for People with Asthma (MMA)						
Total – Medication Compliance 50%	N/A	70.39%↑	67.48%↑	63.51%↑	61.65%↑	65.14%
Total – Medication Compliance 75%	N/A	47.25%↑	38.35%↑	36.67%↑	35.03%↑	39.56%
Asthma Medication Ratio (AMR)	N/A	70.43%↑	66.37%↑	71.77%↑	71.61%↑	71.14%

Measure	Anthem BCBS Medicaid	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	Weighted Statewide Average
Cardiovascular Conditions[5]						
Controlling High Blood Pressure (CBP)	52.79%↓	57.70%↑	50.61%↓	51.66%↓	55.99%↓	55.04%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	71.43%↓	83.13%↓	79.73%↓	86.00%↑	82.95%↓	82.16%
Diabetes						
Comprehensive Diabetes Care (CDC)[4]						
Hemoglobin A1c (HbA1c) Testing	90.89%↑	87.04%↑	88.87%↑	90.78%↑	88.78%↑	88.78%
HbA1c Poor Control (> 9.0%)[2]	51.14%↑	39.78%↓	66.97%↑	38.43%↓	40.61%↓	43.01%
HbA1c Control (< 8.0%)	38.70%↓	50.18%↑	32.85%↓	50.61%↑	50.49%↑	48.22%
HbA1c Control (< 7.0%)	26.20%↓	36.08%↑	21.67%↓	34.72%↑	39.47%↑	35.33%
Eye Exam (Retinal) Performed	34.68%↓	40.51%↓	39.96%↓	40.70%↓	43.66%↓	41.61%
Medical Attention for Nephropathy	84.06%↑	80.84%↓	84.49%↑	81.74%↑	82.68%↑	82.31%
Blood Pressure Control (< 140/90 mmHg)	58.14%↓	57.85%↓	49.09%↓	66.43%↑	60.00%↓	59.39%
Musculoskeletal Conditions						
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)	63.64%↓	69.19%↓	60.91%↓	61.14%↓	61.25%↓	63.10%
Use of Imaging Studies for Low Back Pain (LBP)	55.18%↓	64.34%↓	56.97%↓	60.20%↓	61.48%↓	61.34%
Behavioral Health						
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	69.55%↑	62.35%↑	68.35%↑	62.67%↑	52.29%↓	58.28%
Effective Continuation Phase Treatment	62.05%↑	46.78%↑	59.71%↑	46.83%↑	37.61%↑	43.95%
Follow-up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	N/A	44.59%↑	42.28%↑	44.84%↑	61.49%↑	51.04%
Continuation and Maintenance (C&M) Phase	N/A	52.35%↑	54.55%↑	58.26%↑	69.62%↑	60.59%
Follow-up After Hospitalization for Mental Illness (FUH)						
7-Day Follow-up	20.52%↓	31.98%↓	20.99%↓	25.00%↓	33.82%↓	30.85%
30-Day Follow-up	37.02%↓	55.82%↓	39.35%↓	49.55%↓	57.18%↓	53.53%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)	82.93%↑	79.35%↓	80.79%↑	89.30%↑	82.24%↑	82.01%
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	N/A	68.89%↓	58.70%↓	58.33%↓	70.08%↑	67.63%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)[3]	N/A	N/A	N/A	N/A	82.14%	82.14%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	57.14%↓	63.50%↑	45.91%↓	56.09%↓	66.58%↑	63.06%

Measure	Anthem BCBS Medicaid	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	Weighted Statewide Average
Use of Multiple Concurrent Antipsychotics in Children and Adolescents – Total (APC)[1,2]	N/A	1.13%	0.00%	3.57%	1.31%	0.83%
Metabolic Monitoring for Children and Adolescents on Antipsychotics – Total (APM)[1]	N/A	20.69%	40.27%	24.31%	25.00%	23.66%
Medication Management[6]						
Annual Monitoring for Patients on Persistent Medications (MPM)						
ACE Inhibitors or ARBs	90.15%↑	89.34%↑	90.02%↑	92.00%↑	91.21%↑	90.71%
Digoxin	N/A	47.93%↓	50.00%↓	61.46%↑	53.66%↓	53.05%
Diuretics	90.62%↑	89.54%↑	90.36%↑	92.68%↑	92.09%↑	91.21%
Total	90.10%↑	89.07%↑	89.93%↑	92.04%↑	91.24%↑	90.62%

[1]There are no benchmark rates available for comparison either because this is a new measure or due to specification changes that prevent comparisons.
[2]A lower rate reflects better performance.
[3]Only WellCare of Kentucky reported a rate for this measure.
[4]The following CDC numerators were retired: LDL-C screening, LDL-C control (< 100 mg/dL) and BP control (< 140/80 mmHg).
[5]The Cholesterol Screening for People with Cardiovascular Disease measure was discontinued.
[6]The following MPM numerator was retired: annual monitoring for members on anticonvulsants.
BCBS: Blue Cross and Blue Shield; N/A: denominator fewer than 30; ↑: above NCQA national average for Medicaid; ↓: below NCQA national average for Medicaid.

The rates for the HEDIS Effectiveness of Care measures for MY 2014 showed mixed results (Table 16).

Performance was above the NCQA national Medicaid average for all five plans for the following measures (Table 16): Comprehensive Diabetes Care (Hemoglobin A1c (HbA1c) Testing), Antidepressant Medication Management (Effective Continuation Phase Treatment), and Annual Monitoring for Patients on Persistent Medications (ACE Inhibitors or ARBs, Diuretics, and Total). Rates were also above the NCQA national average for four of four (4 of 4) MCOs that reported rates for the following measures: Use of Appropriate medications for People with Asthma, Medication Management for People with Asthma (Both numerators), Asthma Medication Ratio, and Follow-up Care for Children Prescribed ADHD Medication (Both Numerators).

Conversely, performance was below the NCQA national average for all five plans for the following measures (Table 16): Cervical Cancer Screening, Avoidance of Antibiotic treatment in Adults with Acute Bronchitis, Eye Exam, Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis, Use of Imaging Studies for Low Back Pain, and Follow-up After Hospitalization for Mental Illness (Both numerators). Rates were also below the NCQA national average for four of four (4 of 4) MCOs that reported rates for Appropriate Treatment for Children with URI; additionally, for three of three (3 of 3) for Breast Cancer Screening.

The statewide average rates exceeded the NCQA national Medicaid average for the following measures: Adult BMI Assessment, Immunizations for Adolescents (All three (3) numerators), Use of Appropriate Medications for People with Asthma, Medication Management for People with Asthma (Both numerators), Comprehensive Diabetes Care (Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (> 9.0%), HbA1c Control (< 8.0%), HbA1c Control (< 7.0%), and Medical Attention for Nephropathy), Antidepressant Medication Management (Both numerators), Follow-up Care for Children Prescribed ADHD Medication (Both numerators), Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medication, Adherence to Antipsychotic Medications for Individuals with Schizophrenia, and Annual Monitoring for Patients on Persistent Medications (ACE Inhibitors or ARBs, Diuretics, and Total).

HEDIS Access/Availability of Care measure domain examines the percentages of children and adolescents who access their PCP for preventive services and adults who receive ambulatory health care services, access to prenatal and postpartum services for the Medicaid product line, call answer timeliness and measures of access for a variety of other services. Table 17 presents selected HEDIS Access and Availability measure rates for MY 2014 along with the weighted state wide averages and comparison to the NCQA HEDIS 2015 NCQA national average for Medicaid. An up arrow (↑) means the rate is greater than the NCQA national average for Medicaid. A down arrow (↓) means the rate is lower than the NCQA national average for Medicaid.

Table 17: HEDIS 2015 Access and Availability Measures

Measure	Anthem BCBS Medicaid	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	Weighted Statewide Average
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
20–44 Years	74.61%↓	81.16%↑	72.68%↓	82.58%↑	84.36%↑	81.33%
45–64 Years	84.17%↓	87.23%↑	83.52%↓	89.39%↑	91.05%↑	88.45%
65+ Years	N/A	82.47%↓	78.36%↓	94.00%↑	88.94%↑	84.24%
Total	78.49%↓	83.21%↑	77.16%↓	85.17%↑	86.91%↑	83.99%
Children and Adolescents' Access to Primary Care Practitioners (CAP)						
12–24 Months	N/A	97.20%↑	92.39%↓	98.35%↑	97.49%↑	97.49%
25 Months– 6 Years	N/A	90.63%↑	82.52%↓	90.25%↑	92.02%↑	90.91%
7–11 Years	N/A	96.32%↑	88.32%↓	94.19%↑	96.30%↑	95.63%
12–19 Years	N/A	95.05%↑	85.11%↓	92.92%↑	95.22%↑	94.39%
Annual Dental Visit (ADV)	21.49%↓	57.34%↑	46.40%↓	63.64%↑	60.36%↑	59.41%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)						
Initiation of AOD Treatment: Total	34.32%↓	32.99%↓	25.91%↓	25.18%↓	30.79%↓	30.31%
Engagement of AOD Treatment: Total	9.87%↓	7.43%↓	7.27%↓	2.89%↓	6.16%↓	6.33%
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	64.29%↓	84.91%↑	69.34%↓	86.89%↑	87.29%↑	85.67%
Postpartum Care	48.70%↓	59.12%↓	51.58%↓	68.67%↑	51.41%↓	57.58%
Call Answer Timeliness (CAT)	87.75%↑	78.20%↓	90.82%↑	77.62%↓	80.43%↓	80.63%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – Total (APP)[1]	N/A	59.60%	60.71%	67.86%	65.33%	64.07%

[1]There are no benchmark rates available for comparison either because this is a new measure or due to specification changes that prevent comparisons.
BCBS: Blue Cross and Blue Shield; N/A: not applicable; ↑: above NCQA national average; ↓: below NCQA national average.

Statewide PMs related to Access and Availability was an area of strength (Table 17). The statewide average ranked above the Medicaid NCQA national average for all measures except: Adults' Access to Preventive/Ambulatory Health Services (65+ Years), Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Both numerators), Prenatal and Postpartum Care (Postpartum Care), and Call Answer Timeliness. Additionally, three of five (3 of 5) MCOs' rates ranked above the NCQA national average for the following measures: Adults' Access to Preventive/Ambulatory Health Services (20-44 Years, 45-64 Years, and Total), and Annual Dental Visit.

HEDIS Use of Services domain (Table 18) contains four measures that have the same structure as the Effectiveness of Care measures, including: Frequency of Ongoing Prenatal Care: 81+ Percent; Well-Child Visits In the First 15-Months of Life: 6+ Visits; Well-Child Visits In the Third, Fourth, Fifth and Sixth Years of Life; and Adolescent Well-Care Visits. They are subject to the same guidelines as the Effectiveness of Care domain for calculation, including the inclusion of all claims. They are also reported as percentages with a higher percentage indicating better performance. Table 18 presents selected HEDIS Use of Services measure rates for measurement year (MY) 2014 along with the weighted state wide averages and comparison to the HEDIS 2014 NCQA national average for Medicaid. An up arrow (↑) means the rate is greater than the NCQA national average for Medicaid. A down arrow (↓) means the rate is lower than the NCQA national average for Medicaid.

Table 18: HEDIS 2015 Use of Services

Measure	Anthem BCBS Medicaid	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	Weighted Statewide Average
Frequency of Ongoing Prenatal Care: 81%+ Expected Visits (FPC)	59.74%↑	72.02%↑	47.45%↓	75.12%↑	72.32%↑	71.91%
Well-Child Visits in the First 15 Months of Life: 6+ Visits (W15)	N/A	50.24%↓	46.53%↓	66.24%↑	47.19%↓	52.46%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	N/A	57.73%↓	62.29%↓	74.77%↑	59.75%↓	62.16%
Adolescent Well-Care Visits (AWC)	24.19%↓	43.07%↓	32.60%↓	51.37%↑	41.85%↓	43.79%
Ambulatory Care: Total Outpatient Visits (AMBA) (Per 1,000 MM)	348.44↓	571.16↑	415.84↑	367.69↑	546.89↑	501.16
Ambulatory Care: Total Emergency Department Visits[1] (AMBA: ER) (Per 1,000 MM)	87.05↑	79.32↑	92.71↑	84.33↑	85.15↑	83.92
Inpatient Utilization: General Hospital/Acute Care (IPU) (Per 1,000 MM)						
Total Discharges (Per 1,000 MM)	8.39↑	9.14↑	9.57↑	10.23↑	10.31↑	N/A
Medicine Discharges (Per 1,000 MM)	4.28↑	4.08↑	5.72↑	4.24↑	4.84↑	N/A
Surgery Discharges (Per 1,000 MM)	3.20↑	1.39↓	2.27↑	2.99↑	2.56↑	N/A
Maternity Discharges (Per 1,000 MM)	0.95↓	5.60↑	0.08↓	4.37↑	4.21↑	N/A
Identification of Alcohol and Other Drug Services (IAD) (Per 1,000 MM)						
Total Outpatient (Per 1,000 MM)	7.11%↑	3.52%↓	6.91%↑	3.89%↓	5.24%↑	4.68%
Total Any (Per 1,000 MM)	8.49%↑	3.94%↓	8.36%↑	4.61%↓	6.16%↑	5.48%
Total Intensive (Per 1,000 MM)	0.17%↓	0.07%↓	1.34%↑	0.00%↓	0.10%↓	0.17%
Total Inpatient (Per 1,000 MM)	2.44%↑	0.82%↓	2.47%↑	1.30%↓	1.73%↑	1.47%

Measure	Anthem BCBS Medicaid	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	Weighted Statewide Average
Mental Health Utilization (MPT)						
Total Any (Per 1,000 MM)	5.74%↓	8.02%↓	10.47%↓	2.95%↓	9.41%↓	7.69%
Total Intensive (Per 1,000 MM)	0.16%↓	0.21%↓	6.58%↑	0.00%↓	0.60%↑	0.82%
Total Inpatient (Per 1,000 MM)	1.16%↓	0.88%↓	1.28%↓	0.13%↓	1.25%↓	0.93%
Total Outpatient (Per 1,000 MM)	4.90%↑	7.65%↓	9.85%↓	2.82%↓	8.76%↓	7.22%

[1] A lower rate is better performance; BCBS: Blue Cross and Blue Shield; N/A: not applicable.

Statewide, the Use of Services measures showed mixed performance (Table 18). The statewide average rate exceeded the NCQA national average rate for one of four (1 of 4) of the Effectiveness of Care-like measures, Frequency of Ongoing Prenatal Care (≥ 81%+). All of the plans showed variations in performance, except Passport Health Plan, with rates that exceeded the NCQA national average for all four (4) measures. Conversely, Humana-CareSource showed rates below the NCQA national average for all four (4) measures. The greatest opportunity for improvement was seen for Well-Child Visits in the First 15 Months of Life: 6+ Visits (W15), Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life and Adolescent Well-Care Visits, where three of five (3 of 5) MCOs' rates and the statewide average rate fell below the NCQA national average.

The last three Use of Services measures also showed mixed performance (Table 18). For Inpatient Utilization, although there is no statewide average, all five (5) MCOs were above the NCQA national average for Total Discharges (Per 1,000 MM). Conversely, Mental Health Utilization: Total Any (Per 1,000 MM) showed rates below the NCQA national average for all five (5) plans. Lastly, for Identification of Alcohol and Other Drug Services: Total Any (Per 1,000 MM), Anthem Blue Cross and Blue Shield Medicaid, Humana-CareSource, and WellCare of Kentucky were above the NCQA national average while CoventryCares of Kentucky and Passport Health Plan were below the NCQA national average.

It is difficult to interpret performance for the remaining two measures: Ambulatory Care: Outpatient Visits and Ambulatory Care: Emergency Department Visits (Table 18). For Outpatient Visits, rates for four (4) MCOs and the statewide average were above the national Medicaid average. The statewide average exceeds the 90th percentile. Without more detailed information, it cannot be determined, however, whether this reflects appropriate utilization of services. Rates for all five (5) MCOs and the statewide average were above the NCQA national average for Ambulatory Care: Emergency Department Visits. The statewide average again exceeds the 75th percentile. Generally speaking, higher rates for ED visits are considered poorer performance.

Consumer Satisfaction Measures – Reporting Year 2015

DMS requires that all plans conduct an annual assessment of member satisfaction with the quality of and access to services using the CAHPS surveys. MCOs contract with an NCQA certified survey vendor to field these member satisfaction surveys for both the adult and child member populations to assess both satisfaction with the MCO and with participating providers. Questions are grouped into categories that reflect satisfaction with service and care. Using AHRQ's nationally recognized survey allows for uniform measurement of consumers' health care experiences and for comparison of results to benchmarks. Through Quality Compass®, NCQA releases benchmarks for both the adult satisfaction survey and the child/adolescent satisfaction survey. Findings and interventions for improvement are reported to DMS and upon request, disclosed to members.

CAHPS 5.0H Adult Version

The adult member satisfaction survey was sent to a random sample of members aged 18 years and older as of December 31, 2014, and who were continuously enrolled for at least five of the last six months of 2014 and are enrolled at the time the survey is completed. Table 19 presents the HEDIS CAHPS 5.0H Adult Version rates for MY 2015[1] for each of the MCOs along with the weighted state wide averages[2] and comparison to the HEDIS 2015 NCQA national average for Medicaid. An up arrow (↑) means the rate is greater than the NCQA national average for Medicaid. A down arrow (↓) means the rate is lower than the NCQA national average for Medicaid.

Table 19: CAHPS 5.0H Adult Version – RY 2015

Measure[1]	Anthem BCBS Medicaid	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	Weighted Statewide Average
Getting Needed Care[2]	84.69%↑	83.27%↑	86.32%↑	83.21%↑	84.53%↑	84.24%
Getting Care Quickly[2]	85.26%↑	81.48%↑	83.10%↑	81.55%↑	83.18%↑	82.66%
How Well Doctors Communicate[2]	92.34%↑	91.88%↑	96.07%↑	89.51%↓	91.64%↑	91.87%
Customer Service[2]	89.17%↑	88.70%↑	96.36%↑	89.87%↑	90.56%↑	90.60%
Rating of All Health Care	73.93%↑	71.07%↓	80.57%↑	69.32%↓	75.15%↑	73.76%
Rating of Personal Doctor	79.82%↑	80.00%↑	85.61%↑	73.57%↓	84.16%↑	81.24%
Rating of Specialist Seen Most Often	80.63%↑	73.58%↓	81.46%↑	80.48%↓	74.57%↓	76.62%
Rating of Health Plan	78.70%↑	71.19%↓	79.59%↑	81.56%↑	80.44%↑	78.43%

[1]For "Rating of" measures, Medicaid rates are based on ratings of 8, 9 and 10; for measures that call for respondents to answer with "Always," "Usually," "Sometimes" or "Never" the Medicaid rate is based on responses of "Always" and "Usually."
[2]These indicators are composite measures.
BCBS: Blue Cross and Blue Shield; ↑: above NCQA national average; ↓: below NCQA national average.

The statewide average rate ranked above the NCQA national average rate for seven of eight (7 of 8) measures, all except Rating of Specialist Seen Most Often (Table 19). Rates that met or exceeded the 75th percentile included: Getting Needed Care, and Customer Service. No statewide rates fell at or below the 10th percentile.

In general, the MCOs' individual performance demonstrates a substantial opportunity for improvement, with the exception of Anthem Blue Cross and Blue Shield Medicaid and Humana-CareSource, with rates that exceeded the NCQA national average for eight of eight (8 of 8) metrics (Table 19). The other three (3) MCOs had rates above the average for only four to seven (4 to 7) measures. Additionally, for all four (4) MCOs, rates surpassed the NCQA national average for three of eight (3 of 8) measures which include: Getting Needed Care, Getting Care Quickly, and Customer Service.

[1] The full reports of CAHPS® data for each of the MCOs are available on the DMS Managed Care Oversight – Quality Branch Reports web page at: http://chfs.ky.gov/dms/pqomcoqbreports.htm
[2] A weighted rate or average is obtained by combining different numbers according to the relative importance of each. In this case, the MCOs' individual performance rates are combined according to the size of the eligible populations as a portion of the total number of eligible members across all MCOs.

CAHPS 5.0H Child Version

The child and adolescent member satisfaction survey was sent to the parent/guardian of randomly sampled members of 17 years of age and younger as of December 31, 2014, and who were continuously enrolled for at least five of the last six months of 2014 and were enrolled at the time the survey was completed. Table 20 displays the HEDIS CAHPS 5.0H Child Version rates for MY 2015 for each of the MCOs for selected survey items and composite measures[22] as well as a weighted statewide average.[23]

Table 20: CAHPS 5.0H Child Version – RY 2015

Measure[1]	Anthem BCBS Medicaid	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	Weighted Statewide Average
Getting Needed Care[2]	83.58%↓	86.60%↑	81.32%↓	89.42%↑	88.25%↑	87.17%
Getting Care Quickly[2]	90.90%↑	94.65%↑	87.84%↓	92.08%↑	89.75%↑	91.17%
How Well Doctors Communicate[2]	95.17%↑	94.11%↑	93.13%↑	93.94%↑	94.13%↓	93.31%
Customer Service[2]	86.16%↓	87.25%↓	91.52%↑	90.88%↑	85.40%↓	86.47%
Rating of All Health Care	80.94%↓	83.82%↓	81.14%↓	86.38%↑	86.34%↑	84.75%
Rating of Personal Doctor	89.01%↑	87.08%↓	82.18%↓	87.91%↓	87.56%↓	86.73%
Rating of Specialist Seen Most Often	81.48%↓	83.81%↓	N/A	86.52%↑	83.90%↓	83.71%
Rating of Health Plan	75.00%↓	79.57%↓	82.37%↓	90.44%↑	84.85%↑	83.45%

[1]For "Rating of" measures, Medicaid rates are based on ratings of 8, 9 and 10; for measures that call for respondents to answer with "Always," "Usually," "Sometimes" or "Never" the Medicaid rate is based on responses of "Always" and "Usually."
[2]These indicators are composite measures.
BCBS: Blue Cross and Blue Shield; ↑: above NCQA national average; ↓: below NCQA national average; N/A: not applicable.

Showing lower performance to the adult survey, the statewide average rate ranked above the NCQA national average rate for two of eight (2 of 8) measures: Getting Needed Care, and Getting Care Quickly (Table 20). Two measures ranked in the 50th percentile. No statewide rates fell at or below the 10th percentile. Additionally, none of the rates surpassed the NCQA national average for all five (5) MCOs.

The MCOs' individual performance for the child survey remains as an opportunity for improvement (Table 20). The rates for Passport Health Plan exceeded the NCQA national average for seven of eight (7 of 8) measures. The other four (4) MCOs had rates that exceeded the NCQA national average for two to four (2 to 4) measures.

[22] The full reports of CAHPS® data for each of the MCOs are available on the DMS Managed Care Oversight – Quality Branch Reports web page at: http://chfs.ky.gov/dms/pqomcoqbreports.htm
[23] A weighted average is an average in which some values count for more than others. In this case, the MCOs with greater eligible populations were counted more toward the statewide average.

Validation of Performance Improvement Projects

This section of the report presents the results of IPRO's evaluation of the Medicaid PIPs in progress during CY 2015 and submitted to DMS in September 2015.[24] The assessments were conducted using tools developed by IPRO and consistent with CMS EQR protocols for PIP validation.

The following narratives summarize the PIPs proposed or in progress for each of the MCOs during 2013–2015 and IPRO's validation results.

Anthem Blue Cross and Blue Shield Medicaid – Performance Improvement Projects 2014–2015

Anthem Blue Cross and Blue Shield Medicaid 2015 PIP: Use of Antipsychotics in Children and Adolescents (Statewide Collaborative)

Status: Baseline Measurement
Baseline Report Submitted: 9/1/15

Study Topic Selection
Anthem Blue Cross and Blue Shield Medicaid's 2015 behavioral health PIP topic is increasing effective and appropriate use of antipsychotic medications in children and adolescents. The objective of the PIP is to answer the following questions:

Can analysis of data combined with intensive provider and member education:

- Increase the proportion of children and adolescents 1–17 years on antipsychotics who had metabolic testing?
- Increase the proportion of children and adolescents 1–17 years who were newly prescribed an antipsychotic and who had first-line psychosocial care?
- Decrease the proportion of children and adolescents 1–17 years who were on ≥ 2 concurrent antipsychotics?

The PIP indicators are the following six HEDIS and proposed HEDIS indicators[25], as directed by DMS:

- HEDIS Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC);
- HEDIS Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP);
- HEDIS Metabolic Monitoring for Children and Adolescents Newly on Antipsychotics (APM);
- proposed HEDIS measure: Metabolic Screening for Children and Adolescents on Antipsychotics;
- proposed HEDIS measure: Use of Higher-Than-Recommended Doses of Antipsychotics in Children and Adolescents; and
- proposed HEDIS measure: Follow-up Visits for Children and Adolescents on Antipsychotics.

The MCO implemented the following interventions:

Provider Interventions:

- Conducted direct outreach to notify providers of panel members with gaps in metabolic monitoring.
- Conducted direct outreach to providers who prescribe multiple antipsychotics.

Member Interventions:

- Made outreach calls parents/guardians regarding the need for first-line psychosocial care.

Data Analysis and Results
Results for the baseline measurement period are shown in Table 21.

[24] The full PIP reports for each of the MCOs submitted at the time of the final re-measurement are available on the DMS Managed Care Oversight - Quality Branch Reports web page at: http://chfs.ky.gov/dms/pqomcoqbreports.htm
[25] Note that some of these indicators may not be reportable for Anthem Blue Cross and Blue Shield Medicaid due to limited time in the Medicaid program and members do not meet continuous enrollment criteria.

Table 21: Anthem Blue Cross and Blue Shield Medicaid 2015 PIP: Use of Antipsychotics in Children and Adolescents – Baseline Results

Indicators	Eligible Population	Baseline Results MY 2014	Performance Target
HEDIS APC: Use of Multiple Concurrent Antipsychotics	No eligible population	N/A	Improve by 3 percentage points (decrease)
HEDIS APP: Use of First-Line Psychosocial Care	< 30	N/A	Improve by 3 percentage points (increase)
HEDIS APM: Metabolic Monitoring	No eligible population	N/A	Improve by 3 percentage points (increase)
Follow-up Visit	No eligible population	N/A	Improve by 3 percentage points (increase)
Metabolic Screening	No eligible population	N/A	Improve by 3 percentage points (increase)
Use of Higher-than-Recommended Doses	No eligible population	N/A	Improve by 3 percentage points (decrease)

N/A: not applicable

Achievement of Improvement

Improvement cannot be assessed at the baseline phase. Additionally, the MCO cannot report measure rates at this time due to continuous enrollment constraints for child and adolescent members.

Strengths

Key strengths include:

- The MCO conducted direct outreach to members without first-line psychosocial care for facilitation of referrals to behavioral health care providers is a robust intervention.
- The MCO conducted direct outreach to providers prescribing antipsychotics but not compliant with metabolic testing is a robust intervention.
- The MCO collected and reviewed medical records for members in the HEDIS APC, APM and APP measure samples to help identify barriers and root-causes that will facilitate development of effective interventions.

Opportunities for Improvement

Key opportunities include:

- The aim statement and study questions do not address all of the 6 DMS-directed indicators (metabolic testing; first-line psychosocial care; multiple, concurrent antipsychotics, metabolic screening, follow-up visits, and use of higher-than-recommended doses). Goals are stated only for the three HEDIS indicators. The MCO should revise the aim statement, study questions, and goals to address all six DMS-directed indicators. All six indicators are listed in the methodology, with a goal of three percentage point improvement.
- The MCO should evaluate health plan barriers such as limited access to behavioral health providers, especially in Kentucky's more rural areas.
- The MCO should review the literature for best practices related to care for children and adolescents prescribed antipsychotics in order to identify evidence-based, effective intervention strategies.
- The MCO should develop interventions that target the health plan processes.
- The MCO should collect and analyze input from providers on perceived barriers and develop related interventions.

Overall Credibility of Results

The credibility of the results cannot be assessed at this time because the MCO could not report baseline data due to enrollment limitations/eligible population < 30.

Anthem Blue Cross and Blue Shield Medicaid 2015 PIP: Emergency Department Utilization

Status: Baseline Measurement

Baseline Report Submitted: 9/1/15

It should be noted that Anthem Blue Cross and Blue Shield Medicaid initially submitted a PIP proposal for the topic Adolescent Well-Care Visits. Since MCO members would not meet the measure's HEDIS continuous enrollment criteria, the MCO was instructed to develop a new PIP proposal for the topic ED utilization, since this indicator does not require continuous enrollment.

Study Topic Selection

Anthem Blue Cross and Blue Shield Medicaid's 2015 physical health PIP topic is increasing members' effective and appropriate use of ED services. The objective of the PIP is to answer the following questions:

Can a combination of a member and provider-focused interventions:

- Decrease the number of ED visits annually?
- Decrease the number of members with ≥ 10 ED visits annually?
- Reduce the total number of ED visits among members enrolled in the top-five high-volume PCP practices and the 5 PCP practices with the highest ED utilization?
- Increase the HEDIS Adult Access to Preventive/Ambulatory Services (AAP) rate?
- Increase the HEDIS Children and Adolescents' Access to Primary Care Practitioners (CAP) rate?

The PIP indicators are:

- HEDIS Ambulatory Care: ED Utilization;
- HEDIS Adult Access to Preventive/Ambulatory Services; and
- HEDIS Children and Adolescents' Access to Primary Care Practitioners.

The MCO has implemented the following interventions:

Provider Interventions:

- Provided the top-five high-volume PCP practices and the five practices with the highest ED utilization with data on panel members' ED visits.

Member Interventions:

- Assigned Case Managers to focus on frequent ED users.
- Distributed member education letters on the PCP-relationship, the 24-Hour Nurse Line, when to use the ED, alternative settings to the ED, and transportation services.
- Initiated post-ED follow-up calls to members.

Data Analysis and Results

Results for the baseline period are shown in Table 22.

Table 22: Anthem Blue Cross and Blue Shield Medicaid 2015 PIP: Emergency Department Utilization – Baseline Results

Indicator	Baseline Results MY 2014	Performance Target
HEDIS AMB: Ambulatory Care: ED Visits	87.05/ 1,000 MM	5 percentage point decrease (82.05/1,000 MM)
HEDIS AMB: Ambulatory Care: Outpatient Visits	348.44/ 1,000 MM	Not stated
HEDIS AAP: Adults' Ambulatory or Preventive Care Visit	78.49%	5 percentage point increase (83.59%)
HEDIS CAP: Children's and Adolescents' Access to PCPs	N/A	5 percentage point increase (TBD HEDIS 2016)
Members with ≥ 10 ED Visits Resulting in Discharge	NR	3 percentage point decrease (TBD)
Rate of ED Visits for Top-5 High-Volume ED Utilization PCP Panels	NR	3 percentage point decrease (TBD)

MY: measurement year; ED: emergency department; MM: member months; TBD: to be determined; N/A: not applicable; NR: not reported

Achievement of Improvement

Improvement cannot be assessed at the baseline phase. Additionally, the MCO needs to report results for the intervention process measures.

Strengths

Key strengths include:

- High frequency ED utilizers are targeted for case management and ED lock-in.
- Post-ED visit follow-up calls may identify causes for ED use and barriers to PCPs use and are an opportunity for member education.
- Interventions target PCPs with high numbers of ED utilizers in their panels.
- Process measures (e.g., # outreached for case management, # engaged in case management) will facilitate monitoring the interventions' success.

Opportunities for Improvement

Key opportunities include:

- The MCO should analyze ED claims data to determine the over-utilization patterns and develop specific, targeted interventions.
- Since most of the interventions focus only on high-ED utilizers, this may not impact the overall rate of ED visits. The MCO should develop an intervention strategy that targets a larger proportion of the member population.

Overall Credibility of Results

There were no validation findings which indicate that the credibility of the PIP results is at risk. The MCO was not able to report one PIP indicator for the child and adolescent population due to continuous enrollment constraints.

Anthem Blue Cross and Blue Shield Medicaid 2016 PIP: Managing Preventive Health Risks for Members with Serious Mental Illness (Statewide Collaborative)

Status: Proposal
Submitted: 11/2/15
Revised: 2/29/16

Study Topic Selection

The purpose of this project is to obtain meaningful data and knowledge regarding the physical health risk of members with serious mental illness (SMI), i.e., those with a diagnosis of schizophrenia and/or bipolar disorder. The objective of the PIP is to answer the following questions:

Can a combination of member/provider education and awareness:

- Increase access to a PCP for members in the target population?
- Increase provider awareness of screening needs and interventions for members with SMI?
- Increase metabolic and cardiovascular risk screening (i.e., blood pressure, BMI, diabetes screening, and LDL-C) for the target population?
- Increase member participation in tobacco cessation counseling?

The PIP indicators are:

- The percentage of members 18–64 years of age with SMI who had an ambulatory or preventative care visit during the measurement year;
- The percentage of members 18–64 years of age with SMI that were screened for tobacco use;
- The percentage of members 18–64 years of age with SMI who had at least one blood pressure assessment;
- The percentage of members 18–64 years of age with SMI who had a body mass index (BMI) documented;
- The percentage of members 18–64 years of age with SMI and had one or more LDL-C screening tests; and
- The percentage of members 18–64 years of age with SMI prescribed any antipsychotic medication and had screening for diabetes.

The MCO has planned the following interventions:

Member Interventions:

- Provide information in member newsletter.
- Develop a "Did You Know" texting program for members that have a SafeLink phone.
- Conduct outreach to members on gaps in care and assist with scheduling appointments.
- Collaborate with the physical and behavioral health case management teams to improve clinical outcomes for members with SMI.

Provider Interventions:

- Develop provider education material that addresses lack of preventive care for members with SMI.
- Educate providers that tobacco cessation counseling is a paid service.
- Educate providers on the medical benefits available for members that have a tobacco addiction.
- Encourage providers to refer members to "Quit Now Kentucky" (www.QuitNowKentucky.org).

Strengths

Key strengths include:

- The MCO prepared additional content for the topic and rationale.
- The MCO identified both member and provider barriers.
- The intervention strategy incorporates direct member outreach.

Opportunities for Improvement

Key opportunities include: The MCO needs to state the quantitative goal for each indicator. The MCO omitted the indicator for diabetes screening for members with schizophrenia and bipolar disorder on antipsychotics, HEDIS® SSD. The MCO should address health plan barriers. The MCO needs to describe the interventions in more detail. The MCO needs to include process measures to track the progress of the interventions.

Overall Credibility of Results

Not applicable. Baseline results will be reported in September 2016.

Anthem Blue Cross and Blue Shield Medicaid 2016 PIP: Increase Annual Dental Visits in EPSDT population

Status: Proposal
Submitted: 9/1/15

Study Topic Selection
The purpose of this project is to increase the number of EPSDT members ages 2–21 who have an annual dental visit. The goal is to improve performance for the HEDIS Annual Dental Visits (ADV) measure over the next 3 years to achieve the 2018 Quality Compass 25th percentile. The objective of the PIP is to answer the following questions:

- Will identifying and eliminating barriers Increase the number of individuals age 2–21 who obtain an annual dental visit?
- Will the availability of school based dental sealant programs increase dental visits?

The PIP indicator is:
- The percentage of members 2–21 years of age who had at least one dental visit during the measurement year. Six age stratifications will be reported: 2–3 years, 4–6 years, 7–10 years, 11–14 years, 15–18 years, 19–21 years; as well as total.

The MCO planned the following interventions:

Member Interventions:
- Conduct telephone outreach to members with gaps in dental care and assist in making appointments (MCO).
- Send annual dental visit reminder mailings (MCO).
- Call members who do not a claim for dental services within the year (DentaQuest).
- Add a link on the MCO's website to DentaQuest's web provider directory so that members can locate a dental provider more easily.
- Analyze member grievance data to determine if there are complaints related to barriers to dental care.
- Provide reimbursement for oral health screenings performed by public health departments.
- Collaborate with public health departments and identify school-based dental sealant programs and refer members with gaps in care to the school-based programs.

Provider Interventions:
- Conduct a network recruitment campaign to expand the dental provider network and reduce travel time for members (DentaQuest).
- Conduct a provider directory validation study to ensure network participation, accurate provider demographic information, and office hours (DentaQuest).

Health Plan Interventions:
- Add dental billing codes for broken appointment to covered dental benefits in order to track broken appointments.
- Share broken appointment data with case managers who will intervene with members.
- Conduct a literature review of the CMS Oral Health Initiative resources to identify evidence-based best-practice interventions for the Medicaid population.

Strengths
Key strengths include:
- The topic selection is well supported by data and health services literature.
- The PIP performance indicator is a HEDIS measure and performance can be benchmarked.
- The barrier analysis is based on data, such as disenrollment reasons and member and provider feedback.
- The intervention strategy addresses and incorporates members, providers, the dental vendor, and public health agencies.

Opportunities for Improvement

Key opportunities include:

- The MCO should re-evaluate the Quality Compass™ 25th percentile goal once the baseline rate is determined.
- The MCO might analyze the rates to determine if there are regional differences in performance.
- The MCO needs to add process measures to track and evaluate the major interventions.

Overall Credibility of Results

Not applicable. Baseline results will be reported in September 2016.

CoventryCares of Kentucky 2013 PIP: Decreasing Non-emergent/Inappropriate Emergency Room Utilization

Status: Final Measurement
Final Report Submitted: 9/1/2015

Study Topic Selection
CoventryCares of Kentucky's 2013 PIP topic was decreasing non-emergent and avoidable ED utilization. The objective of the PIP was to answer the following questions:

- Will member education regarding appropriate ED utilization reduce the HEDIS Ambulatory Care: ED Utilization rate?
- Can enrollment in case management decrease the volume of high-utilizers' ED visits?

The PIP indicators are:
- HEDIS Ambulatory Care: ED Utilization; and
- the number of ED visits annually by members who are high-utilizers (those with ≥ 9 ER visits per year).

The MCO implemented the following interventions:

Provider Interventions:
- Informed providers of panel members who over-utilized the ED/used the ED for inappropriate reasons.
- Educated providers via the provider newsletter, Urgent Treatment Center brochure, and the Outreach and Provider Relations Departments.

Member Interventions:
- Educated members about different levels of care and appropriate use of the ED via mail/brochures;
- Informed members of the availability of the 24 Hour Nurse Line.
- Educated members about transportation options and assisted with arranging transportation services.
- Educated members about preventive health guidelines and immunization schedules.
- Promoted preventive and wellness activities via reminder letters.

Health Plan Interventions:
- Collaborated to send reminder letters about ED follow-up visits with PCPs.
- Partnered with a local hospital to reduce over-utilization of the ED.
- Assisted members with special needs to identify PCPs and specialists.

Data Analysis and Results
Results for the baseline, interim and final measurement periods are shown in Table 23.

Table 23: CoventryCares of Kentucky 2013 PIP: Decreasing Non-emergent/Inappropriate ED Utilization - Final Results

Indicator	Baseline Results MY 2012	Interim Results MY 2013	Final Results MY 2014	Performance Target[1]
HEDIS Ambulatory Care: ED Utilization	81.97/ 1,000 MM	73.53/ 1,000 MM	74.97/ 1,000 MM	Decrease rate/1,000 MM by 2 percentage points (79.97/1,000 MM)
The number of visits by members with high ED utilization (≥ 9 visits)[1]	0.87%	0.46%	0.61%	Decrease visit rate by 10% in 2013 (0.78%) and by an additional 2% in 2014 (0.77%)

ED: Emergency Department; MY: measurement year; MM: member months. [1] A lower rate represents better performance.

Achievement of Improvement

Improvement was achieved at the interim measurement for both indicators. Improvement was not sustained through the final measurement period; however, the final rates were an improvement relative to baseline and exceeded the performance targets (Table 23).

Strengths

Key strengths include:

- A strong rationale supported by data and evidence to support topic relevance to the MCO's members.
- Identification of possible barriers to care, and evidence-based interventions that targeted both high utilizers and the general member population.
- The MCO recruited PCPs to improve access and expanded the network from 2012 to 2014.
- The plan developed a case management tracking system for high utilizers and hired a dedicated case manager for the ED initiative.

Opportunities for Improvement

Key opportunities include:

- The MCO should identify barriers to sustained improvement and develop related interventions.
- The plan should develop and implement a more pro-active intervention strategy for the general member population.

Overall Credibility of Results

The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution since the active interventions were focused primarily on the high-utilizers, whereas the general population received primarily passive interventions.

The project scores for the interim and final PIP reports are displayed in Table 24. As directed by DMS, CoventryCares of Kentucky implemented a CAP for this PIP.

Table 24: CoventryCares of Kentucky: 2013 Decreasing Non-emergent/Inappropriate ED Utilization PIP – Final Score

Review Element	Compliance Level	Points Earned	Points Available
Review Element 1 – Project Topic	Met	5	5
Review Element 2 – Topic Relevance	Met	5	5
Review Element 3 – Quality Indicator(s)	Partially met	7.5	15
Review Element 4 – Baseline Study Methodology	Partially met	5	10
Review Element 5 – Baseline Study Population and Sampling	Met	10	10
Review Element 6 – Interventions	Met	15	15
Review Element 7 – Demonstrable Improvement	Partially met	10	20
Total Score at Interim Measurement[1]	Met	57.5	80.0
Review Element 1S – Subsequent or Modified Interventions	Partially Met	2.5	5.0
Review Element 2S – Sustained Improvement	Partially Met	7.5	15.0
Total Score at Final Measurement	Met	10.0	20.0
Overall Project Score	Met	67.5	100

[1] This interim score was revised/updated based on improvements made between the interim and final reports. The original score was 37.5 points (Not Met).

CoventryCares of Kentucky 2013 PIP: Major Depression: Antidepressant Medication Management and Compliance

Status: Final Measurement
Final Report Submitted: 9/1/15

Study Topic Selection

CoventryCares of Kentucky's 2013 behavioral health PIP topic was management of medications for major depression. The objective of the PIP was to answer the following questions:

Will provider and member education and reminders:

- Lead to more effective treatment for major depression?
- Increase members' compliance with antidepressant medication?
- Increase members' overall medication possession ratio (MPR) to ≥ 0.8?
- Increase the proportion of members with MPR ≥ 0.8; however, this measure was deleted from the final report.

The PIP indicators were:

- HEDIS Antidepressant Medication Management (AMM): Effective Acute Phase Treatment;
- HEDIS Antidepressant Medication Management (AMM): Effective Continuation Phase Treatment; and
- Medication Possession Ratio for members on antidepressant therapy.

The MCO implemented the following interventions:

Provider Interventions:

- Distributed the American Psychological Association's (APA) Clinical Practice Guidelines for diagnosing and managing major depression and how to assist patients with medication adherence.
- Identified prescribing patterns of PCPs with non-compliant members.

Member Interventions:

- Tracked medication adherence for members newly diagnosed with depression.
- Conducted behavioral health screenings for new members and made referrals to MHNet care management where needed.
- Provided information on major depression to members via the website and targeted mailings.

Health Plan Interventions:

- Collaborated with the MCO's pharmacy department to identify members' adherence and omission gaps.

Data Analysis and Results

Results for the baseline, interim and final re-measurement periods are shown in Table 25.

Table 25: CoventryCares of Kentucky 2013 PIP: Antidepressant Medication Management and Compliance – Final Results

Indicator	Baseline Results MY 2012	Interim Results MY 2013	Final Results MY 2014	Performance Target
HEDIS AMM: Acute Phase	52.33%	61.14%	62.35%	Interim Year 1: 2% increase (53.38%) Final: 90th percentile (59.22%)
HEDIS AMM: Continuation Phase	31.40%	44.40%	46.78%	Interim Year 1: 2% increase (32.03%) Final: 90th percentile (44.08%)
Average MPR	0.68 MPR	0.93 MPR	0.90 MPR	0.80 MPR
Members with MPR ≥ 0.80	NR	NR	NR	NR

MY: measurement year; AMM: Antidepressant Medication Management; MPR: Medication Possession Ratio; NR: not reported.

Achievement of Improvement

The MCO's rate for HEDIS Antidepressant Management: Acute Phase increased more than 10 percentage points, and for HEDIS Antidepressant Management: Continuation Phase, the MCO's rate improved by over 15 percentage points (Table 25). Both exceeded the interim goal of achieving a 2% increase. The MCO chose performance targets for the final re-measurement period that were lower than the interim rates.

The average MPR increased overall from 0.68 to 0.90, and exceeded the performance target and benchmark rate of 0.80; however, the rate of improvement was not sustained from interim to final re-measurement. The interim-reported rate for members with an MPR ≥ 0.80 increased over 30 percentage points from baseline to interim, as reported in the interim report; however, this measure was not included in the final report.

Strengths

Key strengths include:

- A strong rationale supported by literature citations and MCO-specific data.
- The MCO chose a topic (major depressive disorder) that is a highly prevalent condition and improvement can have a large impact on health outcomes for members.

Opportunities for Improvement

Key opportunities are:

- The MCO should track members' MPR individually, as this is an indicator of member access to medication.
- There appeared to be some confusion between the indicators (1) member MPR standard of 80% and the proportion of members with MPR ≥80%.
- The plan should develop and implement a more active intervention strategy. The majority of the interventions are passive education activities including mailings and website postings.
- The MCO planned a more active approach, i.e., identifying noncompliant members and referring for outreach; however, rather than contact members with MPR <80%, the plan contacted the providers and thus, missed an opportunity for direct contact with members.
- It is not clear how the intervention for screening, identifying, and referring members with depression can increase medication adherence since these would be newly diagnosed cases.
- Moreover, target rates that are greater than the interim rates need to be set for the final measurement.

Overall Credibility of Results

The validation findings generally indicate that the credibility of the PIP results is not at risk after the MCO completed revisions and clarifications suggested by the EQRO. The MCO also implemented a DMS-directed CAP that was closed 1/2016. However, due to the targeting of interventions to providers rather than members and use of an aggregate plan average for the MPR measure, the results for the MPR measure lack face validity and should be interpreted with

caution. In addition, as stated above, the MCO chose performance targets for the final remeasurement period that were lower than the interim rates.

The project score for interim PIP report is reported in Table 26.

Table 26: CoventryCares of Kentucky 2013 PIP: Antidepressant Medication Management and Compliance – Final Score

Review Element	Compliance Level	Points Earned	Points Available
Review Element 1 – Project Topic	Partially met	2.5	5
Review Element 2 – Topic Relevance	Met	5	5
Review Element 3 – Quality Indicator(s)	Partially met	7.5	15
Review Element 4 – Baseline Study Methodology	Partially met	5	10
Review Element 5 – Baseline Study Population and Sampling	Met	10	10
Review Element 6 – Interventions	Partially met	7.5	15
Review Element 7 – Demonstrable Improvement	Partially met	10	20
Total Score at Interim Measurement	Not met	47.5	80
Review Element 1S – Subsequent or Modified Interventions[1]	Partially met	2.5	5
Review Element 2S – Sustained Improvement[1]	Partially met	7.5	15
Total Score at Final Measurement	Not met	10	20
Overall Project Score	Not met	57.5	100

[1]Not applicable at this time; the PIP was scored at the interim phase only. N/A: not applicable.

CoventryCares of Kentucky 2014 PIP: Secondary Prevention by Supporting Families of Children with ADHD

Status: Interim Measurement
Interim Report Submitted: 9/1/15

Study Topic Selection
Coventry's 2014 behavioral health PIP topic was initially related to support for families of children with ADHD; however, the indicators proposed by the MCO were not measurable or valid. As recommended by the EQRO, the MCO modified the topic to address the HEDIS measure Follow-Up Care for Children Prescribed ADHD Medication. The objective of the PIP is to answer the following questions:

Will provider and member knowledge/education/reminders lead to:

- Increased compliance with follow-up visits during the medication initiation phase rates for members with ADHD and their providers?
- Increased compliance with follow-up visits during the medication continuation and maintenance phase rates for members with ADHD and their providers?

The PIP indicators are:

- HEDIS Follow-up Care for Children and Adolescents Prescribed ADHD Medication: Initiation Phase; and
- HEDIS Follow-up Care for Children and Adolescents Prescribed ADHD Medication: Continuation and Maintenance Phase.

The MCO implemented the following interventions:
Provider Interventions:

- Conducted provider education through sharing sending copies of member educational letters and packets.
- Hosted a series of provider events (i.e., the Aetna Road Show) in each of the 8 Regions of Kentucky.
- Posted on ADHD guidelines on the provider website.
- Sent fax blasts with ADHD guidelines to all non-psychiatric medical providers who have prescribed ADHD medications.

Member Interventions:

- Identified members newly prescribed ADHD medications and mailed educational letters and packets to the parents/guardians to encourage receipt of therapy services and provided ADHD education.

Health Plan Interventions:

- Created a monthly pharmacy report to identify children ages 6–12 years newly prescribed ADHD medications.
- Developed a program to identify members at risk.
- Conducted an educational outreach program targeting elementary schools in counties with highest number of MCO members with ADHD prescriptions.

Data Analysis and Results

Results for the baseline measurement period are reported in Table 27. Note that the interim rates were not reported.

Table 27: CoventryCares of Kentucky 2014 PIP: Follow-Up Care for Children Prescribed ADHD Medication – Interim Results

Indicator	Baseline Results HEDIS 2015 (MY 2014)	Interim Result HEDIS 2016 (MY 2015)	Performance Target
HEDIS ADHD Measure: Initiation Phase	44.59%	NR	50.59%
HEDIS ADHD Measure: Continuation and Maintenance Phase	52.35%	NR	58.35%

MY: measurement year; NR: not reported.

Achievement of Improvement

Improvement cannot currently be evaluated. Based on EQRO recommendations, the MCO revised the PIP topic and indicators and conducted a new baseline measurement (MY 2014), rather than using the original baseline period (MY 2013). Therefore, interim results were not reported in September 2015.

Strengths

Key strengths include:

- The topic represents an important and prevalent health concern for MCO members.
- The barrier analysis describes a broad variety of member, provider, and health plan barriers.

Opportunities for Improvement

Key opportunities include:

- The MCO should report the baseline measurement for CY 2013/HEDIS 2014 and report interim data for MY 2014/HEDIS 2015.
- The MCO should implement more active interventions because the current intervention strategy is primarily passive distribution of educational information.
- The MCO should describe the ADHD Preventive Behavioral Health Program discussed in the report.

Overall Credibility of Results

Because the MCO revised the baseline measurement period from CY 2013 to CY 2014, and interventions occurred during the baseline period (CY 2014), the credibility of the baseline results is questionable. Additionally, no interim results were reported. If the MCO revises the baseline period back to CY 2013, the credibility of the PIP results will be more certain.

Table 28: CoventryCares of Kentucky 2014 PIP: Supporting Families of Children with ADHD – Interim Score

Review Element	Compliance Level	Points Earned	Points Available
Review Element 1 – Project Topic	Met	5	5
Review Element 2 – Topic Relevance	Met	5	5
Review Element 3 – Quality Indicator(s)	Met	15	15
Review Element 4 – Baseline Study Methodology	Met	10	10
Review Element 5 – Baseline Study Population and Sampling	Met	10	10
Review Element 6 – Interventions	Partially Met	7.5	15
Review Element 7 – Demonstrable Improvement	Not Met	0	20
Total Score at Interim Measurement	Met	52.5	80
Review Element 1S – Subsequent or Modified Interventions[1]	N/A	N/A	5
Review Element 2S – Sustained Improvement[1]	N/A	N/A	15
Total Score at Final Measurement	N/A	N/A	20
Overall Project Score	N/A	N/A	100

[1]Not applicable at this time; the PIP was scored at the interim phase only. N/A: not applicable.

CoventryCares of Kentucky 2014 PIP: Decreasing Avoidable Hospital Readmissions

Status: Interim Measurement
Interim Report Submitted: 9/1/15

Study Topic Selection
CoventryCares of Kentucky's 2014 physical health PIP topic was decreasing avoidable hospital readmissions. The objective of the PIP is to answer the following question:

- Will the implementation of an enhanced program of member education in conjunction with timely post discharge follow-up decrease hospital readmissions?

The PIP indicator was:
- HEDIS Plan All-Cause Readmission (PCR); and
- MCO All-Cause 30-Day Readmission Rate

The MCO implemented the following interventions:

Provider Interventions:
- Evaluated readmission processes and requested feedback at Quality Management/Utilization Management (QM/UM) provider forums.

Member Interventions:
- Conducted outreach to discharged members via mailings.
- Conducted outreach to discharged members with COPD and heart disease via phone calls.

Health Plan Interventions:
- Implemented new Aetna system to track and report case management interventions (transportation assistance, assistance with scheduling appointments, providing educational materials, notation of members who could not be reached and members who declined assistance, documenting member enrollment in case management).

Data Analysis and Results
Results for the baseline measurement period are reported in Table 29.

Table 29: CoventryCares of Kentucky 2014 PIP: Decreasing Avoidable Hospital Readmissions – Interim Results

Indicator	Baseline Results MY 2013	Interim Results MY 2014	Performance Target
30-Day Readmission Rate (MCO-Defined Indicator)	23.54%	21.27%	Decrease by 2 percentage points (21.54%)
HEDIS Plan All-Cause Readmission (PCR)	NR	NR	NR

MY: Measurement Year.

Achievement of Improvement

For the MCO-defined readmission indicator, improvement was achieved and the target rate was surpassed (a lower rate is better performance). As a result, the MCO revised the goal for the final remeasurement to an additional 2 percentage point decrease (21.27% to 19.27%). Note that the HEDIS PCR measure results were not reported for the baseline or interim periods.

Strengths

Key strengths include:

- A strong project rationale supported by statewide and plan-specific data.
- The MCO selected a topic which provided ample opportunity for improvement.
- The MCO implemented interventions to track member discharges in real time.
- The MCO conducted phone outreach, member education, assistance with appointments scheduling, transportation, and prescriptions and performed quarterly member follow-up.

Opportunities for Improvement

Key opportunities include:

- The MCO should report the HEDIS PCR measure since this indicator is referenced in the aim statement.
- The MCO should include a title and headings for the results table that provide the specific measure name(s) and timeframe/measurement years.

Overall Credibility of Results

The overall credibility of results is questionable due to the discrepancy between the performance measure stated in the aim statement and performance measure reported in the results (HEDIS PCR versus the MCO-defined member readmission rate). The PIP results will be more credible if the MCO reports the HEDIS PCR measure results.

The score for the interim PIP is shown in Table 30.

Table 30: CoventryCares of Kentucky 2014 PIP: Decreasing Avoidable Hospital Readmissions – Interim Score

Review Element	Compliance Level	Points Earned	Points Available
Review Element 1 – Project Topic	Partially Met	2.5	5
Review Element 2 – Topic Relevance	Met	5	5
Review Element 3 – Quality Indicator(s)	Partially Met	7.5	15
Review Element 4 – Baseline Study Methodology	Partially Met	5	10
Review Element 5 – Baseline Study Population and Sampling	Partially Met	5	10
Review Element 6 – Interventions	Met	15	15
Review Element 7 – Demonstrable Improvement	Partially Met	10	20
Total Score at Interim Measurement	Met	50	80
Review Element 1S – Subsequent or Modified Interventions[1]	N/A	N/A	5
Review Element 2S – Sustained Improvement[1]	N/A	N/A	15
Total Score at Final Measurement	N/A	N/A	20
Overall Project Score	N/A	N/A	100

[1]Not applicable at this time; the PIP was scored at the interim phase only. N/A: not applicable.

CoventryCares of Kentucky 2015 PIP: Use of Antipsychotics in Children and Adolescents (Statewide Collaborative)

Status: Baseline Measurement
Baseline Report Submitted: 9/1/15

Study Topic Selection
Coventry's 2015 behavioral health PIP topic is use of antipsychotic medications in children and adolescents. The objective of the PIP is to answer the following questions:

Will provider and member knowledge/education/reminders lead to improved performance:

- Related to appropriate prescribing practices for antipsychotics for children and adolescents?
- Related to first-line psychosocial care and metabolic monitoring for children and adolescents who receive antipsychotic medications?

The PIP indicators are the following six HEDIS and proposed HEDIS indicators, as directed by DMS:

- HEDIS Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC);
- HEDIS Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP);
- HEDIS Metabolic Monitoring for Children and Adolescents Newly on Antipsychotics (APM);
- proposed HEDIS measure: Metabolic Screening for Children and Adolescents on Antipsychotics;
- proposed HEDIS measure: Use of Higher-Than-Recommended Doses of Antipsychotics in Children and Adolescents; and
- proposed HEDIS measure: Follow-up Visits for Children and Adolescents on Antipsychotics.

The MCO implemented the following interventions:

Provider Interventions:

- Developed a provider education resource packet, including: clinical practice guidelines; a list of network behavioral health providers and distributed via mail, at provider forums, at internal committee meetings, via fax and at provider outreach events;
- Developed a Pediatric Antipsychotic Look-up Tool to identify members on antipsychotic medications and assign a risk score.
- Prioritized education for physicians who prescribed antipsychotic medications and whose members have an assigned risk score ≥ 6.

- Developed a tracking system to identify physicians who inappropriately prescribe antipsychotics (higher-than-recommended doses, multiple concurrent prescriptions, for non-psychotic indications).
- Developed a tracking system to record provider outreach activities.
- Conduct ongoing provider education on best practice parameters via fax blast.
- Developed and distributed a "Tip Sheet" for HEDIS measures on antipsychotic medication use.
- Added behavioral health resources to the provider web page.

Member Interventions:

- Developed and disseminated a member educational resource packet including a list of behavioral health providers; how to obtain assistance with transportation, how to locate participating behavioral health specialists, how to make appointments for behavioral health services.
- Conducted outreach calls to members' parents 3-5 days after the educational packets were mailed.
- Used the new Pediatric Antipsychotic Look-up Tool to identify members who are prescribed antipsychotic medications and assign a risk score.
- Prioritized members with an assigned risk score of ≥ 6 for education.
- Developed a tracking system to identify members who receive inappropriate prescriptions for antipsychotic medications and conduct follow-up.
- Developed a tracking system to record member outreach activities.
- Reviewed members identified as "high-risk" (score ≥ 6) and assigned outreach and education responsibility accordingly. Members deemed high risk are assigned to case management, members in foster care members assigned to clinical health services, and the remaining members will be assigned to quality management staff.
- Added behavioral health resources and links to the member web page.
- Published a member newsletter article on antipsychotic use in children and adolescents.

Health Plan Interventions:

- Developed a Pediatric Antipsychotic Look-up Tool and generated a monthly report to identify members on antipsychotics with a risk score ≥ 6.
- Developed a tracking system to identify members who are prescribed antipsychotics inappropriately.
- Conducted outreach to pharmacies around the state to request input on the use of antipsychotics in children and adolescents.

Data Analysis and Results

Results for the baseline measurement period are reported in Table 31.

Table 31: CoventryCares of Kentucky 2015 PIP: Use of Antipsychotics in Children and Adolescents – Baseline Results

Indicator	Baseline Results MY 2014	Performance Target
HEDIS : Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)	NR	NR
HEDIS Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NR	NR
HEDIS Metabolic Monitoring for Children and Adolescents Newly on Antipsychotics (APM)	NR	NR
Proposed HEDIS measure: Metabolic Screening for Children and Adolescents on Antipsychotics	NR	NR
Proposed HEDIS measure: Use of Higher-Than-Recommended Doses of Antipsychotics in Children and Adolescents	NR	NR
Proposed HEDIS measure: Follow-up Visits for Children and Adolescents on Antipsychotics	NR	NR

MY: Measurement Year; NR: not reported

Achievement of Improvement
Improvement cannot be evaluated at the baseline phase. However, the baseline results were not reported.

Strengths
Key strengths include:
- A strong rationale supported by literature citations, statistics, Medicaid-specific data, and MCO data.
- A broad interventions strategy that targets members, providers, and the health plan and relates to the barriers identified.

Opportunities for Improvement
Key opportunities include:
- The MCO needs to report the baseline data for all six indicators.
- The MCO needs to determine performance goals based on the baseline data.
- The MCO should use the data from tracking member outreach to report process measures.

Overall Credibility of Results
The MCO did not report baseline data; therefore, the validity of the findings could not be evaluated.

CoventryCares of Kentucky 2015 PIP: Increasing Comprehensive Diabetes Testing and Screening

Status: Baseline Measurement
Baseline Report Submitted: 9/1/15

Study Topic Selection
Coventry's 2015 physical health PIP topic is increasing diabetes testing and screening. The PIP aims to answer the following questions:

Will provider and member knowledge/education/reminders lead to:
- Increased HbA1C testing rates among members with diabetes?
- Increased retinal eye exam rates among members with diabetes?

The PIP indicator is:
- HEDIS Comprehensive Diabetes Care (CDC).

The MCO has implemented the following interventions:

Provider Interventions:
- Contacted PCPs (646) who serve members with diabetes (8,937) and provide reminders about screening and testing as well as patient education materials;
- conduct outreach to ophthalmologists and optometrist regarding barriers encountered in providing retinal eye exams to members with diabetes;
- post American Diabetes Association (ADA) clinical practice guidelines on the MCO website; and
- develop and distribute a tip sheet that includes HEDIS CDC requirements, correct coding information, and links to online resources.

Member Interventions:
- develop and distribute member educational materials on diabetes for members that are reported as non-compliant for diabetes services including – member letter, Krames educational materials on diabetes, Nurse Line brochure, contact for transportation assistance; and
- develop and distribute a diabetes education packet for members in case management, including Krames educational materials on diabetes, nutrition resources, transportation assistance contact information.

Health Plan Interventions:

- hired a Prevention and Wellness Coordinator;
- enhance disease management educational efforts from only one mailing to quarterly messaging, care gap reviews, phone outreach for missed services;
- create a community resource grid for case managers on county-specific government resources and programs for CM use and to post on MCO website;
- develop a tracking system in NavCare CM system for members with diabetes to track educational efforts, reminders, outreach and services received by each member;
- conduct a barrier analysis related to members receiving insulin in the ED versus self-administering at home routinely; and
- collaborate with Park DuValle Community Health Clinic to provide reports on gaps in care for their panel members with diabetes and expand to other provider practices.

Data Analysis and Results

Results for the baseline measurement period are reported in Table 32.

Table 32: CoventryCares of Kentucky 2015 PIP: Increasing Comprehensive Diabetes Testing and Screening – Baseline Results

Indicator	Baseline Results MY 2014	Performance Target (Next NCQA Percentile)
Eye Exam	40.51%	45.00% (25th)
HBA1C Testing	87.04%	87.59% (75th)

MY: Measurement Year.

Achievement of Improvement

Not applicable.

Strengths

Key strengths of this PIP include:

- The MCO planned a robust intervention strategy that includes gap reports, collaboration with a community health center and plans to expand the collaboration to other provider sites.
- The MCO intends to develop a case management tracking system.
- The MCO is planning ongoing barrier-analysis via vision provider interviews and a study of members with diabetes being treated in the ED.

Opportunities for Improvement

Key areas for improvement include:

- In the results, the tables and figures as well as narrative need to be revised for clarity.
- The MCO needs to describe the current status, specific start date (month, year) and end date (month, year) where applicable for each intervention/intervention component.

Overall Credibility of Results

There were no validation findings which indicate that the credibility of the PIP results is at risk.

CoventryCares of Kentucky 2016 PIP: Preventive Care for Members with Serious Mental Illness (SMI) (Statewide Collaborative)

Status: Proposal

Submitted: 11/2/15

Study Topic Selection

The project topic addresses the physical health problems and shortened life expectancy that members with serious mental illness face. As instructed by the Department of Medicaid Services (DMS) for the Commonwealth of Kentucky, all Managed Care Organizations (MCO's) will participate in a collaborative Performance Improvement Project (PIP) effort to improve the physical health and screenings of our members suffering from SMI. The study aim was indicated by the following question:

- Will an increased focus on member and provider outreach, member access and utilization of preventative/ambulatory services, education and enrollment in Case Management (CM) lead to physical health improvements and increased screening rates for members with SMI?

The PIP indicators are the following:
- Access to preventive/ambulatory health services for members with SMI;
- Body Mass Index screening for members with SMI;
- HEDIS Cholesterol Screening for People with SMI Who Are Prescribed Antipsychotic Medication (APC)s;
- Blood pressure assessment for people with SMI;
- Tobacco screening and follow-up for people with SMI; and
- HEDIS Diabetes Screening for People with SMI Who Are Prescribed Antipsychotic Medications.

An additional PIP indicator is the proportion of eligible members with SMI who are enrolled in Case Management, which will be reported as a process measure.

Strengths
Key strengths include:
- The MCO identified the number of eligible members in the target population in the initial proposal.
- The MCO has incorporated an additional performance indicator that addresses member engagement in case management.
- The MCO identified member, provider and health plan barriers.
- The MCO has designed interventions to address members, providers, and health plan processes.
- The MCO has identified process measures to monitor interventions.

Opportunities for Improvement
Key opportunities include:
- The lists of members provided to case management should include all members in the eligible population, not only those with SMI and diabetes.
- All members with SMI should receive the outreach intervention.
- The Prevention and Wellness Coordinator outreach to community agencies who work with the transient population should incorporate member-specific contact interventions.

CoventryCares of Kentucky 2016 PIP: Postpartum Care

Status: Proposal
Submitted: 9/1/15
Revised: 2/25/16

Study Topic Selection
CoventryCares of Kentucky's 2016 physical health PIP topic is perinatal physical and behavioral health, with specific aims to improve the rate of timely postpartum visits, as well as prenatal and postpartum depression screening. The objectives of the PIP are to answer the following questions:

- Will additional member outreach and incentives increase the rate of timely postpartum visits?
- Will early detection of a prior history of depression increase the number of members identified as at risk for perinatal depression?

- Will outreach promoting depression screenings to pregnant members and providers increase the proportion of members who are screened for depression in the prenatal period and in the postpartum period?

PIP performance indicators are the following:

- The proportion of women who received the following prenatal care services:
  Screening, Risk Identification, and Intervention for:
  1. Tobacco Use
  2. Alcohol Use
  3. Substance/Drug Use
  Education/Counseling for:
  4. Prescription/ Over the Counter (OTC) Medication Use
  5. Nutrition
  Screening for:
  6. Depression
  7. Domestic Violence
- The proportion of women who received the following postpartum care service:
  Screening for:
  8. Postpartum Depression

Strengths

Key strengths include:

- The PIP addresses both prenatal and postpartum health, and both physical and behavioral perinatal health.
- The MCO will use Healthy Kentuckians performance measures.

Opportunities for Improvement

Key opportunities include:

- The MCO should add process indicators related to screening and identification of risk for perinatal depression.
- The MCO should analyze the data for members who failed to have timely postpartum visits to determine if there were no visits or visits were outside the prescribed timeframe.
- The MCO should notify providers of their patients who are found to be at risk for perinatal depression.

Humana-CareSource 2014 PIP: Untreated Depression

Status: Interim Measurement
Interim Report Submitted: 8/28/15

Study Topic Selection
Humana-CareSource's 2015 behavioral health PIP topic was untreated depression. The objective of the PIP was to answer the following questions:

Can Humana-CareSource increase the number of members with depression who remain on an antidepressant medication:

- During the acute treatment phase, for at least 84 days (12 weeks)?
- During the continuation treatment phase, for at least 180 days (6 months)?

The PIP indicators were:

- HEDIS Antidepressant Medication Management (AMM): Effective Acute Phase Treatment; and
- HEDIS Antidepressant Medication Management (AMM): Effective Continuation Phase Treatment.

It should be noted that due to the expansion in service area from Region 3 only to statewide, the MCO reported rates for both Region 3 and statewide service areas. Both baseline and interim measurements were reported for the Region 3 service area. Only baseline rates were reported for the statewide service area. The interim measurement for the statewide service area will not be available until RY 2016.

The MCO implemented the following interventions:

Provider Interventions:

- Collaborated with the behavioral health vendor, Beacon Health Strategies, to develop and conduct provider education.

Member Interventions:

- Developed and mailed a member education article on the role of medication management in treating depression.

Health Plan Interventions:

- Monitored pharmacy refill data for targeted care management member outreach.

Data Analysis and Results
Baseline rates for both the Region 3 and statewide service areas and interim results for the Region 3 service area are reported in Table 33.

Table 33: Humana-CareSource 2014 PIP: Untreated Depression – Interim Results

Indicator	Baseline Results MY 2013	Interim Results MY 2014	Performance Target
HEDIS AMM – Effective Acute Phase Treatment-Region (modified) - Region 3 Service Area	26.83% (MY 2013)	43.58% (MY 2014)	Increase by 10% (29.51%)
HEDIS AMM – Effective Continuation Phase Treatment (modified) - Region 3 Service Area	13.41% (MY 2013)	29.76% (MY 2014)	Increase by 10% (14.75%)
HEDIS AMM – Effective Acute Phase Treatment-HEDIS-Statewide Service Area	68.35% (MY 2014)	NA (MY 2015)	Increase by 10% (75.19%)
HEDIS AMM – Effective Continuation Phase Treatment- HEDIS-Statewide Service Area	59.61% (MY 2014)	NA (MY 2015)	Increase by 10%

MY: measurement year; AMM: Antidepressant Medication Management.

For the Region 3 service area, the baseline MY is 2013. For the statewide service area, the baseline MY is 2014.
For the Region 3 service area, the interim MY is 2014. For the statewide service area, the interim MY is 2015.

Achievement of Improvement
The MCO reported improvement exceeded their goal: acute-phase from 26.83% to 43.58% (goal = 29.51%); continuation phase from 13.41% to 29.76% (goal = 14.76%). However, improvement cannot be evaluated for the statewide rates until RY 2016.

Strengths
Key strengths include:
- The MCO is working with external collaborators.
- The rationale is well-developed and supported by MCO-specific, national, and global statistics.

Opportunities for Improvement
Key opportunities include:
- The MCO should revise the aim statement/study question to include a description of the interventions.
- The MCO should define the numerator and denominator for the medical record audit measures more fully.
- The MCO should consider adding process measures to track the interventions.

Overall Credibility of Results
There were no validation findings to indicate that the credibility of the PIP is at risk.

The interim report score is shown in Table 34.

Table 34: Humana-CareSource 2014 PIP: Untreated Depression – Interim Score

Review Element	Compliance Level	Points Earned	Points Available
Review Element 1 – Project Topic	Met	5	5
Review Element 2 – Topic Relevance	Met	5	5
Review Element 3 – Quality Indicator(s)	Met	15	15
Review Element 4 – Baseline Study Methodology	Met	10	10
Review Element 5 – Baseline Study Population and Sampling	Met	10	10
Review Element 6 – Interventions	Met	15	15
Review Element 7 – Demonstrable Improvement	Met	20	20
Total Score at Interim Measurement	Met	80	80
Review Element 1S – Subsequent or Modified Interventions[1]	N/A	N/A	5
Review Element 2S – Sustained Improvement[1]	N/A	N/A	15
Total Score at Final Measurement	N/A	N/A	20
Overall Project Score	N/A	N/A	100

[1]Not applicable at this time; the PIP was scored at the interim phase only. N/A: not applicable.

Humana-CareSource 2014 PIP: Emergency Department Use Management

Status: Interim Measurement
Submitted: 8/30/15

Study Topic Selection
Humana-CareSource's 2014 physical health PIP topic was management of ED use. The objective of the PIP was to answer the following questions:
- Can Humana-CareSource decrease the number of ED visits by Medicaid members?
- Can Humana-CareSource reduce the number of members/1,000 who incur ≥ four (4) ED visits annually?

The PIP indicators are:

- The number of ED visits during the measurement year; and
- The number of members who incurred ≥ 4 ED visits during the measurement year.

It should be noted that due to the expansion in service area from Region 3 only to statewide, the MCO reported both Region 3 and statewide rates. The interim measurement for the statewide rates will not be available until RY 2016.

The MCO implemented the following interventions:

Provider Interventions:

- Conducted PCP education programs on standards for timely access to care.
- Published provider newsletter articles related to PCP access standards.
- Disseminated information related to access to care and ED lock-in.
- Explore the development of a provider education webinar on ED utilization.

Member Interventions:

- Initiated case management and self-management programs targeted at members with ≥ 4 ED visits per year.
- Distributed member newsletter articles and educational mailings on appropriate use of the ED.
- Disseminated information on appropriate sites of care for routine, urgent, and emergency treatment.
- Maintained a 24/7 Nurse Triage phone line to direct members seeking care to the appropriate site.
- Conducted outreach to high-utilizers that used the ED for non-urgent or routine care.
- Developed member education materials on how to manage common non-emergent conditions/symptoms.

Health Plan Interventions:

- Retained a vendor to conduct a "Secret Shopper" survey to assess PCP after-hours availability.
- Implemented interventions to address providers who were non-compliant with after-hours availability standards.
- Developed a report to identify primary and secondary diagnoses for high-ED utilizers.
- Referred high-ED utilizers to care management.
- Explored collaboration with local Emergency Medical Services (EMS) for an ED diversion program.

Data Analysis and Results

Baseline and interim measurement data for the Region 3 service area and baseline measurement data for the statewide service area is reported in Table 35.

Table 35: Humana-CareSource 2014 PIP: Emergency Department Use Management – Interim Results

Indicator	Baseline Results MY 2013	Interim Results MY 2014	Performance Target
ED Visits/1,000 Members - Region 3 only	501.4/1,000 members	652.25/1,000 members	5% reduction (476.33/1,000 members)
Members with ≥ 4 ED Visits/1,000 Members - Region 3 only	26.29/1,000 members	39.88/1,000 members	5% reduction (24.98/1,000 members)
Indicator	**Baseline Results MY 2014**	**Interim Results MY 2015**	**Performance Target**
ED Visits/1,000 Members - Statewide	651.68/1,000 members	N/A	5% reduction
Members with ≥ 4 ED Visits/1,000 Members - Statewide	26.29/1,000 members	N/A	5% reduction

MY: measurement year; ED: Emergency Department; N/A: not applicable.

Achievement of Improvement

The MCO did not achieve improvement or its goal for either indicator for Region 3. The interim results for the statewide rates will be reported in September 2016.

Strengths
Key strengths include:
- Collaboration with provider groups and EMS.
- Well-defined interventions that target members, providers, and health plan processes.
- Use of process measures to track the interventions.

Opportunities for Improvement
Key opportunities include:
- The MCO should revise the aim statement/study question to include a description of the interventions.
- The MCO should analyze ED claims to identify the most common diagnoses and member demographics and develop a targeted intervention strategy to address these.

Overall Credibility of Results
There were no validation findings to indicate that the credibility of the PIP is at risk. However, because of the change in service area, and the new baseline rates, Humana-CareSource might consider continuing the PIP for an additional remeasurement period.

The interim report score is reported in Table 36.

Table 36: Humana-CareSource 2014 PIP: Emergency Department Use Management – Interim Score

Review Element	Compliance Level	Points Earned	Points Available
Review Element 1 – Project Topic	Met	5	5
Review Element 2 – Topic Relevance	Met	5	5
Review Element 3 – Quality Indicator(s)	Met	15	15
Review Element 4 – Baseline Study Methodology	Met	10	10
Review Element 5 – Baseline Study Population and Sampling	Met	10	10
Review Element 6 – Interventions	Met	15	15
Review Element 7 – Demonstrable Improvement	Partially Met	10	20
Total Score at Interim Measurement	Met	70	80
Review Element 1S – Subsequent or Modified Interventions[1]	N/A	N/A	N/A
Review Element 2S – Sustained Improvement[1]	N/A	N/A	N/A
Total Score at Final Measurement	N/A	N/A	N/A
Overall Project Score	N/A	N/A	N/A

[1]Not applicable at this time; the PIP was scored at the interim phase only. N/A: not applicable.

Humana-CareSource 2015 PIP: Safe and Judicious Antipsychotic Use in Children and Adolescents (Statewide Collaborative)

Status: Baseline Measurement
Submitted: 8/28/15

Study Topic Selection
Humana-CareSource's 2015 behavioral health PIP topic is antipsychotic medication use in children and adolescents. The objective of the PIP is to answer the following questions:

Can Humana-CareSource use pharmacy and medical management databases to:
- Decrease the percentage of children and adolescents on higher-than-recommended of antipsychotic medications?
- Decrease the percentage of children and adolescents on two or more concurrent antipsychotic medications?

- Increase the percentage of children and adolescents with a new prescription for an antipsychotic medication who receive first-line psychosocial care?
- Increase the percentage of children and adolescents with a new prescription for an antipsychotic medication who have at least one follow-up visit?
- Increase the percentage of children and adolescents with a new prescription for an antipsychotic medication who have baseline metabolic screening?
- Increase the percentage of children and adolescents on antipsychotic medications who had metabolic monitoring?

Can Humana-CareSource use provider education strategies to:
- Decrease prescribing of higher-than-recommended doses and multiple concurrent antipsychotics for children and adolescents?
- Increase metabolic screening and monitoring for children and adolescents on antipsychotics?

Can Humana-CareSource use letters to parents/guardians to:
- Increase the use of first-line psychosocial care for children and adolescents on antipsychotics?
- Increase the rate of follow-up visits for children and adolescents on antipsychotics?

The PIP indicators are the following six HEDIS measures and proposed HEDIS indicators, as directed by DMS:
- HEDIS Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC);
- HEDIS Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP);
- HEDIS Metabolic Monitoring for Children and Adolescents Newly on Antipsychotics (APM);
- proposed HEDIS measure: Metabolic Screening for Children and Adolescents on Antipsychotics;
- proposed HEDIS measure: Use of Higher-Than-Recommended Doses of Antipsychotics in Children and Adolescents; and
- proposed HEDIS measure: Follow-up Visits for Children and Adolescents on Antipsychotics.

The MCO planned and implemented the following interventions:

Provider Interventions:
- Distributed quarterly performance profile reports to prescribers.
- Implemented prior authorization edits for prescribed higher-than-recommended doses of antipsychotics and multiple concurrent antipsychotics.
- Developed web-based notification for higher-than-recommended doses of antipsychotics and use of multiple concurrent antipsychotics.
- Distribute a prescriber guideline sheet for antipsychotic use in children and adolescents.
- Delivered an educational webinar and posted it on the provider portal.
- Developed a system to send letters with practice recommendations to prescribers within 30 days of when a new antipsychotic is dispensed.

Member Interventions:
- Conducted outreach to children and adolescents on antipsychotics who have not received first line psychosocial care.
- Facilitated follow-up appointments for children and adolescents on antipsychotics.
- Identified children and adolescents with new antipsychotic prescriptions that lack metabolic screening and/or monitoring.
- Sent letters to parents/guardians on the importance of follow-up visits and metabolic screening for children and adolescents on antipsychotics.
- Evaluated children and adolescents on antipsychotics for enrollment in case management.

Health Plan Interventions:
- Utilized monthly State Report #106 to identify the volume of youth/children on antipsychotics.

Data Analysis and Results

Results for the baseline period are shown in Table 37.

Table 37: Humana-CareSource 2015 PIP: Use of Antipsychotics in Children and Adolescents – Baseline Results

Indicator	Baseline Results MY 2014	Performance Target
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)	0.0%	10% Reduction (0/maintain rate)
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP),	60.7%	25% Increase (75.9%)
Metabolic Monitoring for Children and Adolescents Newly on Antipsychotics (APM)	40.3%	25% Increase (50.4%)
Metabolic Screening for Children and Adolescents on Antipsychotics	7.0%	25%Increase (8.75%)
Use of Higher-Than-Recommended Doses of Antipsychotics in Children and Adolescents	3.9%	10% Reduction (4.29%)
Follow-up Visits for Children and Adolescents on Antipsychotics	53.7%	10% Increase (59.1%)

MY: measurement year.

Achievement of Improvement
Improvement cannot be evaluated at this time as only baseline results have been reported. Interim results will be reported in September 2016.

Strengths
Key strengths include:

- A strong rationale supported by statistics, literature, Medicaid-specific data, and clinical practice guidelines.
- A creative intervention - the use of prior authorization edits to identify multiple, concurrent antipsychotic prescriptions and higher-than-recommended doses.

Opportunities for Improvement
Key opportunities include:
The MCO should report the eligible populations, denominators, and numerators in the results tables.
The MCO should include the measurement years for baseline, interim, and final in the results tables.

Overall Credibility of Results
There were no validation findings which indicate that the credibility of the PIP results is at risk.

Humana-CareSource 2015 PIP: Postpartum Care

Status: Baseline Measurement
Baseline Report Submitted: 8/28/15

Study Topic Selection
Humana-CareSource's 2015 physical health PIP topic is postpartum care. The objective of the PIP is to answer the following questions:

Can the use of targeted telephonic/written outreach and education:

- Increase the percentage of members who attend a postpartum visit between 21–56 days post-delivery?
- Increase the percentage of women who receive education on family planning at a postpartum visit?
- Increase the percentage of women who receive screening for depression at a postpartum visit?

Can receipt of a postpartum visit between 21–56 post-delivery:

- Decrease the number of members with 60-day inpatient re-admissions?

The PIP indicators are:

- HEDIS Prenatal and Postpartum Care Postpartum Care;
- the percentage of members who receive family planning education at the postpartum visit;
- the percentage of members who receive depression screening at the postpartum visit; and
- the number of members with a 60-day postpartum inpatient re-admission.

The MCO implemented the following interventions:

Provider Interventions:

- Published annual provider newsletter articles on postpartum care topics.
- Explored producing a provider webinar or continuing education program on preconception and interconception care.
- Explored implementation of a provider pay-for-performance program for postpartum measure(s).
- Explored conducting a prenatal and postpartum clinical practice guideline (CPG) audit and use the results of the audit to drive additional interventions.

Member Interventions:

- Produced a twice-annual member newsletter article on prenatal and postpartum care.
- Employed an obstetric case manager to work with high-risk pregnant members and oversee postpartum visit outreach for all pregnant members.
- Modified the *Babies First* program to address this PIP topic.
- Initiated routine mailings at key intervals during pregnancy and postpartum.
- Developed member education materials specific to preconception and interconception care.
- Developed targeted education materials for pregnant adolescent members.
- Conducted telephonic outreach to members for postpartum education and visit reminders and assisted with scheduling and transportation (if needed).
- Mailed postpartum visit reminder postcards/letters to members.

Health Plan Interventions:

- Hired a case manager (CM) with obstetrical (OB) experience to work with high risk pregnant members and oversee the outreach to postpartum members.
- Considered using results of postpartum CPG audit to drive additional interventions with providers either individually or collectively.

Data Analysis and Results

The baseline results are reported in Table 38.

Table 38: Humana-CareSource 2015 PIP: Postpartum Care – Baseline Results

Indicator	Baseline Results MY 2014	Performance Target
The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	51.58%	Increase by 5 percentage points by year 3
Post-partum visit rate of members who were not readmitted within 60 days of delivery	37.20%	Determine if there is a statistically significant difference in re-admission rates for members with/without postpartum visits
Post-partum visit rate of members who were readmitted within 60 days of delivery	30.00%	Determine if there is a statistically significant difference in re-admission rates for members with/without postpartum visits
Documentation of education regarding family planning at the postpartum visit	NR	Statistically significant improvement from baseline rate
Documentation of screening for depression at the postpartum visit	NR	Statistically significant improvement from baseline rate

MY: measurement year; NR: not reported.

Achievement of Improvement

Improvement cannot be evaluated at this time as only baseline results have been reported. Interim results will be reported in September 2016.

Strengths

Key strengths include:

- A rationale supported by benchmarked plan-specific data, literature, and clinical practice guidelines.
- The aim statement includes measureable objectives, clearly stated goals, and clear and concise study questions.
- The intervention strategy is broad and targets members, providers, and health plan processes.

Opportunities for Improvement

Key opportunities include:

- The MCO should continue to identify and address barriers as the PIP progresses.
- The MCO should consider providing direct feedback and coaching to providers when the CPG audit is conducted.
- The MCO should consider revising the methodology for the indicators 60-day readmission rates for members with postpartum visits and without postpartum visits to a measure that compares the proportion of members with timely postpartum visits who have readmissions to the proportion of members without timely postpartum visits who have readmissions.

Overall Credibility of Results

There were no validation findings which indicate that the credibility of the PIP results is at risk.

Humana-CareSource 2016 PIP: Effectiveness of Coordinated Care Management on Physical Health Risk Screenings for Members with Serious Mental Ill (SMI) Population (Statewide Collaborative)

Status: Proposal

Submitted: 10/30/15

Study Topic Selection

The purpose of this project is to improve preventive care among Humana-CareSource (HCS) Medicaid members age 18–64 years with serious mental illness (SMI) by implementing provider-targeted, member-targeted, and health plan care coordination interventions. The objective of the PIP is to answer the following questions:

- Are there demographic differences (i.e., age, sex, race/ethnicity, region, and county type) between members who received preventive services/screenings and members who did not?

- What are barriers and enablers in getting preventive services/screenings from the perspectives of members/families, providers, and the MCO system?
- Can the interventions improve access to care for members with SMI?
- Can the interventions increase the percentage of members with SMI who received screenings related to metabolic syndrome/cardiovascular risk?
- Can the interventions reduce ED utilization for medical conditions among members with SMI?

The PIP indicators are:
- the percentage of members 18–64 years of age with SMI that were screened for tobacco abuse;
- the percentage of members 18–64 years of age with SMI who had who had at least one blood pressure assessment;
- the percentage of members ages 18–64 years of age with SMI who had a body mass index (BMI) documented;
- the percentage of members 18–64 years of age with SMI on an antipsychotic medication who had one or more LDL-C screening tests;
- the percentage of members 18–64 years of age with SMI who had an ambulatory or preventative care visit;
- the percentage of members 18–64 years of age with SMI on an antipsychotic medication who had screening for diabetes; and
- the percentage of members 18-64 years of age with SMI who have an ED visit.

The MCO plans to implement the following interventions:

Provider Interventions:
- Develop, share and promote current standards of care and expected outcomes.

Member Interventions:
- Provide member education material via member portal/mail.
- Implement care coordination and case management in collaboration with Beacon Health Strategies (behavioral health vendor).
- Collaborate with Beacon Health Strategies to conduct telephonic outreach to members.

Member and Provider Interventions:
- Seek input from members and providers to determine perceived barriers.
- Explore providing provider and/or member Incentives.

Health Plan Interventions:
- Generate member profile reports to identify and track members' compliance with recommended screenings.

Strengths
Key strengths include:
- The MCO incorporated an additional performance indicator focusing on prevention of ED utilization for physical health conditions.
- The MCO is conducting member and provider interviews to assess perceived barriers and develop related interventions.
- The intervention strategy is strong, multifaceted, and evidence-based and targets providers, members, and health plan processes.
- The member profile report intervention provides a method of continually monitoring members at risk and providing follow up and care coordination.

Opportunities for Improvement
Key opportunities for improvement were addressed by the MCO in its revised proposal.

Overall Credibility of Results
There were no validation findings which indicate that the credibility of the PIP results is at risk.

Humana-CareSource 2016 PIP: HbA1c Control

Status: Proposal
Submitted: 8/28/15

Study Topic Selection

The purpose of this project is to improve diabetes care among Humana-CareSource (HCS) Medicaid members with diabetes (Type 1 and Type 2) ages 18-75 years as measured by an increased number of members with HbA1c level < 9. The objective of the PIP is to answer the following questions:

- How do member characteristics (i.e., age, sex, race/ethnicity, and region) distinguish the members with poorly controlled A1c from those who do not?
- What are barriers and enablers in managing HbA1c from the perspectives of members, providers, and HCS system?
- Can a new process increase the percentage of the members with diabetes who have HbA1c testing?
- Can a new process decrease the percentage of the members with poorly controlled HbA1c?
- Can a new process reduce the per capita cost of care for the members with diabetes?

The PIP indicators are:

- the percentage of members with HbA1c testing performed during the measurement year (MY); and
- the percentage of members whose most recent HbA1c level is >9.0% or who do not have evidence of HbA1c testing during the MY.

The MCO plans to implement the following interventions:

Member Interventions:

- Distribute member education materials via member portal and mail.
- Develop and implement member-targeted Interventions to educate and encourage compliance.
- Explore the use of electronic educational devices (EED), e.g., TV, tablets, for members in provider office waiting rooms.

Provider Interventions:

- Develop, share and promote current standards of care and expected outcomes.

Member and Provider Interventions:

- Develop and implement care coordination interventions to assess barriers.
- Explore conducting HbA1c Testing at the point of care to promote timely treatment adjustments and minimize extra follow up.

Strengths

Key strengths include:

- The project topic selection is supported by literature, MCO-performance data, statistics and national and state health goals.
- The MCO provided stratified current performance data by age, gender, eligibility category, and region.
- The MCO interviewed providers and members to assess perceived barriers.
- The MCO plans to continue to evaluate barriers as the project progresses.
- The MCO is working with providers from both urban and rural areas to pilot its interventions.

Opportunities for Improvement

Key opportunities include:

- The MCO should assess for statistically significant differences between the various groups (e.g., age, gender, geographic area) in order to effectively target interventions.

Overall Credibility of Results

There were no validation findings which indicate that the credibility of the PIP results is at risk.

Passport Health Plan 2014 PIP: Psychotropic Drug Intervention Program (PDIP)

Status: Interim Measurement
Interim Report Submitted: 8/30/15

Study Topic Selection

Passport Health Plan's 2014 behavioral health PIP topic was management of psychotropic medications. The objective of the PIP was to answer the following questions:

Can identifying and educating members and prescribers:

- Increase medication adherence?
- Reduce polypharmacy?
- Improve therapeutic dosing of psychotropic medications (selective serotonin reuptake inhibitors [SSRIs] and serotonin/norepinephrine reuptake inhibitors [SNRIs)?

The PIP indicators are:

- HEDIS Antidepressant Medication Management (AMM): Effective Acute Treatment Phase;
- HEDIS Antidepressant Medication Management (AMM): Continuation Treatment Phase;
- Medication Possession Ratio (MPR);
- Adherence for SSRI and SNRI medications; adherence;
- Proportion of members on less than usual therapeutic doses of SSRI and SNRI medications; and
- Proportion of members with polypharmacy (defined as duplicative prescriptions for psychotropic drugs from one or more prescribers).

The MCO implemented the following interventions:

Provider Interventions:

- Initiated an on-call psychiatrist phone line to assist non-behavioral health providers with medications and dosing.
- Conducted provider outreach and education on medication adherence, polypharmacy, and suboptimal dosing.
- Created and used physician profiles for on-site education about appropriate SSRI/SNRI use.

Member Interventions:

- Sent educational mailings about medication adherence to identified members.
- Used member newsletter and on-hold SoundCare messages to educate members on how to take medications safely.
- Educated members not to discontinue psychotropic medications without speaking with their doctor.
- Conducted member education during inpatient discharge planning and performed follow-up after discharge.
- Developed a member outreach program for members newly prescribed antidepressant medications (Beacon Health Strategies).

Health Plan Interventions:

- Educated all Quality Committees about the program and resources.

Data Analysis and Results

Results for the baseline and interim measurement period are reported in Table 39.

Table 39: Passport Health Plan 2014 PIP: Psychotropic Drug Intervention Program – Interim Results

Indicator	Baseline Results MY 2013	Interim Results MY 2014	Performance Target[1]
Medication Adherence: SSRIs and SNRIs	NR	NR	Increase 10%/ Increase by 20%
Polypharmacy (single and multi-class)	NR	NR	Increase by 10%/ Decrease by 75%
Suboptimal dosing	NR	NR	Improve by 10% Decrease by 90%
Medication Possession Ratio (MPR)	NR	NR	Increase 10%/ Increase by 20%
HEDIS AMM – Acute Phase	58.82%	62.67%	Increase 10% (64.70%; also targeted higher rate of 66.05%)
HEDIS AMM – Continuation Phase	42.45%	46.83%	Increase 10% (46.70%; also targeted higher rate of 51.26%)

[1]The MCO identified two performance targets for each of the performance measures in different sections of the report. The performance targets need to be clarified.
MY: measurement year; AMM: Antidepressant Medication Management; NR: not reported; N/A: not applicable.

Achievement of Improvement
The plan demonstrated improvement in the HEDIS AMM measures from baseline to interim periods; however the rate for the acute phase indicator did not meet the target. The MCO did not report the stated indicators related to adherence, polypharmacy, suboptimal dosing, and MPR.

Strengths
Key strengths include:
- The focus of the PIP, psychotropic medications, is an area with substantial opportunity for improvement and has the potential to make a large, positive impact on the health and well-being of members with behavioral health conditions.

Opportunities for Improvement
Key opportunities include:
- The MCO should report the baseline and interim rates for the non-HEDIS indicators.
- The MCO should ensure that the indicator statements are fully described, including denominator and numerator definitions.
- The MCO should clarify which drugs will be assessed for the single and multi-class polypharmacy measures.
- The MCO should address the data sources, data collection methods, and efforts to ensure reliability and validity in the report.
- The MCO should clarify the performance target for each of the indicators.

Overall Credibility of Results
The MCO reported there were data integrity issues during the baseline measurement period; therefore, results must be analyzed with caution until the issues are identified and resolved and/or addressed.

The interim report score is shown in Table 40.

Table 40: Passport Health Plan 2014 PIP: Psychotropic Drug Intervention Program – Interim Score

Review Element	Compliance Level	Points Earned	Points Available
Review Element 1 – Project Topic	Met	5	5
Review Element 2 – Topic Relevance	Met	5	5
Review Element 3 – Quality Indicator(s)	Met	15	15
Review Element 4 – Baseline Study Methodology	Met	10	10
Review Element 5 – Baseline Study Population and Sampling	Met	10	10
Review Element 6 – Interventions	Met	15	15
Review Element 7 – Demonstrable Improvement	Met	20	20
Total Score at Interim Measurement	Met	80	80
Review Element 1S – Subsequent or Modified Interventions[1]	N/A	N/A	N/A
Review Element 2S – Sustained Improvement[1]	N/A	N/A	N/A
Total Score at Final Measurement	N/A	N/A	N/A
Overall Project Score	N/A	N/A	N/A

[1]Not applicable at this time; the PIP was scored at the interim phase only. N/A: not applicable.

Passport Health Plan 2014 PIP: You Can Control Your Asthma! Development and Implementation of an Asthma Action Plan

Status: Baseline Measurement #2
Baseline Report Submitted: 8/28/15

Study Topic Selection
Passport Health Plan's 2014 physical health PIP topic was development and implementation of asthma action plans for members with persistent asthma. The objective of the PIP was to answer the following question:

- Can identifying high-risk members with asthma, conducting member education, and developing and implementing an asthma action plan decrease utilization of higher levels of care?

The PIP indicators are:

- HEDIS Use of Appropriate Medications for People with Asthma (AMM);
- HEDIS Medication Management for People with Asthma (MMA);
- HEDIS Asthma Medication Ratio (AMR);
- Pharmacy Quality Alliance (PQA) Medication Therapy, Asthma Suboptimal Control;
- PQA Medication Therapy, Asthma- Absence of Controller Therapy;
- Rate of ER visits for a primary diagnosis of asthma;
- Rate of inpatient admissions for a primary diagnosis of asthma;
- Rate of 30-day readmissions for a primary diagnosis of asthma;
- Rate of 23-hour observation stays for a primary diagnosis of asthma;
- Rate of appropriate pharmaceutical management/medication adherence: average number of prescriptions filled per member [specific medication(s) not defined];
- Rate of members reporting an increase in self-management skills after implementation of an asthma action plan; and
- Member perception of health status and quality of life: SF-12 scores.

The MCO implemented the following interventions:

Provider Interventions:

- Develop provider education tools on management of persistent asthma.
- Conducted one-on-one provider education on asthma guidelines and provided tools to educate office staff.
- Created a standardized asthma action plan.

- Initiated provider outreach to engage in development of the asthma action plan.
- Conducted telephone outreach to providers of members identified as high-risk for asthma action plan use and coordination of care.
- Collaborated with 2 provider offices with a high-volume of members with asthma and embedded a Case Manager to focus on asthma education.
- Developed and distributed letters to providers with a list members enrolled in disease management and a copy of their plan of care.
- Collaborated with the Department of Health to conduct home environmental assessments for high-risk asthma members.
- Explored use of an interdisciplinary advisory group to assist with program review, intervention, and implementation.
- Mailed letters to treating PCPs/specialists to notify the providers that the MCO is unable to contact at-risk members and request assistance locating the member.
- Sent an e-News issue entitled '*My Asthma Action Plan, Encourage Self Management'* to providers.
- Sent an e-News issue entitled *'Basketball Event Raises Asthma Awareness'* to providers.
- Proposed incorporating components of asthma care to the Provider Recognition Program.
- Established a provider workgroup of asthma specialists to obtain feedback on local and regional practice standards.

Member Interventions:

- Developed asthma assessment tools for children ages 2-4 years and 5 years and above to identify member-specific asthma management issues.
- Developed and tested a tool to identify members with persistent asthma.
- Conducted outreach to engage members in developing an asthma action plan.
- Monitored members' ER utilization and readmission reports and medication compliance and conducted telephone follow up.
- Developed and distributed targeted education for identified members and ensured proper discharge education.
- Created a member mailing with the Asthma Action Plan and Instructions.
- Initiated outreach calls to members identified as high-risk to enroll them in the asthma disease management program.
- Enrolled high-risk members in one-on-one care coordination program with a Chronic Respiratory Disease Manager.
- Distributed new member packets and assessment forms to members newly diagnosed with asthma.
- Investigated telemonitoring for members with persistent asthma and an active asthma action plan.
- Coordinated with Passport Health Plan's ER Navigators and Case Managers for member follow up/ coordination of care.
- Coordinated efforts with the Community Outreach Department and participated in community events.
- Utilized the Rapid Response Outreach Team (RROT) to assist members with urgent asthma needs.
- Worked with the Pharmacy and Disease Management departments to develop an outreach process for members who are 30 days behind on controller medication refills. Identified and outreached members in need of controller medication refills.
- Investigated collaborating with the Mommy Steps Program to identify and intervene with pregnant members.
- Proposed development of a member incentive program for asthma.

Health Plan Interventions:

- Developed and tested a tool to identify members with persistent asthma members who have a probability of ER/IP/ICU utilization.
- Developed, initiated and revised an asthma action plan to be more user-friendly for members, providers, and staff.
- Created a Child & Adolescent Committee subcommittee to increase communication between ER/hospitals and providers and to increase asthma discharge education.
- Collaborated with the Pharmacy and Disease Management departments to explore ways to increase member access to medications by decreasing or eliminating co-pays and initiating 90-day supply and mail order.

Data Analysis and Results

Results for the baseline measurement period are reported in Table 41.

Table 41: Passport Health Plan 2014 PIP: Development and Implementation of an Asthma Action Plan – Baseline #2 Results

Indicator	Baseline Results MY 2013	Baseline Results #2 MY 2014	Performance Target
HEDIS Use of Appropriate Medications for People with Asthma (AMM)	NR	88.48%	NR
HEDIS Medication Management for People with Asthma (MMA)[1]	NR	36.67%	43.08% (+6.41)
HEDIS Asthma Medication Ratio (AMR)[1]	NR	71.77%	76.23% (+4.46)
PQA Medication Therapy, Asthma – Suboptimal Control[2]	NR	4.68%	3.98% (-0.70)
PQA Medication Therapy, Asthma – Absence of Controller Therapy[2]	NR	1.52%	1.29% (-0.23)
Number of ER visits for asthma (ages 5–20)	1,714	2.55	2.30
Number of ER visits for asthma (ages 21+)	401	2.41	2.17
Number of 23-hour OBS for asthma (ages 5–20)	NR	8.2	7.38
Number of 23-hour OBS for asthma (ages 21+)	NR	5.31	4.80
Number of IP admissions for asthma (ages 5–20)	140	1.21	1.09
Number of IP admissions for asthma (ages 21+)	23	1.24	1.12
Number of IP ICU admissions for asthma (ages 5–20)	NR	1.84	1.66
Number of IP ICU admissions for asthma (ages 21+)	NR	1.42	1.28
Number of 30-day re-admissions for asthma (ages 5–20)	7	0	0
Number of 30-day re-admissions for asthma (ages 21+)	0	0	0
Number of OP visits for asthma (ages 5–20)	1,315	0.46	0.51
Number of OP visits for asthma (ages 21+)	1,192	0.26	0.29
Number of PCP visits for asthma (ages 5–20)	1,997	1.96	2.16
Number of PCP visits for asthma (ages 21+)	627	1.76	1.94
Number of SPEC visits for asthma (ages 5–20)	2,060	2.34	2.57
Number of SPEC visits for asthma (ages 21+)	387	2.33	2.56
Number of prescriptions filled for asthma (ages 5–20)	26,677	10.94	12.03
Number of prescriptions filled for asthma (ages 21+)	25,975	13.19	14.51

[1] Goal was set at the Quality Compass 90th percentile benchmark; [2] Goal was set at 15% improvement; [3] Because the indicators were not constructed correctly, only the numbers of visits are reported for the baseline rates.
MY: measurement year; ER: Emergency Room; OBS: observation stay; IP: inpatient; ICU: Intensive Care Unit; OP: outpatient; PCP: primary care provider; SPEC: specialist NR: not reported.

Achievement of Improvement

Not applicable. The MCO was not able to report MY 2013 rates for many of the indicators and requested that the baseline measurement be repeated in MY 2014. DMS consented. Therefore, MY 2014 was reported as the baseline measurement and an interim measurement was not reported in September 2015. Additionally, rates for some of the indicators were not reported. Therefore, improvement cannot be evaluated.

Strengths

A key strength includes:

- The potential to reduce Emergency Department utilization and inpatient admissions for asthma by targeting high-risk members with poor asthma management and their providers.

Opportunities for Improvement

Key opportunities include:

- The MCO needs to more precisely define the eligible population, indicator definitions, and methodology.
- The MCO needs to report the baseline rates for all the PIP indicators.

Overall Credibility of Results
There were no validation findings to indicate that the baseline rates should be interpreted with caution. Data was not reported for indicators, the eligible population needs to be clarified, and the indicators and methodology were not fully specified.

The interim report score is displayed in Table 42.

Table 42: Passport Health Plan 2014 PIP: Development and Implementation of an Asthma Action Plan – Interim Score

Review Element	Compliance Level	Points Earned	Points Available
Review Element 1 – Project Topic	N/A[1]	N/A[1]	N/A[1]
Review Element 2 – Topic Relevance	N/A[1]	N/A[1]	N/A[1]
Review Element 3 – Quality Indicator(s)	N/A[1]	N/A[1]	N/A[1]
Review Element 4 – Baseline Study Methodology	N/A[1]	N/A[1]	N/A[1]
Review Element 5 – Baseline Study Population and Sampling	N/A[1]	N/A[1]	N/A[1]
Review Element 6 – Interventions	N/A[1]	N/A[1]	N/A[1]
Review Element 7 – Demonstrable Improvement	N/A[1]	N/A[1]	N/A[1]
Total Score at Interim Measurement	N/A[1]	N/A[1]	N/A[1]
Review Element 1S – Subsequent or Modified Interventions[1]	N/A[1]	N/A[1]	N/A[1]
Review Element 2S – Sustained Improvement[1]	N/A[1]	N/A[1]	N/A[1]
Total Score at Final Measurement	N/A[1]	N/A[1]	N/A[1]
Overall Project Score	N/A[1]	N/A[1]	N/A[1]

[1]Not applicable at this time. Although this PIP was initiated as a 2014 PIP (2014-2016) and should be in the interim phase, Passport Health Plan was allowed to conduct a repeated baseline measurement. Therefore, a narrative baseline review was repeated, rather than an interim scored review. N/A: not applicable.

Passport Health Plan 2015 PIP: Use of Antipsychotics in Children and Adolescents (Statewide Collaborative)

Status: Baseline Measurement
Baseline Report Submitted: 8/30/15

Study Topic Selection
Passport Health Plan's 2015 behavioral health PIP topic is use of antipsychotics in children and adolescents. The objective of the PIP is to answer the following questions:

Will a multidisciplinary strategy targeting appropriate prescribing and effective management of antipsychotics in children and adolescents:
- Decrease the use of higher-than-recommended doses of antipsychotics?
- Decrease the use of multiple concurrent antipsychotics?
- Increase the use of first-line psychosocial care for children and adolescents on antipsychotics?
- Increase the percentage of follow-up visits for children and adolescents on antipsychotics?
- Increase metabolic screening for children and adolescents newly on antipsychotics?
- Increase metabolic monitoring for children and adolescents on antipsychotics?

The PIP indicators are the following six HEDIS and proposed HEDIS indicators, as directed by DMS:
- HEDIS Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC);
- HEDIS Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP);

- HEDIS Metabolic Monitoring for Children and Adolescents Newly on Antipsychotics (APM);
- proposed HEDIS measure: Metabolic Screening for Children and Adolescents on Antipsychotics;
- proposed HEDIS measure: Use of Higher-Than-Recommended Doses of Antipsychotics in Children and Adolescents; and
- proposed HEDIS measure: Follow-up Visits for Children and Adolescents on Antipsychotics.

The MCO plans to implement the following interventions:

Provider Interventions:
- Adopt clinical practice guidelines for prescribing and monitoring antipsychotics for children and adolescents and distribute via website, email, and mail.
- Develop and distribute a Provider Pocket Guide with American Academy of Child and Adolescent Psychiatry (AACAP) guidelines for use of antipsychotics.
- Develop provider resources and tools – e.g., Electronic Medical Record (EMR) charting tools, pocket guides, lunch and learn.
- Conduct a provider survey to determine perceived barriers to using 1-800-psychiatrist hotline and develop interventions to increase hotline use.

Member Interventions:
- Develop member/caregiver education materials on antipsychotic medications, side effects, symptoms to report, long term monitoring, alternative treatment options, misconceptions, and risks.
- Elicit feedback from the member committee regarding education materials for members.
- Initiate telephone and mail outreach to educate members/caregivers on antipsychotic medications.
- Conduct telephone outreach to members/caregivers who experience difficulty accessing psychiatric care.
- Conduct outreach to members/caregivers in the foster system that experience difficulty locating psychiatric care. Use community resources and collaborate with the Foster Care Liaison and DCBS to address issues.
- Use available community resources to mitigate member/caregiver transportation issues.
- Engage behavioral health case managers to address fear and stigma with members/caregivers.
- Work with school-based liaisons to develop collaboration on treatment plans for members receiving behavioral health care in school settings.

Health Plan Interventions:
- Collaborate with Bingham Child Guidance Center to use tele-health in rural areas.
- Collaborate with Bingham Clinic for pilot project placing psychiatrist or fellow at rural pediatrician practices to integrate mental health and primary care services.
- Use proposed behavioral health liaison to educate providers and determine provider needs.
- Conduct a provider focus group to determine providers' needs regarding prescribing and monitoring antipsychotics for children and adolescents.
- Monitor pharmacy data to identify members prescribed multiple, concurrent and/or higher-than-recommended doses and educate the prescribers.
- Monitor treatment plans to assess compliance with practice guidelines.
- Monitor claims for therapy services and laboratory claims to identify if members are receiving psychosocial therapy and metabolic screenings.

Data Analysis and Results

Baseline results are presented in Table 43.

Table 43: Passport Health Plan 2015 PIP: Use of Antipsychotics in Children and Adolescents - Baseline Results

Indicators	Eligible population	Denominator	Numerator	Rate	Performance Target
Use of Higher-than-Recommended Doses of Antipsychotics	NR	NR	NR	NR	Decrease by 10 percentage points
Use of Multiple, Concurrent Antipsychotics (HEDIS APC)[1]	252	252	9	3.57%	0%
Use of First-Line Psychosocial Care (HEDIS APP)[1]	837 (-39 exclusions)	798	568	67.86%	Increase by 10 percentage points (77.86%)
Follow-Up Visit	NR	NR	NR	NR	Increase by 10 percentage points
Metabolic Screening	NR	NR	NR	NR	Increase by 10 percentage points
Metabolic Monitoring (HEDIS APM)[1]	2,126	2,126	736	34.62%	Increase by 10 percentage points (44.62%)

[1] The MCO did not report the baseline rates. Data for these measures was taken from the HEDIS IDSS.
IDSS: Interactive Data Submission System; NR: not reported.

Achievement of Improvement
Improvement cannot be evaluated at the baseline phase. Interim results will be reported in September 2016. Additionally, the MCO did not report baseline rates for any of the indicators. Data for some indicators was available from the HEDIS Interactive Data Submission System (IDSS).

Strengths
Key strengths include:
- The intervention strategy is robust and varied, and targets providers, members, and health plan systems.
- The intervention strategy incorporates multiple collaborators, including Bingham Clinic and school-based liaisons.
- The barrier analysis is thorough and the MCO is analyzing data to determine how best to target interventions.
- The MCO plans to continue to assess provider and member barriers.
- The MCO is conducting a pilot program to address access to psychiatric services in rural areas via tele-health and placing behavioral health practitioners in rural primary care settings.

Opportunities for Improvement
A key opportunity includes:
- The MCO should report the baseline rates for all stated indicators.

Overall Credibility of Results
The credibility of the PIP results cannot be evaluated as the MCO did not report the baseline rates.

Passport Health Plan 2015 PIP: Reducing Readmission Rates of Postpartum Members

Status: Baseline Measurement
Baseline Report Submitted: 8/29/15

Study Topic Selection

Passport Health Plan's 2015 physical heath topic is reducing postpartum re-admissions. The objective of the PIP is to answer the following question:

Will a multidisciplinary strategy of provider and member interventions:
- Increase the rate of postpartum visits between 21–56 days postpartum?
- Decrease the rate of postpartum re-admissions within 30 days after delivery discharge?

The PIP indicators are:
- Postpartum 30-Day Readmissions
- HEDIS Prenatal and Postpartum Care: Postpartum Care Visits (PPC)

The MCO implemented the following interventions:

Member Interventions:
- Reworked the case management procedure to include targeting high-risk/complex/C-section deliveries for inpatient contact attempts and outreach within 4 days of discharge.
- Explored availability of case managers to assist members with postpartum self-care, monitoring, and appointments.
- Created On-hold SoundCare messages on the importance of postpartum visits.
- Implemented a member incentive for attending a timely postpartum visit.

Provider Interventions:
- Established a mechanism for provider performance feedback.
- Distributed OB provider/group performance reports, including timely postpartum visit.
- Worked with high-volume delivery facilities to obtain notification of deliveries prior to discharge.
- Considered authorization requirement for deliveries to facilities that do not notify the plan of member deliveries prior to discharge.
- Investigated the feasibility of collaborating with facilities to schedule the postpartum visit as part of the routine discharge process.

Health Plan Interventions:
- Recruited a full-time OB/GYN Medical Director.
- Developed a report to summarize postpartum re-admissions for root-cause analysis.
- Tracked members receiving intervention for re-admission rates and postpartum visits.
- Conducted a retrospective chart review for members with re-admissions.

Results and Data Analysis
The baseline results are reported in Table 44.

Table 44: Passport Health Plan 2015 PIP: Reducing Readmission Rates of Postpartum Members - Baseline Results

Indicators	Eligible population	Denominator	Numerator	Rate	Performance Target
Postpartum Readmissions – 30 days[1]	NR	NR	NR	1.82%	1.37%
HEDIS Postpartum Care [2]	5362	450	309	68.67%	2014 Quality Compass™ 90th percentile = 69.47%

[1]The MCO did not report baseline rates. Data for this indicator was taken from the Project Topic/Aim Statement section of the report (page 8).
[2]The MCO did not report the baseline rates. Data for this indicator was taken from the HEDIS IDSS.
IDSS: Interactive Data Submission System; NR: not reported.

Achievement of Improvement
Improvement is not evaluated at the baseline phase.

Strengths
Key strengths include:
- Analyses of data from a variety of sources used for ongoing barrier analysis, including: custom reports of re-admissions, audit of facility medical records, and member interviews.
- The intervention strategy is broad, detailed, and multi-faceted and targets the health plan processes, OB GYN providers, delivery facilities and members.

Opportunities for Improvement
A key opportunity includes:
- The MCO needs to report the baseline rates for all performance indicators.

Overall Credibility of Results
It is not possible to evaluate the credibility of the PIP results since the baseline rates were not reported.

Passport Health Plan 2016 PIP: Integrated Healthcare: The Collaboration of Behavioral Health and Primary Care (Statewide Collaborative for People with Serious Mental Illness (SMI))

Status: Proposal
Submitted: 10/31/15
Revised: 12/9/15

Study Topic Selection
Passport Health Plan's 2016 behavioral health PIP topic is Management of Physical Health Risks in the Seriously Mentally Ill Population. The objective of the PIP is to answer the following question
- Will improved care coordination and integrated care approaches between primary care and behavioral health providers:
    - Improve the primary care services for our members with SMI?

The PIP indicators are the following as directed by DMS:
- Cholesterol Screening for People with Schizophrenia or Bipolar Disorder who are Prescribed Antipsychotic Medications;
- HEDIS Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD);
- HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP) for members with SMI
- Tobacco Use Screening and Follow-up for People with Serious Mental Illness;
- Blood Pressure Assessment for People with Schizophrenia or Bipolar Disorder; and
- Body Mass Index Assessment for People with Schizophrenia or Bipolar Disorder

The MCO plans to implement the following interventions:

Provider Interventions:
- Identify educational opportunities to increase knowledge of current member health status.
- Identify opportunities to improve lack of coordination and improve communication between behavioral health and primary care providers.
- Identify high-volume behavioral health providers for gap reporting on preventive health screenings for members with SMI.
- Increase provider counseling for smoking cessation and physical activity for members with SMI.

Member Interventions:
- Increase member engagement and trust via an embedded case manager in high volume provider practices.

- Send postcard appointment reminders.
- Outreach members with SMI with two or more gaps for preventive screenings and conduct health education.

Health Plan Interventions:
- Assess members' current knowledge of preventive care via analysis of case management documentation.
- Assess members' current physical health practices through data collection and analysis.

Strengths
Key strengths include:
- The PIP has the potential to improve prevention and management of physical health risks among members with SMI.
- The MCO plans to conduct onsite interviews with providers to identify perceived barriers.
- The MCO plans to analyze the baseline data to identify factors that influence member receipt or lack of preventive care services.
- The interventions are varied and address providers, members, and the health plan barriers.
- The interventions include providing face-to-face provider education, using embedded case management staff, and developing tools and resources to support providers.
- Creating an integrated physical and behavioral health home will help address multiple obstacles to care for members with SMI.
- The MCO plans to implement a pilot program for physical and behavioral care integration at one or more sites.

Opportunities for Improvement
Key opportunities include:
- The MCO should provide plan-specific data that supports the topic's relevance, e.g., prevalence of SMI among members.
- The MCO should ensure that each stated barrier is addressed by an associated intervention.

Passport Health Plan 2016 PIP: Promoting Healthy Smiles through Increased Utilization of Preventative Dental Care

Status: Proposal
Submitted: 8/29/15

Study Topic Selection
Passport Health Plan's 2016 physical health PIP topic is increasing the percentage of Passport Health Plan members who receive preventative dental care annually. The objective of the PIP is to answer the following questions:
- Will a multidisciplinary strategy targeting provider and member interventions result in an increase in preventative dental visits for all members, including children and adults?
- Will provider specific feedback on performance related to dental services received by their attributed members increase their focus on oral health within the provider/member consultation?

The PIP indicators are the following:
- Fluoride services for children ages 6-10 applied by a dental provider; and
- Fluoride services for children under the age of 21 applied by the PCP.

The MCO plans to implement the following interventions:

Member Interventions include:
- Conduct a member survey to determine perceived barriers to regular dental care.
- Conduct member education.
- Implement a member incentive program.
- Conduct monthly outreach to members without a claim for a dental visit in previous 12 months.
- Create a pediatric dental provider directory.

Provider Interventions include:

- Conduct provider survey to determine perceived barriers to regular dental care.
- Adopt an oral health clinical practice guideline for PCPs and dental providers.
- Conduct PCP education on caries assessment and fluoride varnish training.
- Establish a streamlined workflow for PCPs for dental follow-up referral.

Health Plan Interventions include:

- Evaluate the dental fee schedule for equitable reimbursement for dentists and PCPs.
- Explore use of mobile dental services for screenings in areas of limited access.
- Explore collaboration with school-based dental services in areas with barriers to access.
- Outline a dental provider incentive plan to maximize dental care access.
- Review dental benefits manager contract and consider building performance accountability into the contract.
- Recruit a dental program director and develop a Dental Workgroup.
- Incorporate the Smiles for Life national oral health curriculum into training opportunities for providers and Passport Health Plan staff.

Strengths

Key strengths include:

- The PIP topic addresses a significant health issue, particularly in Kentucky and addresses a health priority for the state.
- The MCO has recruited multiple partners to collaborate with in conducting this PIP.
- The topic selection is supported by statistics, literature, and MCO-specific data.
- The methodology is detailed and includes tables that present current performance.

Opportunities for Improvement

A key opportunity includes:

- The MCO should establish process measures to track and assess the progress of the interventions.

WellCare of Kentucky 2013 PIP: Utilization of Behavioral Health Medication in Children

Status: Final Measurement
Final Report Submitted: 9/1/15

Study Topic Selection

WellCare of Kentucky's 2013 behavioral health PIP topic was use of psychotropic medications in the pediatric population. The objective of the PIP was to answer the following questions:

Can implementation of robust PCP and member interventions:

- Increase the frequency of assessment and diagnosis prior to prescribing psychotropic medications?
- Improve the management and treatment of behavioral health disorders and psychotropic medication use in the pediatric population?

The PIP indicators are:

- The percentage of members with a diagnosis of ADHD who have been prescribed an ADHD medication.
- The percentage of members who have the recommended follow-up visits after initiation of ADHD medication.

The MCO implemented the following interventions:

Provider Interventions:

- Developed provider toolkits to assist with diagnosis, treatment, and management of ADHD.
- Distributed toolkits to all PCPs via the website and during Provider Relations/QI staff visits.
- Identified PCP prescribers with high numbers of members lacking follow-up visits and medication adherence, and conducted performance feedback.
- Sent letters to prescribers whose panel members were dispensed ADHD medications and lacked follow-up visits and prescription refills.

Member Interventions:

- Developed and distributed member education materials to members on ADHD medications.
- Sent letters to members/guardians for children on ADHD medications that did not have follow-up visits and prescriptions refills.

Health Plan Interventions:

- Trained Provider Relations and Case Management teams on ADHD prescribing patterns and the ADHD provider toolkit.
- Deployed Provider Relations and Case Management staff to distribute toolkits during routine and ad hoc contacts/visits with providers.

Data Analysis and Results

Results for the final period are shown in Table 45.

Table 45: WellCare of Kentucky 2013 PIP: Utilization of Behavioral Health Medication in Children – Final Results

Indicator	Baseline Results MY 2012	Interim Results MY 2013	Final Results MY 2014	Performance Target
Members who were dispensed ADHD medication and had an ADHD diagnosis	85.70%	87.90%	89.40%	88.70%
Members who were dispensed ADHD medication who had ≥ 2 follow-up visits	71.60%	75.10%	82.0%	76.60%

MY: measurement year, ADHD: attention deficit hyperactivity disorder.

Achievement of Improvement
Final rates exceeded target rates for each of the two performance measures.

Strengths
- The MCO is focusing on pediatric behavioral health care.
- There is a strong rationale with multiple literature citations and data related to MCO member population.
- The MCO clearly defined indicators with specific criteria for member age, diagnoses, and medications.
- There is an improvement for both indicators.

Opportunities for Improvement
- The MCO should explore additional barriers to members' obtaining follow-up visits and medication refills, such as lack of transportation and develop process indicators to evaluate the progress and success of interventions.
- The MCO should also note that the indicator for the presence of an ADHD diagnosis when ADHD medication is dispensed may measure only coding practices and not adequately assess providers' assessment and diagnosis of ADHD.

Overall Credibility of Results
The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution as the performance indicator may reflect ADHD coding practices rather than appropriate assessment and diagnosis procedures. The final scoring results are presented in Table 46.

Table 46: WellCare of Kentucky 2013 PIP: Utilization of Behavioral Health Medication in Children – Final Score

Review Element	Compliance Level	Points Earned	Points Available
Review Element 1 – Project Topic	Partially Met	2.5	5
Review Element 2 – Topic Relevance	Met	5	5
Review Element 3 – Quality Indicator(s)	Partially Met	7.5	15
Review Element 4 – Baseline Study Methodology	Met	10	10
Review Element 5 – Baseline Study Population and Sampling	Met	10	10
Review Element 6 – Interventions	Partially Met	7.5	15
Review Element 7 – Demonstrable Improvement	Met	20	20
Total Score at Interim Measurement	Met	62.5	80
Review Element 1S – Subsequent or Modified Interventions[1]	Met	5	5
Review Element 2S – Sustained Improvement[1]	Met	15	15
Total Score at Final Measurement	Met	20	20
Overall Project Score	Met	82.5	100

WellCare of Kentucky 2013 PIP: Inappropriate Emergency Department Utilization

Status: Final Measurement
Final Report Submitted: 9/1/15

Study Topic Selection

WellCare of Kentucky's 2013 physical health PIP topic was inappropriate ED utilization. The objective of the PIP was to answer the following question:

- Does implementation of robust member and provider interventions decrease members' use of the ED for non-urgent conditions?

The PIP indicators were:

- HEDIS Ambulatory Care: Emergency Department Visits (AMB-ED);
- HEDIS Children and Adolescents' Access to Primary Care Practitioners (CAP);
- the top-ten ED diagnoses;
- the number of members diverted from the ED by the 24-hour Nurse Triage Line; and
- the number of members who require case management outreach for having ≥ 6 ED visits.

The MCO implemented the following interventions:

Provider Interventions:

- WellCare implemented the Prudent Layperson Standard.
- identified PCPs with high numbers of ED utilizers and conducted targeted outreach and issued High-ED Utilizer Reports.

Member Interventions:

- The MCO identified members with high ED utilization and conducted targeted telephonic outreach.
- WellCare promoted the 24/7 Nurse Triage Line.
- They developed and distributed member educational materials on appropriate treatment of pediatric non-urgent conditions.
- The MCO published a member newsletter article on participating urgent care center locations.

Health Plan Interventions:

- The MCO evaluated and corrected provider data and member assignments where needed.

Data Analysis and Results

Results for the final period are shown in Table 47.

Table 47: WellCare of Kentucky 2013 PIP: Inappropriate Emergency Department Utilization – Final Results

Indicator	Baseline Results MY 2012	Interim Results MY 2013	Final Results MY 2014	Performance Target	Target Met
HEDIS Children's and Adolescents' Access to Primary Care Practitioners (Ages 12–24 months)	97.72%	98.07%	97.49%	QC 90th Percentile	No
HEDIS Children's and Adolescents' Access to Primary Care Practitioners (Ages 25 Months–6 Years)	93.61%	93.02%	92.02%	QC 90th Percentile	No
HEDIS Children's and Adolescents' Access to Primary Care Practitioners (Ages 7–11 Years)	NR[1]	97.47%	96.30%	QC 90th Percentile	Yes
HEDIS Children's and Adolescents' Access to Primary Care Practitioners (Ages 12–19 Years)	NR[1]	96.45%	95.22%	QC 90th Percentile	Yes
HEDIS Ambulatory Care – ED Visits[2]	86.85/1,000 MM	83.58/1,000 MM	85.15/1,000 MM	QC 50th Percentile	No

[1]A rate could not be reported for CY 2012 as continuous enrollment criteria were not met for any members in these age groups.
[2]A lower rate indicates better performance.
MY: measurement year; QC: Quality Compass®; NR: not reported; MM: member months; ED: Emergency Department.

Achievement of Improvement

Improvement varied across the indicators (Table 47). For HEDIS Children and Adolescents' Access to Primary Care Practitioners (AAP), the performance target was not met for the age groups 12–24 months and 25 months to 6 years old. The target was met for ages 7-11 and 12–19 years of age. The rate for HEDIS Ambulatory Care – ED Visits (AMB-ED) did not meet the performance target.

Strengths

- The topic ED utilization impacts both quality and cost of care and is a significant challenge in serving the Medicaid population.
- The rationale is supported by multiple literature citations and uses data to demonstrate relevance to the MCO's membership; and charts provide a very effective presentation of the project rationale.

Opportunities for Improvement

- The MCO is in the process of developing a new system that will allow for increased tracking/reporting capabilities. This new system should incorporate a means to track, compare and analyze PCP and ED visits by age groups with the aim of targeting specialized case management and provider interventions toward age groups not meeting ongoing targets for increase PCP visits and decreased ED use, as well as tracking potentially preventable ED visits and hospitalizations using standardized measures, e.g., ambulatory sensitive conditions.
- The MCO should conduct member focus study groups to further research the reasons behind choosing ED over PCP visits, as well as analyze availability and access data, and address specific access issues identified.

Overall Credibility of Results

The validation findings generally indicate that the credibility of the PIP results is not at risk.

Table 48: WellCare of Kentucky 2013 PIP: Inappropriate Emergency Department Utilization – Final Score

Review Element	Compliance Level	Points Earned	Points Available
Review Element 1 – Project Topic	Partially Met	2.5	5
Review Element 2 – Topic Relevance	Met	5	5
Review Element 3 – Quality Indicator(s)	Met	15	15
Review Element 4 – Baseline Study Methodology	Met	10	10
Review Element 5 – Baseline Study Population and Sampling	Met	10	10
Review Element 6 – Interventions	Partially Met	7.5	15
Review Element 7 – Demonstrable Improvement	Partially Met	10	20
Total Score at Interim Measurement	Met	60	80
Review Element 1S – Subsequent or Modified Interventions[1]	Partially Met	2.5	5
Review Element 2S – Sustained Improvement[1]	Partially Met	7.5	15
Total Score at Final Measurement	Met	10	20
Overall Project Score	Met	70	100

WellCare of Kentucky 2014 PIP: Management of Chronic Obstructive Pulmonary Disease

Status: Interim Measurement
Interim Report Submitted: 9/1/15

Study Topic Selection
WellCare of Kentucky's 2014 physical health PIP topic was management of chronic obstructive pulmonary disease (COPD). The objective of the PIP was to answer the following questions:

Can robust interventions to improve care for members with a new diagnosis of COPD:
- increase the proportion of members who receive Spirometry testing to confirm diagnosis?
- increase the proportion of members who receive a systemic corticosteroid medication within 14 days of hospitalization/ED visit for COPD?
- increase the proportion of members who receive a bronchodilator within 30 days of hospitalization/ED visit for COPD?

Can robust interventions to improve assessment and management of COPD:
- decrease 7-day re-admission rates for COPD hospitalizations?
- decrease 30-day re-admission rates for COPD hospitalizations?

The PIP indicators are:
- HEDIS Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR),
- HEDIS Pharmacotherapy Management of COPD Exacerbation (PCE), and
- the proportion of members who receive outreach within 24 hours of discharge from a hospitalization for COPD.

The following additional measures will be tracked:
- Re-admission rates within 7 days of discharge from a hospitalization for COPD,
- Re-admission rates within 30 days of discharge from a hospitalization for COPD,
- The proportion of facilities requiring education due to 30-day re-admission rates ≥ 11%,
- The proportion of PCPs requiring education due to panel members not receiving appropriate COPD medications (corticosteroids or bronchodilators), and
- The proportion of PCPs requiring education due to panel members with a new diagnosis of COPD not receiving spirometry testing.

The MCO implemented the following interventions:

Provider Interventions:
- Established an interdisciplinary workgroup to address improving care for members with COPD;
- Provided information on appropriate diagnosis and treatment for COPD via monthly mailings to targeted facilities;
- Distributed information on appropriate diagnosis and treatment for COPD via monthly mailings to targeted providers; and
- Generated monthly reports to identify members with a new diagnosis of COPD and no evidence of Spirometry testing and/or who were not prescribed appropriate medications.

Member Interventions:
- Conducted case management outreach to ensure appropriate discharge plans for members hospitalized for COPD;
- Conducted case management outreach to members within one day of discharge; and
- Generated monthly lists to identify members with a new diagnosis of COPD and no evidence of Spirometry testing and mailed information about the importance of Spirometry testing.

Health Plan Interventions:
- Designated UM nurses for telephonic consultation to all facilities.

Data Analysis and Results
Results for the baseline period are shown in Table 49.

Table 49: WellCare of Kentucky 2013 PIP: Management of Chronic Obstructive Pulmonary Disease – Interim Results

Indicator	Baseline Results MY 2013	Interim Results	Performance Target
NR	NR	23.27%	QC 50th Percentile
HEDIS PCE Rate: Systematic Corticosteroids	37.13%	65.07%	QC 50th Percentile
HEDIS PCE Rate: Bronchodilators	47.05%	79.61%	QC 50th Percentile
7-day hospital re-admission rates	4.57%	5.13%	2.29%
30-day hospital re-admission rates	18.12%	20.95%	9.06%

MY: measurement year; NR: not reported; PCE: pharmacotherapy for chronic obstructive pulmonary disease exacerbation; QC: Quality Compass®.

Strengths
- The MCO provided improvement goals for each measure.
- Interventions targeted providers, facilities, members.
- The MCO provided sample education letters developed for providers and members.

Opportunities for Improvement
- Based on the unfavorable increase in re-admission rates, WellCare of Kentucky identified additional barriers regarding discharge planning and coordination of care transitions.
- The MCO began development of new Clinical Practice Guidelines. In addition, the plan initiated monthly interventional mailings to targeted PCPs and members who were identified as non compliant for PCE or SPR.
- The MCO should also target PCPs identified as non-compliant with the new 3rd QTR 2015 provider educational outreach.
- The distribution of the new CPG on smoking cessation guidelines for providers should be disseminated to all providers.

Overall Credibility of Results
There are no validation findings that indicate the credibility of the PIP results is at risk.

Table 50: WellCare of Kentucky 2014 PIP: Management of Chronic Obstructive Pulmonary Disease – Interim Score

Review Element	Compliance Level	Points Earned	Points Available
Review Element 1 – Project Topic	Met	5	5
Review Element 2 – Topic Relevance	Met	5	5
Review Element 3 – Quality Indicator(s)	Met	15	15
Review Element 4 – Baseline Study Methodology	Met	10	10
Review Element 5 – Baseline Study Population and Sampling	Met	10	10
Review Element 6 – Interventions	Met	15	15
Review Element 7 – Demonstrable Improvement	Met	20	20
Total Score at Interim Measurement	Met	80	80
Review Element 1S – Subsequent or Modified Interventions[1]	N/A[2]	N/A[2]	N/A[2]
Review Element 2S – Sustained Improvement[1]	N/A[2]	N/A[2]	N/A[2]
Total Score at Final Measurement	N/A[2]	N/A[2]	N/A[2]
Overall Project Score	N/A[2]	N/A[2]	N/A[2]

[1]Not applicable at this time; the PIP was scored at the interim phase only. N/A: not applicable.

WellCare of Kentucky 2014 PIP: Follow-up After Hospitalization for Mental Illness

Status: Interim Measurement
Interim Report Submitted: 9/1/15

Study Topic Selection
WellCare of Kentucky's 2014 behavioral health PIP topic was follow-up after hospitalization for mental illness. The objective of the PIP was to answer the following questions:

Can robust interventions aimed at improving MCO, provider, and member performance:
- increase the proportion of members who receive follow-up care within 7 days of discharge?
- increase the proportion of members who receive follow-up care within 30 days of discharge?

Can interventions aimed at improving follow-up care for mental illness:
- decrease 7-day re-admission rates?
- decrease 30-day re-admission rates?

The PIP indicators are:
- HEDIS Follow-up After Hospitalization for Mental Illness (FUH),
- the proportion of facilities that score < 80% on medical record audits, and
- the proportion of members outreached within 24 hours of discharge from an acute hospitalization for mental illness.

The MCO implemented the following interventions:

Provider Interventions:
- Established an interdisciplinary workgroup to analyze barriers to discharge planning and access to care;
- Mailed quarterly letters to hospital administrators with facilities' HEDIS Follow-up After Hospitalization for Mental Illness performance and a list of members lacking 7-day follow-up;
- Conducted medical record audits for all high volume inpatient facilities; and
- Developed clinical transition of care/discharge planning guidelines.

Member Interventions:
- Conducted case management outreach to follow-up on after-care appointments within one day of discharge.

Health Plan Interventions:

- Designated a UM coordinator to aid timely communication between the facilities and the UM department and expedite member referrals to behavioral health case management for timely outreach after discharge.

Data Analysis and Results

Results for the interim period are shown in Table 51.

Table 51: WellCare of Kentucky 2014 PIP: Follow-up After Hospitalization for Mental Illness – Interim Results

Indicator	Baseline Results MY 2013	Interim Results MY 2014	Performance Target
HEDIS FUH 7-Day Rate	36.07%	33.82%	QC 50th Percentile
HEDIS FUH 30-Day Rate	61.79%	57.18%	QC 50th Percentile
7-Day Re-admission Rate	5.97%	5.38%	2.99%
30-Day Re-admission Rate	16.60%	16.32%	8.3%

MY: measurement year, FUH: follow-up after hospitalization for mental illness; QC: Quality Compass®.

Achievement of Improvement

None of the performance indicators met their targeted goal. The data presented in tables was not able to show improvement year over year for the FUH measure. However the 7- and 3- day re-admission rates did decrease slightly.

Strengths

- Addressed a vulnerable population with a goal of increasing transitional/follow-up care and preventing re-admissions.
- Incorporated local research (by University of Louisville) in the proposal.
- Conducted extensive barrier analysis, including with facility administrators.

Opportunities for Improvement

- Consider analyzing data on principle diagnosis, geographic location, and/or other factors to facilitate barrier analysis.
- Consider conducting calls to determine if members kept their scheduled follow-up appointments; and report the process measure results.

Overall Credibility of Results

There are no validation findings that indicate the credibility of the PIP results is at risk.

Table 52: WellCare of Kentucky 2014 PIP: Follow-up After Hospitalization for Mental Illness Interim Score

Review Element	Compliance Level	Points Earned	Points Available
Review Element 1 – Project Topic	Met	5	5
Review Element 2 – Topic Relevance	Met	5	5
Review Element 3 – Quality Indicator(s)	Met	15	15
Review Element 4 – Baseline Study Methodology	Met	10	10
Review Element 5 – Baseline Study Population and Sampling	Met	10	10
Review Element 6 – Interventions	Met	15	15
Review Element 7 – Demonstrable Improvement	Met	20	20
Total Score at Interim Measurement	Met	80	80
Review Element 1S – Subsequent or Modified Interventions[1]	N/A[1]	N/A[1]	N/A[1]
Review Element 2S – Sustained Improvement[1]	N/A[1]	N/A[1]	N/A[1]
Total Score at Final Measurement	N/A[1]	N/A[1]	N/A[1]
Overall Project Score	N/A[1]	N/A[1]	N/A[1]

[1]Not applicable at this time; the PIP was scored at the interim phase only. N/A: not applicable.

WellCare of Kentucky 2015 PIP: Use of Antipsychotics in Children and Adolescents (Statewide Collaborative)

Status: Baseline Measurement
Baseline Report Submitted: 9/1/15

Study Topic Selection
WellCare of Kentucky's 2015 behavioral health PIP topic is use of antipsychotics in children and adolescents. The objective of this PIP is to answer the following questions:

Do robust interventions aimed at improving MCO, provider and member performance:

- decrease the proportion of children and adolescents on antipsychotic medications who receive higher-than-recommended doses?
- decrease the percentage of children and adolescents who are prescribed two or more antipsychotic medications?
- increase the percentage of children and adolescents with a new prescription for an antipsychotic medication who have first-line psychosocial care?
- increase the percentage of children and adolescents with a new prescription for an antipsychotic medication who have one or more follow-up visits?
- increase the percentage of children and adolescents with a new prescription for an antipsychotic medication who have baseline metabolic screening?
- increase the percentage of children and adolescents with a new prescription for an antipsychotic medication who have metabolic monitoring?

The PIP indicators are the following six HEDIS and proposed HEDIS indicators, as directed by DMS:

- HEDIS Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC),
- HEDIS Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP),
- HEDIS Metabolic Monitoring for Children and Adolescents Newly on Antipsychotics (APM),
- proposed HEDIS measure: Metabolic Screening for Children and Adolescents on Antipsychotics,
- proposed HEDIS measure: Use of Higher-Than-Recommended Doses of Antipsychotics in Children and Adolescents, and
- proposed HEDIS measure: Follow-up Visits for Children and Adolescents on Antipsychotics.

The MCO plans to implement the following interventions:

Provider Interventions:
- Post practice parameters for the use of Atypical Antipsychotics in Children and Adolescents from the American Academy of Child and Adolescent Psychiatry (AACAP)on the provider website;
- Develop a comprehensive "Assessment, Screening and Monitoring Tool" based on AACAP practice parameters and post on the provider website;
- Send monthly informational/educational mailings targeting general practitioners and pediatricians;
- Assess access to psychiatrists in Kentucky as a barrier and if necessary and feasible, provide resources on psychiatric care to general practitioners and pediatricians; and
- Evaluate other venues for provider education, such as an educational conference/summit on best practices.

Member Interventions:
- Publish a member newsletter article for members/caregivers about care for children with behavioral conditions issues.
- Send targeted educational mailings care for children taking antipsychotic medications to members newly prescribed an antipsychotic medication.
- Assess access to psychiatrists in Kentucky as a barrier and if necessary and feasible, provide resources on psychiatric care to general practitioners and pediatricians.

Health Plan Interventions:
- Collect and review data on prescribing practices for antipsychotics for members ages 0–17 years, including provider type(s)/specialties, monitoring outliers (e.g., children ≤ age 5) and develop associated interventions.
- Refer outliers to the Quality of Care (QOC) Department for further review by the QOC Nurse and the Behavioral Health Medical Director, as necessary.

Data Analysis and Results
Not applicable. Interim results will be reported in September 2016.

Table 53: WellCare of Kentucky 2015 PIP: Use of Antipsychotics in Children and Adolescents – Baseline Results

Indicator	Baseline Results MY 2014	Performance Target
Use of Multiple Concurrent Antipsychotics (APC)	1.31%	6.0%
Use of First-Line Psychosocial Care (APP)	65.33%	48.2%
Metabolic Monitoring (APM)	24.98%	18.5%
Use of Higher-Than-Recommended Doses	22.79%	7.9%
Follow-up Visit	78.28%	72.8%
Metabolic Screening	0.33%	6.0%

MY: measurement year,

Achievement of Improvement
Not applicable. Interim results will be reported in September 2016.

Strengths
Key strengths include: the proposal references relevant performance indicators, scientific literature, and clinical practice guidelines and the study questions and objectives are clearly stated and include specific improvement goals.

Opportunities for Improvement

- Incorporate interventions to address use of first line psychosocial care and incorporate more active interventions than web-postings and mailings such as facilitating appointments for members and onsite visits to non-psychiatric prescribers.
- Develop process measures to monitor each major intervention; the MCO needs to reset all performance targets so that they measure improvement relative to baseline.

Overall Credibility of Results
There were no validation findings which indicate that the credibility of the PIP results is at risk.

WellCare of Kentucky 2015 PIP: Postpartum Care

Status: Baseline Measurement
Baseline Report Submitted: 9/1/15

Study Topic Selection
WellCare of Kentucky's 2015 physical health PIP topic is postpartum care. The objective of this PIP is to answer the following questions:

Do robust interventions aimed at improving MCO, provider and member performance:
- increase the percentage of members who have a postpartum visit on or between 21–56 days after delivery?
- increase postpartum depression screenings?
- decrease the percentage of 30-day post-delivery re-admissions and
- decrease the percentage of 60-day post-delivery re-admissions?

The PIP indicators are:
- HEDIS Postpartum Care,
- Healthy Kentuckians Postpartum Depression Screening,
- the percentage of 30-day postpartum re-admissions, and
- the percentage of 60-day postpartum re-admissions.

The MCO plans to implement the following interventions:

Provider Interventions:
- Adding additional QI HEDIS Advisors to educate/coach providers on guidelines;
- Publish a provider newsletter article on tips for documenting postpartum visits;
- Post the Edinburgh Postnatal Depression Scale on the provider website; and
- Conduct targeted education for providers who do not complete postpartum screening for depression.

Member Interventions:
- Use vendor, Alere, to implement a comprehensive perinatal program for pregnant members;
- Conduct member outreach post-delivery with reminders about postpartum visits and well-child visits and to assist with appointment scheduling; and
- Publish information on the importance of postpartum visits in the member newsletter.

Data Analysis and Results
Not applicable. Interim results will be reported in September 2016.

Table 54: WellCare of Kentucky 2015 PIP: Postpartum Care – Baseline Results

Indicator	Baseline Results MY 2014	Performance Target
HEDIS Postpartum Care (PPC)	51.41%	QC 50th percentile 62.15% (2015)
HK Postpartum Depression Screening	30.22%	Increase 50% 45.33%
30-Day Re-admission Rate Post-Delivery	1.65%	Decrease 20% 1.32%
60-Day Re-admission Rate Post-Delivery	2.15%	Decrease 20% 1.72%

MY: measurement year; QC: Quality Compass®.

Achievement of Improvement
Not applicable. Interim rates will be reported in September 2016.

Strengths
- This was a topic selection supported by references to clinical practice guidelines.
- MCO performance data with benchmarks, and literature citations was provided.
- A solid rationale for the performance goals was provided
- The barrier analysis is detailed and there are process measures to track the progress of the interventions.

Opportunities for Improvement
- The MCO should consider analyzing if the members with re-admissions had a postpartum visit.
- Continue to develop the provider interventions past focusing primarily on documentation issues.
- Consider focusing interventions on the top re-admission diagnoses.
- The focus group convened by WellCare of Kentucky was comprised of only internal MCO staff.
- As the PIP progresses, the MCO should assess barriers through direct communication with providers and members.

Overall Credibility of Results
Not applicable. Baseline results will be reported in September 2015.

WellCare of Kentucky 2016 PIP: Effectiveness of Coordinated Care Management on Physical Health Risk Screenings for Members with Serious Mental Illness (SMI) Population (Statewide Collaborative)

Status: Proposal
Submitted: 10/29/15
Revised: 12/15/15

Study Topic Selection
WellCare of Kentucky aims to improve preventive physical health care, including access to preventive/ambulatory health services and screenings for metabolic and cardiovascular risks, in the seriously mentally ill population. The objective of the PIP is to answer the following questions:

Do robust interventions aimed at improving MCO, provider, and member performance:
- increase the percentage of members, 18 to 64 years of age with a diagnosis of schizophrenia or bipolar disorder, who received a preventive/ambulatory health service?
- increase the percentage of members, 18 to 64 years of age with a diagnosis of schizophrenia or bipolar disorder, who received obesity screening?
- increase the percentage of members, 18 to 64 years of age with a diagnosis of schizophrenia or bipolar disorder who are prescribed an antipsychotic medication and who also received cholesterol screening?

- increase the percentage of members, 18 to 64 years of age with a diagnosis of schizophrenia or bipolar disorder who received blood pressure screening?
- increase the percentage of members, 18 to 64 years of age with a diagnosis of schizophrenia or bipolar disorder, who received tobacco screening and follow-up care?
- increase the percentage of members, 18 to 64 years of age with a diagnosis of schizophrenia or bipolar disorder who are prescribed an antipsychotic medication and who also received diabetes screening?

The PIP indicators are:

- the percentage of individuals 18-64 years of age with diagnosis of schizophrenia or bipolar disorder that were screened for tobacco abuse;
- the percentage of individuals 18 to 64 years of age with schizophrenia or bipolar disorder, who had an ambulatory or preventive care visit with a PCP during the measurement year, and who had at least one blood pressure assessment performed during the measurement year;
- the percentage of members ages 18 to 64 years of age, with a diagnosis of schizophrenia or bipolar disorder, who had an ambulatory or preventive care visit with a PCP during the measurement year, and who had a body mass index (BMI) documented;
- the percentage of individuals 18 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication during the measurement year, who had an outpatient office visit during the measurement year, and who had one or more LDL-C screening tests during the measurement year;
- the percentage of individuals 18-64 years of age with a diagnosis of schizophrenia or bipolar disorder who had an ambulatory or preventative care visit during the measurement year; and
- the percentage of individuals 18-64 years of age with a diagnosis of schizophrenia or bipolar disorder who had a screening for Diabetes during the measurement year.

The MCO plans to implement the following interventions:

Provider Interventions:

- The health plan will enhance current clinical practice guidelines for the treatment of Schizophrenia and Bipolar Disorder to include best practice recommendations for the provision of preventive physical health screenings for patients diagnosed with these conditions.
- The health plan will develop a preventive physical health "Assessment, Screening, and Monitoring Tool" for adults diagnosed with SMI and will distribute the screening tool via mail to providers as well as by making the tool available via the health plan's provider website.
- The health plan will explore the opportunity to engage practicing physicians, both PCPs and psychiatrists for collaborative baseline information analysis, to include barrier assessment, and additional input and recommendations for interventions to improve the management and coordination of care for members with SMI.
- Individual providers will be identified for the mailings based on data indicating that a new prescription for an antipsychotic was filled in the previous month. Mailings will include information on how to access the Clinical Practice Guidelines on the MCO's website, in addition to the "Assessment, Screening, and Monitoring Tool."

Member Interventions:

- Seek input on perceived barriers and recommended interventions from members, advocates and community partners.
- Send educational appointment reminder letters to members with SMI.
- Develop and distribute behavioral and physical mental health member education materials.

Member and Provider Interventions:

- Explore the opportunity to engage members, advocates and community partners for a collaborative effort to include barrier assessment and additional input and recommendations for interventions to improve the management and coordination of care for members with SMI; and
- Develop and distribute member-specific informational/educational materials related to the behavioral and physical health needs of members with SMI (i.e., medication adherence, risks and potential side effects of psychiatric

medications, nutrition, metabolic screenings, screening for diabetes, diabetes care, screenings for dyslipidemia and hypertension, etc.)

Strengths
Key strengths include:
- The MCO included plan-specific data regarding the prevalence of SMI among the membership.
- The aims, objectives, study questions and goals are well-developed and clearly stated.
- The MCO used information from its provider satisfaction survey in the barrier analysis.

Opportunities for Improvement
Key opportunities for improvement were addressed by the MCO with its revised proposal.

Overall Credibility of Results
Not applicable. Baseline results will be reported in September 2016.

WellCare of Kentucky 2016 PIP: Improving Pediatric Oral Health

Status: Proposal
Submitted: 9/1/15
Revised: 11/30/15

Study Topic Selection
WellCare of Kentucky aims to improve pediatric oral health by increasing the number of members receiving an annual dental visit and preventive oral health care. The objective of the PIP is to answer the following questions:

Do robust interventions aimed at improving MCO, provider, and member performance:
- increase the percentage of members 2 to 21 years of age who had at least one dental visit during the measurement year?
- increase the percentage of members 6 to 14 who receive a dental sealant?
- the percentage of members 0 to 20 who receive at least two fluoride treatment services during the measurement year?

The PIP indicators are:
- increase HEDIS rate for Annual Dental Visit, as defined by HEDIS Technical Specifications;
- increase the rate of members receiving a dental sealant treatment in the measure year; and
- increase the rate of members receiving at least two fluoride treatments in the measurement year.

The MCO plans to implement the following interventions:

Member Interventions:
- The dental provider will develop member newsletter articles.
- The MCO will develop a process, in collaboration with dental vendor to identify member households targeted for additional outreach.

Provider Interventions:
- The dental vendor will develop provider newsletter articles with topics on the importance of collaboration between medical and dental practitioners and tips for interacting with pediatric patients less than 3 years of age.
- The MCO will conduct “meet and greet” for pediatric dentists and physicians.

Health Plan Interventions:
- The MCO will schedule regular workgroup meetings between plan staff and dental vendor and may include contracted dental providers or members as necessary.

Strengths

Key strengths include:

- The PIP topic is one that is a significant health issue, particularly in Kentucky and this is one of the Governor's health priorities.
- The study topic selection is supported by clinical guidelines, health services literature, national statistics, Medicaid statistics, and health plan-specific data.
- The MCO is collaborating with its dental vendor, Avesis, to conduct this PIP.

Opportunities for Improvement

The majority of key opportunities for improvement were addressed by the MCO with its revised proposal. The current intervention strategy is very passive and not likely to be especially effective. The MCO is encouraged to investigate evidence-based interventions and best practices in the literature.

Overall Credibility of Results

Not applicable. Baseline results will be reported in September 2016.

Additional EQR Activities in Progress

In addition to the mandatory EQR activities described in this report, IPRO conducts a number of optional EQR activities. Some were completed in CY2015, some continued in CY2016 and others are ongoing. A descriptive summary of each activity follows:

Managed Care Program Progress Report

IPRO produced a Managed Care Program Progress report for key stakeholders, such as the Kentucky State Legislature. The purpose of this Progress Report is to summarize information from the external quality review activities that describe the status and progress that has occurred in Kentucky's Medicaid Managed Care Program during the period July 1, 2014 through June 30, 2015. IPRO identified program strengths and opportunities for improvement in the areas of program administration, data systems, compliance with federal standards, provider network access, quality assessment, performance improvement and provided recommendations related to improving encounter data quality, enhancing board certification rates, increasing well visits for children and adolescents, conducting further study on access and availability of behavioral health services, improving HEDIS performance where rates fell below the 50th percentile, and more importantly at or below the 10th percentile, increasing response rates for health risk assessments, and enhancing care coordination.

MCO Performance Dashboard

The MCO Performance Dashboard displays the plans' HEDIS and CAHPS rates and highlights overall performance as well as individual measure performance compared to national Medicaid averages. IPRO updates the dashboard annually with each year's HEDIS and CAHPS data and performance trends.

MCO Performance Annual Health Plan Report Card

IPRO collaborated with DMS to produce a Health Plan Report Card (English and Spanish versions) which presents the performance for each of the plans on selected HEDIS and CAHPS measures. The Health Plan Report Card is provided to members to compare the MCOs' performance and assist members in choosing an MCO during the Open Enrollment period. IPRO updates the Health Plan Report card annually prior to the Open Enrollment period.

Quality Companion Guide

IPRO has prepared a Quality Companion Guide as a reference guide to the core EQR quality improvement activities for the MCOs. The guide includes an overview of the processes for the regulatory compliance review, PM calculation and validation and PIP conduct and validation.

Comprehensive Evaluation Summary

IPRO composed a comprehensive evaluation summary which presented an in-depth review of DMS accountability strategy, monitoring mechanisms and compliance assessment system described in the Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services. This was the third annual review, conducted with the intent of continuing the evaluation using updated information, reports and interviews. The report described recent developments in Kentucky's MMC Program including a description of program monitoring responsibilities and the evaluation methodology. The methods for evaluation included interviews with key stakeholders, including MCO and DMS program managers; the Department for Behavioral Health, Developmental and Intellectual Disability (DBHDID); Department of Public Health (DPH); and the Department of Insurance (DOI). IPRO summarized strengths and opportunities for improvement Kentucky's MMC Program relative to program administration, goals and benchmarks, quality monitoring assessment, and quality improvement. Recommendations addressed the quality strategy, the collaborative PIP, MCO statutory report requirements, and the MCO performance dashboard.

Validation of Patient-Level Claims

Encounter data validation is an optional MMC EQR activity. DMS requested that IPRO conduct several encounter data activities during 2014.

Monthly Management Reports

IPRO continued to receive historical claims data from DMS that captures the MCO members' utilization. IPRO produced a set of monthly validation and management reports that display the trends in claims for a variety of services, including inpatient, professional and pharmacy, among others. Monthly report production is an ongoing task.

MCO Encounters vs. IPRO Warehouse Data Validation

DMS requested that IPRO conduct an encounter data validation project. IPRO is in the process of conducting an encounter data validation study to ensure that DMS' data warehouse captures all submitted information from the MCO's. IPRO requested the following from DMS: the latest file specifications sent to MCOs for encounter, dental and pharmacy data submissions, updates to the data submission process since IPRO's first review and documentation of internal queries and edit checks applied to files received. File layouts were reviewed, a request was sent to Kentucky MCOs for data submissions that were submitted to the state based on a specified three month range (July-September 2015) and DMS will be notified of the data requests.

In process is the Data validation for Encounter, Dental and Pharmacy Data Submissions:

- Analysis and comparison of records and dates of service sent by MCOs versus DMS data warehouse Records.
- A discrepancy report will be built to showcase frequencies of missing information, missing and duplicated records for MCOs and DMS as well as any other data inconsistencies.

EPSDT Validation Study

IPRO conducted studies to validate Kentucky Medicaid Managed Care EPSDT visit codes in 2014 and 2015. The 2014 study revealed opportunity for improvement in the receipt of comprehensive EPSDT screenings during well child visits, and oral health assessment was among the specific identified gaps in care. Although rates of oral health assessment during EPSDT visits showed significant improvement in 2015 over 2014 results (61% versus 50%, $P < 0.01$), there is still opportunity for improvement in this area, especially for adolescents, for whom only 52% had an oral health assessment documented. The 2015 study also identified continued opportunity for improvement in the rate of children and adolescents who were documented to be under the care of a dentist or had a referral to a dentist, with a rate of only 16%. Strikingly, 35% of all study sample members, and 44% of adolescents, had neither assessment of oral health needs during their EPSDT visit nor referral for dental care.

In order to support Kentucky's ongoing focus on oral health care in the Healthy Smiles Kentucky and other statewide initiatives ("Healthy Kentucky Smiles," 2006)[26] these findings will be explored in more detail to determine if dental services codes for comprehensive preventive services and exams and restorative dental treatment services reflect preventive and treatment visits as indicated in dental record documentation.

This study aims to validate EPSDT-related dental visit and services codes by comparing dental record documentation and submitted dental encounter data for children enrolled in Kentucky Medicaid Managed Care, and describe age-appropriate EPSDT dental services provided during dental visits.

Study questions:

- Does dental record documentation of dental visits and procedures identified by dental encounter data submission include documentation of preventive, diagnostic and restorative treatment services covered under The Kentucky Medicaid Dental Program[27] for children under age 21 including: oral exams, X-rays, extractions, fillings, root canal therapy, crowns, and sealants?
- Does dental record documentation support claims submitted for EPSDT routine dental preventive and restorative treatment related services?
- To what extent are follow-up dental health diagnostic and dental treatment services planned for problems identified during dental visits?

[26] http://chfs.ky.gov/nr/rdonlyres/67ed0872-8504-43a0-8165-8739f320cac9/0/strategicplan.pdf.

[27] Kentucky Cabinet for Health Services, Department for Medicaid Services, Dental Services. http://chfs.ky.gov/dms/dental.htm. Accessed 11-23-2015.

Quality of Care Focus Studies

Quality of care focus studies are an optional EQR activity. IPRO is conducting two focus studies on behalf of DMS with the participation of the MCOs and other stakeholders, such as DCBS.

Emergency Department Visits for Nontraumatic Dental Problems Among the Adult Kentucky Medicaid Managed Care Behavioral Health Subpopulation

The aim of this focused study is to quantify the prevalence of and risk factors for nontraumatic dental ED visits (NTDV) among the adult Kentucky MMC BH subpopulation.

Administrative encounter data for measurement year June 1, 2014–May 31, 2015 were utilized to assess relationships between the outcome of an ED visit for nontraumatic dental problems and the risk factors among the adult MMC BH subpopulation (aged 18 years and older, as defined in the Kentucky Behavioral Health Study [IPRO/KDMS, 2014]).[28] The following outcomes were evaluated among the total adult BH subpopulation: any (one or more) ED visit(s) for nontraumatic dental problems (i.e., disorders of tooth development and eruption; diseases of hard tissues of teeth [e.g., caries]; disease of pulp and periapical tissues; gingival and periodontal diseases; other diseases of teeth and supporting structures, as defined in Sun et al., 2015).[29] In addition, the subset of the BH population with NTDV, the outcome of multiple NTDVs (MNTDVs) was evaluated for associations with risk factors. Risk factors included demographic characteristics (age group, race, sex); BH conditions; chronic physical conditions; member residence (rural non-Appalachian, urban non-Appalachian, and Appalachian county); managed care organization (MCO); access to primary care providers (PCPs) and BH providers for outpatient visits; access to outpatient dental visits by type (restorative: any dental visit type other than exclusively for preventive/diagnostic or pain/palliative care; preventive/diagnostic without restorative care; pain/palliative care without restorative care; and no outpatient dental visits).

Key findings included:

- The majority of the Kentucky BH MMC population with one or more NTDVs were aged 18–37 years and resided in urban counties.
- Unmet dental need and lack of access to outpatient dental care crossed geographic boundaries.
- Most Kentucky BH MMC members with an NTDV had no outpatient dental visits, yet the highest NTDV rate was among members with an outpatient dental visit for pain/palliative care without any restorative care.
- There was significant variability in the NTDV rate among Medicaid MCOs, and among members with and without visits to PCPs and BH providers.

Recommendations

Kentucky Medicaid MCOs can address the problems and risk factors identified in this focused study by identifying and sharing current gaps and best practices, as well as collaborating with providers for quality improvements by drawing on the following specific recommendations:

- Target care coordination/case management to susceptible subpopulation as indicated by risk factors identified in this report.
- Enhance care management programs for improved outreach and engagement of the BH population for integration of physical health, mental health and oral health care.
- Work with PCPs, BH providers and dentists to improve integration of physical, behavioral and oral health care services.
- Develop partnerships with academic medical centers for implementation of ED dental diversion programs in urban areas.
- Evaluate dental networks in rural and Appalachian counties, and undertake initiatives to improve access and availability of dental providers.

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[28] IPRO/KDMS. Kentucky Behavioral Health Study: Final Report, July 2014.

[29] Sun BC, Chi DL, Schwarz E, Milgrom P, Yagapen A, Malveau S, Chen Z, Chan B, Danner S, Owen E, Morton V, Lowe RA. Emergency department visits for nontraumatic dental problems: a mixed-method study. American Journal of Public Health May 2015; Vol 105(5): 947-955.

- Address each of the non-compliance drivers identified in the Dental Access and Availability Survey in order to ensure that an adequate provider network is available and accessible to members.
- Conduct performance improvement projects (PIPs) to improve the integration of and access to physical, behavioral and oral health care services, with targeted interventions to improve oral health for adolescents and young adults.
- Survey members with MNTDVs to identify barriers to accessing and utilizing outpatient dental care.
- Educate members about the importance of oral health to overall health and well-being, as well as appropriate sources of care and the availability of covered services, and engage providers to deliver preventive and restorative dental care.
- Conduct MCO- and county-specific analysis of NTDV, outpatient preventive and outpatient treatment dental visits, in order to highlight geographic areas of need, such as counties with shortages of dentists willing to provide preventive and treatment dental services.
- Conduct MCO-specific analysis of NTDV to also address patterns of multiple hospital usage, opioid prescription and tobacco use disorder, develop hospital-community partnerships to address these issues, and monitor NTDVs to identify candidates for Lock-In Programs.

KDMS can provide guidance to MCOs in order to address the issues identified in this focused study and develop comprehensive strategies for quality improvement, care coordination, integration and continuity. Specific recommendations for KDMS include the following:

- Initiate a statewide PIP that aims to integrate oral health care with primary health care for adult MMC enrollees with BH conditions, including the high-risk subpopulation of adults with serious mental illness (SMI) and substance abuse disorder (SUD).
- Collaborate with MCOs to implement solutions recommended by the ADA, such as ED dental diversion programs in urban areas with access to urgent care dental clinics.
- Collaborate with the Centers for Medicare and Medicaid Services (CMS) to extend the CMS Oral Health Collaborative to address the adult BH subpopulation.
- Findings from this focused study reinforce the importance of IPRO's recommendation in the Dental Access and Availability Survey that KDMS work with the MCOs to increase dental contact and appointment rates in order to improve access to appropriate dental care.

Prenatal Smoking, Small for Gestational Age (SGA) and Preterm Birth Outcomes, and Smoking Cessation Interventions (in progress)

The aims of the focused study are twofold:

1. Profile smoking prevalence, member characteristics, receipt of prenatal smoking cessation services, and SGA and SGA-indicated preterm birth outcomes among the Kentucky Medicaid Managed Care population who delivered a live or stillborn singleton birth, and evaluate associations between prenatal smoking status, receipt of prenatal smoking cessation services, MCO membership, prenatal visits, and demographic characteristics with the outcomes of prenatal SGA and SGA-indicated preterm birth. Also evaluate the broader outcome(s) of placental-associated syndromes (PAS) linked to prenatal smoking, i.e., placental abruption, placenta previa, stillbirth, as well as SGA and preterm.
2. Profile provider prenatal and postpartum interventions, i.e., 5 "A's", MCO care coordination and case management prenatal and postpartum interventions, whether or not smoking abstinence achieved and, if achieved, whether during prenatal period or postnatal period, and total # quit attempts during prenatal and postpartum periods.

Methodology

1. Administrative Study: For the entire Medicaid Managed Care population of members who delivered a singleton live or stillborn infant during the period from June 1, 2014- May 31, 2015, with continuous enrollment from 43 days prior to delivery through 56 days after delivery, utilize administrative claims/encounter data to achieve the first study aim by evaluating disparities and associations using chi square analysis of proportions and multiple logistic regression statistical analysis, respectively. Use the same ICD-9 codes to define smoking status as those used in the IPRO/KDMS postpartum study (2014) across all encounter settings during the 280 days prior to delivery date.
2. Select a random sample of 400 members from the Administrative Study eligible population, stratified by smoking status and MCO (i.e., 30 smokers + 10 oversample + 30 nonsmokers + 10 oversamples per MCO x 5=400).

3. Abstract data on "5 A's" from provider prenatal and postpartum outpatient visit charts, care coordination and case management prenatal and postpartum interventions for smoking cessation referrals from MCO charts, and both prenatal and postpartum smoking abstinence outcomes from both provider and MCO charts.

Access and Availability Surveys

Conducting surveys is an optional EQR activity. IPRO conducted a variety of access and availability survey activities on behalf of the Kentucky DMS.

Availability of Primary Care Providers

During 2015, IPRO conducted a survey to evaluate access to and availability of primary care providers participating with the Medicaid MCOs. Specifically, this project assessed the ability to make office hour appointments using a secret shopper survey methodology. A total of 1,250 providers were randomly sampled for the survey study. Provider types fell into three categories: primary care providers (PCPs), pediatricians, and obstetricians/gynecologists (ob/gyns). The project comprised three types of calls: routine appointments, non-urgent appointments, and after-hours phone access. At the time of this survey, there were five MCOs: Anthem Blue Cross and Blue Shield Medicaid, CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan, and WellCare of Kentucky.

Overall, 86.3% of the providers for the routine calls and 87.4% of the providers for the non-urgent calls were able to be contacted. After removing exclusions, 31.8% of the providers for the routine calls and 24.8% of the providers for the non-urgent calls were both able to be contacted and scheduled an appointment within the corresponding timeliness standards (i.e., 30 days and 48 hours, respectively). The overall compliance rate for after-hours calls was 52.0%.

Validation of Managed Care Provider Network Submissions

In September 2015, Island Peer review Organization (IPRO), on behalf of the Kentucky Department for Medicaid Services (DMS), conducted its fifth audit of the plans' provider directory data files to validate their accuracy. This is the first provider network validation for FY 2016. There are five managed care organizations (MCOs) operating in Kentucky: Aetna Better Health, Anthem Blue Cross and Blue Shield Medicaid, Humana-CareSource, Passport Health Plan, and WellCare of Kentucky.

Key findings included:

- A total of 206 (45.2%) providers who returned surveys included at least one revision. A higher percentage of PCP records had revisions than specialist records.
- Four survey items had a substantial percentage of providers with missing data in the provider directory 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 65.1% rate of accuracy, most of the revisions were additions, because the original provider directory data were blank. As such, this finding should be interpreted with caution.
- The fields with the most accurate rates were "State" with a 100.0% rate, "National Provider ID (NPI)" with a 99.8% rate, "First Name" with a 99.8% rate, "Last Name" with a 98.0% rate, whether the provider has a contract to accept Medicaid patients with a 98.0% rate, "PCP Panel Size" with a 96.9% rate, "Secondary Specialty" with a 96.7% rate, "Provider Type" with a 96.1% rate, "City" with a 95.8% rate, "Primary Specialty" with a 95.4% rate, "Zip Code" with a 93.9% rate, and "PCP, Specialist, or Both" with a 92.8% rate.
- There was an average of 1.83 revisions per provider for the 206 providers that submitted surveys with changes.
- The "Street Address" element had an accuracy rate of 89.5%. The "Phone Number" element had an accuracy rate of 86.6%, although more than half the revisions coincided with a change in address. The accuracy rate for "PCP Open or Closed Panel" was 91.3%.
- The "License Number" field was reported correctly in 85.4% of records among the 383 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 81.6%. At least one language was added by 82 providers.
- A comparison of the statewide rates of overall accuracy, between the last audit conducted in April 2015 and the current audit, revealed an increase from 49.1% to 54.8%, although the difference was not statistically significant.

One data element, "Provider Type" increased, while none of the data elements decreased significantly in accuracy over time.

Pharmacy Program Reviews

Pharmacy Program Reviews are a Kentucky-specific task included in IPRO's contract. IPRO conducts reviews of the MCO quarterly reports related to pharmaceutical services. The focus of the reviews is non-preferred drug list medications, prior authorizations, and denials. IPRO analyzes the data in the reports for each MCO and provides written reports including MCO-specific findings and recommendations. The findings are shared with the MCOs.

Individual Case Review

Individual case review is an optional EQR activity. IPRO conducts individual case reviews when a potential quality of care concern is identified during the conduct of EQR tasks or when DMS identifies a general concern.

The Kentucky Department for Medicaid Services (DMS) identified a concern related to coordination of care for DCBS foster children enrolled in one of the Medicaid managed care organizations (MCOs). DMS was concerned that the MCO does not adequately coordinate care and participate in discharge planning for children with inpatient behavioral health admissions. Additionally, there was concern related to "decertification" or concurrent denials for continued inpatient stay at behavioral health facilities. This is of particular concern for these foster children who have chronic behavioral health conditions and who may be difficult to place. DMS requested that IPRO conduct a review of selected cases of foster children enrolled in the MCO with an inpatient behavioral health admission.

Overall findings that can be generalized to most or all of the cases include the following:

- UM processes were appropriately followed.
- UM decisions were supported with appropriate rationale.
- UM decisions and communication were timely.
- Although the UM decisions were well-supported, the decisions appeared to have been made in a vacuum, without acknowledgement that there might not have been an alternative placement available for the member.
- Facility quality of care issues were identified, confirmed, and addressed by the MCO.
- There was lack of care management/care coordination, with no MCO assessments or care plans (or copies of the DCBS assessments and care plans) and members were not always followed or monitored on a routine/ongoing basis.
- There was no evidence of linkages to internal MCO services or external resources by the MCO.
- The MCO care management documentation was primarily related to UM activities.
- Although DCBS had primary responsibility for care management, there was minimal evidence of attempts to coordinate with DCBS, obtain information on the members' status and, in most cases, limited participation in discharge planning or none.

There was lack of continuity of care. Specifically, the MCO did not ensure post-discharge follow-up care or continue to monitor the member/attempt to obtain updates on the member's status after UM issues were resolved, the continued stay was denied, and/or the member was discharged.

MCO Responses to Prior Recommendations

Federal EQR regulations for EQR results and detailed technical reports at 42 CFR §438.364 require that the EQR include, in each annual report, an assessment of the degree to which each health plan has addressed the recommendations for quality improvement made in the prior EQR Technical Report. Table 55 through Table 59 provide the MCOs' responses to the recommendations issued in the Kentucky 2015 Technical Report, including an initial plan of action, how the plan was implemented, the outcome and monitoring and future actions planned. The following MCO responses have been included in the report exactly as submitted by the MCO without any revisions.

Table 55: Anthem Blue Cross and Blue Shield Response to Recommendations Issued in 2015 Technical Report

IPRO Recommendation	MCO Response
In the domain of quality, IPRO recommends that Anthem Blue Cross and Blue Shield Medicaid: · Address areas of less than full compliance for all review domains, particularly those with a large number of elements requiring corrective action.	
The Contractor's QI activities shall demonstrate the linkage of QI projects to findings from multiple quality evaluations, such as the EQR annual evaluation, opportunities for improvement identified from the annual HEDIS indicators and the consumer and provider surveys, internal surveillance and monitoring, as well as any findings identified by an accreditation body. <u>Recommendation for Anthem</u> Anthem should ensure that the MCO conducts and documents analysis of available data; presentation to and review of QI activities to by the Kentucky health MCO committees; development and implementation of interventions for improvement and re-evaluation to assess for improvement. This analysis of available data should not be delayed awaiting a second year of data to be reported.	Initial Plan of Action – QMC Schedule is set and in process with the first meeting being held 3/31/16 When and how was this accomplished? QMC schedule set and meetings began 3/31/16 Outcome and Monitoring – Future Actions/Plans – The QMC calendar of reports and documents to be reviewed at the quarterly meetings has been created and Accepted.

IPRO Recommendation	MCO Response
The QAPI program shall be developed in collaboration with input from Members. Recommendation for Anthem Anthem should continue efforts to recruit MCO members to participate in the QMAC, ensure that QMAC meetings are held as required, ensure that the QMAC fulfills required functions per the contract and the committee description, and ensure that relevant components of the QAPI program are developed with consideration of member input.	Initial Plan of Action – · A new written member invitation was drafted for 2016 and submitted for approval (approved by DMS). · Submitted and approved by DMS, the invitation is sent to 100 random members within the region identified for the QMAC meeting. · Members who are still enrolled with Anthem and previously filed a grievance of any type receive a personal invitation. · Any advocates or community leaders who attended meetings in 2015 receive an invitation for the corresponding region meeting scheduled in 2016. · Our Community Relations staff continues to send fliers to member advocates within the regions and encourage those advocates to invite members. · Meetings will be held Jan - Mar: region 6, region 5 Apr - Jun: region 8, region 3 Jul - Sep: region 1, region 7 Oct - Dec: region 4, region 2 When and how was this accomplished? 2 QMAC meetings have been conducted in 2016 March 23, 2016 – Region 6 - Edgewood, Kentucky March 30, 2016 - Region 5 - Lexington, KY Outcome and Monitoring – Multiple members were in attendance at the March 30th Lexington meeting Future Actions/Plans – Continue to follow the above plan of action with the scheduled meetings within the regions.
The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members. Recommendation for Anthem Anthem should ensure that	Initial Plan of Action – · A new written member invitation was drafted for 2016 and submitted for approval (approved by DMS). · Submitted and approved by DMS, the invitation is sent to 100 random members within the region identified for the QMAC meeting. · Members who are still enrolled with Anthem and previously filed a grievance of any type receive a personal invitation. · Any advocates or community leaders who attended meetings in 2015 receive an invitation for the corresponding region meeting scheduled in 2016. · Our Community Relations staff continue to send fliers to member advocates within the regions and encourage

IPRO Recommendation	MCO Response
recruitment of members for the QMAC is conducted as planned and that the committee fulfills its required functions.	those advocates to invite members. · Meetings will be held Jan - Mar: region 6, region 5 Apr - Jun: region 8, region 3 Jul - Sep: region 1, region 7 Oct - Dec: region 4, region 2 When and how was this accomplished? 2 QMAC meetings have been conducted in 2016 March 23, 2016 – Region 6 - Edgewood, Kentucky March 30, 2016 - Region 5 - Lexington, KY Outcome and Monitoring – Multiple members were in attendance at the March 30th Lexington meeting Future Actions/Plans – Continue to follow the above plan of action with the scheduled meetings within the regions.
The Contractor shall collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care. <u>Recommendation for Anthem</u> Anthem should identify and implement strategies to evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care.	Initial Plan of Action – Anthem will identify and assess all members identified on the CI3 with a diagnosis of pancreatitis for depression and Substance Use Disorder with the intent to integrate behavioral health care into the care plan. When and how was this accomplished? Case Management will assess using the PHQ-9 and the Substance Abuse Screener. When a member is identified with the diagnosis of pancreatitis, BH CM will outreach and attempt to compete the assessments. If they are indicative of depression and/or SUD, the BH CM will work with the member to secure needed care, improve member's self care and reduce hospitalizations. Outcome and Monitoring – Members will be monitored for 1. Admission and re-admission 2. Improvement in depression 3. Improvement in substance use. Future Actions/Plans – The members who agree to CM will be followed for six months and prior to case closure, the CM will re-assess for improvement in the areas noted above.
The Contractor shall provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.	Initial Plan of Action – Plan Sr. leadership has conducted numerous meetings with enterprise reporting regarding the need for additional quality checks with regards to datasets associated with reports. All datasets will be saved at the time the report is produced to insure validation is and can be completed. When and how was this accomplished?

IPRO Recommendation	MCO Response
<u>Recommendation for Anthem</u> Anthem should ensure that data systems can be reliably queried to identify member and other data for external and internal quality improvement reviews and initiatives.	Q4 2015 – datasets are saved in enterprise reporting files associated with reports. Outcome and Monitoring – Validation has been conducted on reports 27 and 28 (Grievances and Appeals) with favorable results. Future Actions/Plans – Continue validation of reports produced by enterprise reporting at the time of receipt.
B. Inform the Contractor's Quality Improvement Committee of the final findings and involve the committee in the development, implementation and monitoring of the corrective action plan; <u>Recommendation for Anthem</u> Anthem should inform QM and QIC committees of EQR findings as planned, and engage quality committees in strategies to address findings.	Initial Plan of Action – QMC Schedule is set and in process with the first meeting being held 3/31/16 When and how was this accomplished? QMC schedule set and meetings began 3/31/16 Outcome and Monitoring – Future Actions/Plans – The QMC calendar of reports and documents to be reviewed at the quarterly meetings has been created and Accepted. EQRO findings and updates will be reviewed quarterly.
D. The Contractor shall demonstrate how the results of the External Quality Review (EQR) are incorporated into the Contractor's overall Quality Improvement Plan and demonstrate progressive and measurable improvement during the term of this contract; and <u>Recommendation for Anthem</u> Anthem should ensure that the results of the External Quality Review (EQR) are incorporated into the QAPI program and improvement demonstrated.	Initial Plan of Action – QMC Schedule is set and in process with the first meeting being held 3/31/16 When and how was this accomplished? QMC schedule set and meetings began 3/31/16 Outcome and Monitoring – Future Actions/Plans – The QMC calendar of reports and documents to be reviewed at the quarterly meetings has been created and Accepted.

IPRO Recommendation	MCO Response
The Contractor is accountable to the Department for the quality of care provided to Members. The Contractor's responsibilities of this include, at a minimum: approval of the overall QAPI program and annual QAPI work plan; <u>Recommendation for Anthem</u> Since the Quality Program impacts multiple departments in the MCO, it is essential that the local MCO QM Committee members approve the Work Plan for which they are responsible. Improvement interventions and progress are not documented in the Work Plan.	Initial Plan of Action – QMC Schedule is set and in process with the first meeting being held 3/31/16 When and how was this accomplished? QMC schedule set and meetings began 3/31/16 in which the work plan was reviewed and approved. Outcome and Monitoring – Future Actions/Plans – The QMC calendar of reports and documents to be reviewed at the quarterly meetings has been created and Accepted. The Work plan will be reviewed quarterly with updates.
designation of an accountable entity within the organization to provide direct oversight of QAPI; <u>Recommendation for Anthem</u> The MCO should ensure that the QMC meets regularly as described in the QM Program Description (PD) to ensure ongoing evaluation of the quality of care provided to members. There was no documented detailed discussion of the MCO's QM Program Description or QAPI Work Plan and quality of care provided to members in the QIC minutes, although documents were approved by the QIC.	Initial Plan of Action – QMC Schedule is set and in process with the first meeting being held 3/31/16 When and how was this accomplished? QMC schedule set and meetings began 3/31/16 Outcome and Monitoring – Future Actions/Plans – The QMC calendar of reports and documents to be reviewed at the quarterly meetings has been created and Accepted.
review of written reports from the designated entity on a periodic	Initial Plan of Action –

IPRO Recommendation	MCO Response
basis, which shall include a description of QAPI activities, progress on objectives, and improvements made; <u>Recommendation for Anthem</u> The MCO should ensure regular, ongoing QMC meetings in order to provide sufficient oversight of the Quality Management Program and activities, including a review of progress on quality management objectives and improvements.	QMC Schedule is set and in process with the first meeting being held 3/31/16 When and how was this accomplished? QMC schedule set and meetings began 3/31/16 Outcome and Monitoring – Future Actions/Plans – The QMC calendar of reports and documents to be reviewed at the quarterly meetings has been created and Accepted. Updates and progress within the work plan will be reviewed quarterly and submitted to DMS.
review on an annual basis of the QAPI program; and <u>Recommendation for Anthem</u> The MCO should ensure regular, ongoing QMC meetings in order to provide sufficient oversight of the Quality Management Program and activities, including a review of progress on quality management objectives and improvements.	Initial Plan of Action – QMC Schedule is set and in process with the first meeting being held 3/31/16 When and how was this accomplished? QMC schedule set and meetings began 3/31/16 Outcome and Monitoring – Future Actions/Plans – The QMC calendar of reports and documents to be reviewed at the quarterly meetings has been created and Accepted. Updates and progress within the work plan will be reviewed quarterly and submitted to DMS.
modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization. <u>Recommendation for Anthem</u> The MCO should ensure regular, ongoing QMC meetings in order to provide sufficient oversight of the Quality Management Program and activities, including a review of progress on quality	Initial Plan of Action – QMC Schedule is set and in process with the first meeting being held 3/31/16 When and how was this accomplished? QMC schedule set and meetings began 3/31/16 Outcome and Monitoring – Future Actions/Plans – The QMC calendar of reports and documents to be reviewed at the quarterly meetings has been created and Accepted. Updates and progress within the work plan will be reviewed quarterly and submitted to DMS. Grievance and Appeals reports will be reviewed and trends discussed.

IPRO Recommendation	MCO Response
management objectives and improvements. This should include modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization, such as trends identified, sentinel events, etc.	
The Contractor shall have in place an organizational Quality Improvement Committee that shall be responsible for all aspects of the QAPI program. <u>Recommendation for Anthem</u> The MCO should ensure regular, ongoing QMC meetings in order to provide sufficient oversight of the Quality Management Program and activities, including a review of progress on quality management objectives and improvements. This should include modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization, such as trends identified, sentinel events, etc.	Initial Plan of Action – QMC Schedule is set and in process with the first meeting being held 3/31/16 When and how was this accomplished? QMC schedule set and meetings began 3/31/16 Outcome and Monitoring – Future Actions/Plans – The QMC calendar of reports and documents to be reviewed at the quarterly meetings has been created and Accepted. Updates and progress within the work plan will be reviewed quarterly and submitted to DMS. Grievance and Appeals reports will be reviewed and trends discussed.
The committee structure shall be interdisciplinary and be made up of both providers and administrative staff. It should include a variety of medical disciplines, health professions and individual(s) with specialized knowledge and experience with Individuals with Special Health Care Needs.	Initial Plan of Action – QMC Schedule is set and in process with the first meeting being held 3/31/16 Members of the QMC include: Celia Manlove — Plan President, Chair Dr. Peter Thurman — Plan Medical Director, Co-Chair David Crowley — Plan Behavioral Health Manager Kim Grifasi — Plan Quality Management Director Vicki Meska — Plan Medical Management Director Jennifer Ecleberry — Plan Provider Solutions Director

IPRO Recommendation	MCO Response
<u>Recommendation for Anthem</u> Anthem should ensure inclusion of participating providers of various medical disciplines relevant to the MCO membership as well as representatives of participating facilities and those with expertise with ISHCN in committee structure. The MCO should ensure that the QMC meets regularly and its QMC membership represents a multidisciplinary team.	Rhonda Petr — Plan Marketing and Outreach Director Jeremy Randall — Plan Operations Director Dr Bill Wood — Regional BH Medical Director The MAC committee is comprised of providers of various medical disciplines and reports up to the QMC. When and how was this accomplished? QMC schedule set and meetings began 3/31/16 Outcome and Monitoring – quarterly meetings Future Actions/Plans – The QMC calendar of reports and documents to be reviewed at the quarterly meetings has been created and Accepted. Updates and progress within the work plan will be reviewed quarterly and submitted to DMS. Grievance and Appeals reports will be reviewed and trends discussed.
The committee shall meet on a regular basis and activities of the committee must be documented; all committee minutes and reports shall be available to the Department upon request. <u>Recommendation for Anthem</u> The MCO should ensure regular, ongoing QMC meetings in order to provide sufficient oversight of the Quality Management Program and activities, including a review of progress on quality management objectives and improvements. This should include modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization, such as trends identified, sentinel events, etc.	Initial Plan of Action – QMC Schedule is set and in process with the first meeting being held 3/31/16 When and how was this accomplished? QMC schedule set and meetings began 3/31/16 Outcome and Monitoring – Future Actions/Plans – The QMC calendar of reports and documents to be reviewed at the quarterly meetings has been created and Accepted. Updates and progress within the work plan will be reviewed quarterly and submitted to DMS. Grievance and Appeals reports will be reviewed and trends discussed.

IPRO Recommendation	MCO Response
The Contractor shall integrate other management activities such as Utilization Management, Risk Management, Member Services, Grievances and Appeals, Provider Credentialing, and Provider Services in its QAPI program. <u>Recommendation for Anthem</u> The MCO should ensure regular, ongoing QMC meetings in order to implement the integration of multiple department activities across the MCO into the QAPI Program as described in MCO documents.	Initial Plan of Action – QMC Schedule is set and in process with the first meeting being held 3/31/16 When and how was this accomplished? QMC schedule set and meetings began 3/31/16 Outcome and Monitoring – Future Actions/Plans – The QMC calendar of reports and documents to be reviewed at the quarterly meetings has been created and Accepted. Updates and progress within the work plan will be reviewed quarterly and submitted to DMS. Grievance and Appeals reports will be reviewed and trends discussed.
Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee. <u>Recommendation for Anthem</u> Anthem should ensure that monitoring of providers for compliance with guidelines is implemented in 2016. Monitoring of compliance with guidelines in an area that has been identified as an opportunity for improvement should be considered.	Initial Plan of Action Development of an initiative to increase the percentage of members with a diabetes diagnosis obtaining a retinal eye exam. When and how was this accomplished? 1. Anthem-directed provider outreach efforts are continuous and ongoing and consists of provider mailings, provider newsletters, on-site visits, and chart audits to verify data. 2. There is also collaboration with the vision vendor (Eye quest) to conduct outreach to members to educate them on the importance of a retinal eye exam. Outcome and Monitoring – 1. The goal is to produce a favorable outcome for members by identifying potential effects of diabetes on their eyes, and encourage continuous routine care for the member's eye health. 2. Monthly, quarterly and annual claims review identifying members who obtained a retinal eye exam. 3. Supplemental data collected through medical record collection. Future Actions/Plans – Potential interventions to develop to help increase awareness of the need for a retinal eye exam: 1. Member incentives for completion of an eye exam visit (Ex: I love your eyes campaign). 2. Focused provider education pertaining to evidence-based diabetes care.

IPRO Recommendation	MCO Response
	3. Identification and resolution of barriers resulting in member's seeking vision care services. a. Lack of transportation b. Lack of knowledge of need for eye care c. Assessment of provider network to ensure adequate access, based on regional analysis.
The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues. <u>Recommendation for Anthem</u> The MCO should ensure regular, ongoing QMC meetings in order to implement the integration of multiple department activities across the MCO into the QAPI Program as described in MCO documents. The MCO should ensure that multidisciplinary teams evaluate and address Kentucky-specific data and systems issues. Anthem should ensure that meeting minutes show evidence of ongoing analysis, monitoring and surveillance of available data to identify opportunities for improvement, performing barrier analysis, and addressing findings and developing interventions.	Initial Plan of Action – QMC Schedule is set and in process with the first meeting being held 3/31/16 When and how was this accomplished? QMC schedule set and meetings began 3/31/16 Outcome and Monitoring – Future Actions/Plans – The QMC calendar of reports and documents to be reviewed at the quarterly meetings has been created and Accepted. Updates and progress within the work plan will be reviewed quarterly and submitted to DMS. Grievance and Appeals reports will be reviewed and trends discussed.
Mental Health and Substance Abuse practice guidelines shall be submitted to the Department and DBHDID. <u>Recommendation for Anthem</u> The MCO should submit Mental Health and Substance Abuse practice guidelines to the	Initial Plan of Action – BH CPGs are forwarded to DMS (specifically Corey Kennedy and Stephanie Bates). Stephanie Bates has confirmed on 4/14/16 via email to regulatory that she will be responsible for forwarding the CPGs to DBHDID. When and how was this accomplished? Outcome and Monitoring – Will keep tracking record of submission of BH CPGs to DMS

IPRO Recommendation	MCO Response
Department and DBHDID as per guidelines.	Future Actions/Plans –
Decisions with respect to UM, member education, covered services, and other areas to which the practice guidelines apply shall be consistent with the guidelines. <u>Recommendation for Anthem</u> Anthem should ensure that Kentucky- specific requirements are added to the Policy and Procedure, Development of Marketing and Member Communications.	Initial Plan of Action – Kentucky specific requirement language has been added to the policy Development of Marketing and management Communications and submitted for review. Once approved, this will be forwarded to DMS. When and how was this accomplished? Will be approved 2016 Q2 Outcome and Monitoring – Future Actions/Plans –
The Contractor shall implement steps targeted at health improvement for selected performance measures, in either the actual outcomes or processes used to affect those outcomes. Once performance goals are met, select measures may be retired and new measures, based on CMS guidelines and/or developed collaboratively with the Contractor, may be implemented, if either federal or state priorities change; findings and/or recommendations from the EQRO; or identification of quality concerns; or findings related to calculation and implementation of the measures require amended or different performance measures, the parties agree to amend the previously identified measures. <u>Recommendation for Anthem</u>	Initial Plan of Action – Anthem will identify measures with low quality scores once rates are available in 2016. From that analysis improvement strategies will be put in place. When and how was this accomplished? Outcome and Monitoring – Monthly trending reports will monitor rates of all selected measures. Future Actions/Plans – Annual HEDIS rate trending reports will monitor the success of the interventions.

IPRO Recommendation	MCO Response
Anthem should identify measures with opportunity for improvement when results are available in 2016, and implement strategies for improvement to ensure progress toward goals.	
The Contractor shall establish and maintain an ongoing Quality and Member Access Committee (QMAC) composed of Members, individuals from consumer advocacy groups or the community who represent the interests of the Member population. <u>Recommendation for Anthem</u> Anthem should continue recruitment efforts to ensure member representation on QMAC. QMAC meeting should be held quarterly as intended as per QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC.	Initial Plan of Action – · A new written member invitation was drafted for 2016 and submitted for approval (approved by DMS). · Submitted and approved by DMS, the invitation is sent to 100 random members within the region identified for the QMAC meeting. · Members who are still enrolled with Anthem and previously filed a grievance of any type receive a personal invitation. · Any advocates or community leaders who attended meetings in 2015 receive an invitation for the corresponding region meeting scheduled in 2016. · Our Community Relations staff continues to send fliers to member advocates within the regions and encourage those advocates to invite members. · Meetings will be held Jan - Mar: region 6, region 5 Apr - Jun: region 8, region 3 Jul - Sep: region 1, region 7 Oct - Dec: region 4, region 2 When and how was this accomplished? 2 QMAC meetings have been conducted in 2016 March 23, 2016 – Region 6 - Edgewood, Kentucky March 30, 2016 - Region 5 - Lexington, KY Outcome and Monitoring – Multiple members were in attendance at the March 30th Lexington meeting Future Actions/Plans – Continue to follow the above plan of action with the scheduled meetings within the regions.
Members of the Committee shall be consistent with the composition of the Member population, including such factors as aid category, gender, geographic distribution, parents,	Initial Plan of Action – · A new written member invitation was drafted for 2016 and submitted for approval (approved by DMS). · Submitted and approved by DMS, the invitation is sent to 100 random members within the region identified for the QMAC meeting. · Members who are still enrolled with Anthem and previously filed a grievance of any type receive a personal invitation.

IPRO Recommendation	MCO Response
as well as adult members and representation of racial and ethnic minority groups. Member participation may be excused by the Department upon a showing by Contractor of good faith efforts to obtain Member participation. Responsibilities of the Committee shall include: <u>Recommendation for Anthem</u> Anthem should continue its efforts to recruit MCO members to participate in the QMAC. If MCO members are recruited, an updated list of QMAC members should be submitted to DMS. As noted in the contract, Member participation may be excused by the Department upon a showing by Contractor of good faith efforts to obtain Member participation. Anthem should document recruitment efforts to engage Members in the QMAC.	· Any advocates or community leaders who attended meetings in 2015 receive an invitation for the corresponding region meeting scheduled in 2016. · Our Community Relations staff continues to send fliers to member advocates within the regions and encourage those advocates to invite members. · Meetings will be held Jan - Mar: region 6, region 5 Apr - Jun: region 8, region 3 Jul - Sep: region 1, region 7 Oct - Dec: region 4, region 2 Quarterly reporting of the QMAC attendance list will be submitted to DMS When and how was this accomplished? 2 QMAC meetings have been conducted in 2016 March 23, 2016 – Region 6 - Edgewood, Kentucky March 30, 2016 - Region 5 - Lexington, KY Outcome and Monitoring – Multiple members were in attendance at the March 30th Lexington meeting Future Actions/Plans – Continue to follow the above plan of action with the scheduled meetings within the regions.
The Contractor shall conduct an annual survey of Members' and Providers' satisfaction with the quality of services provided and their degree of access to services. The member satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children, administered	Initial Plan of Action – Annual Provider Satisfaction Surveys are conducted. When and how was this accomplished? 2015 Provider Survey Initial Mailing 9/29/15 Follow-up mailing 10/20/15 Follow-up phone calls 11/10-20/15 Results received January 2016 from vendor, DSS Research; reported to DMS 3/30/16 2016 Provider Survey The 2016 provider satisfaction survey will be conducted during the timeframe of July 21, 2016 – September 12, 2016. The survey tool will be filed with DMS for approval and the survey results will be shared with DMS upon availability.

IPRO Recommendation	MCO Response
by an NCQA certified survey vendor. <u>Recommendation for Anthem</u> The MCO should ensure that Provider satisfaction surveys are conducted annually.	Outcome and Monitoring – A workgroup has been created a recurring meetings scheduled to review outcomes and create action items for improvements. Future Actions/Plans – Continue annual surveys with submission of the tool to DMS prior to the survey and the result once received.
To meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approval the Contractor's provider satisfaction survey tool. <u>Recommendation for Anthem</u> Anthem should ensure submission of provider satisfaction survey instruments to DMS.	Initial Plan of Action – Annual Provider Satisfaction Surveys are conducted. When and how was this accomplished? 2015 Provider Survey Initial Mailing 9/29/15 Follow-up mailing 10/20/15 Follow-up phone calls 11/10-20/15 Results received January 2016 from vendor, DSS Research; reported to DMS 3/30/16 2016 Provider Survey The 2016 provider satisfaction survey will be conducted during the timeframe of July 21, 2016 – September 12, 2016. The survey tool will be filed with DMS for approval and the survey results will be shared with DMS upon availability. Outcome and Monitoring – Future Actions/Plans – Continue annual surveys with submission of the tool to DMS prior to the survey and the result once received.
In the domain of access to/timeliness of care, IPRO recommends that Anthem Blue Cross and Blue Shield Medicaid: Address areas of less than full compliance for all review domains, particularly for Health Risk Assessment, which scored minimal compliance and the domains with the largest number of elements requiring corrective action.	
C. In addition to the above, the Contractor shall include in its network Specialists designated by the Department in no fewer number than 25% of the Specialists enrolled in the Department's Fee-for-Service program by Medicaid region; and include sufficient pediatric	Initial Plan of Action: The Access and Availability policy is to be revised to include the requirement of the enrollment of at least 25% of specialists enrolled in DMS's Fee For Service program by region. The Geo Access report parameters are to be revised to include all participating specialties. When and how was this accomplished?:

IPRO Recommendation	MCO Response
specialists to meet the needs of Members younger than 21 years of age. Access to Specialists shall not exceed 60 miles or 60 minutes. In the event there are less than 5 qualified Specialists in a particular Medicaid region, the 25% shall not apply to that Medicaid region. <u>Recommendation for Anthem</u> The draft Policy and Procedure Access and Availability-KY addressing this requirement should be finalized and implemented. In addition, Anthem should provide evidence of monitoring compliance with this requirement. The revised report parameters for the quarterly Geo Access reports should be implemented to include all participating specialties.	The Access and Availability Policy has been revised to address the requirement and is currently in the finalization process. It will be submitted to DMS. The Geo Access report programming is currently being revised to include all participating specialties and will be complete by second Quarter 2016. Outcome and Monitoring: A new report is in development to monitor the requirement to enroll at least 25% of the specialists in the DMS Fee for Service program. It will be in production during the second Quarter of 2016. Future Actions/Plans: The monitoring report will allow us to determine the specialties where we are falling short of the 25% requirement and we will actively work to recruit providers of those specialties. The annual report due in 2016 will include all participating specialties.
I. In addition to any Community Mental Health Center or Local Health Department which the Contractor has in its network, the Contractor shall include in its network Mental Health and Substance Abuse providers for both adults and children in no fewer number than fifty (50%) percent of the Mental Health and Substance Abuse providers enrolled in the Medicaid program by Medicaid Region to provide	Initial Plan of Action: Non-Emergent Visits Anthem will develop a policy outlining the process for member outreach and education on alternatives to the Emergency Room. When and how was this accomplished?: We have worked with DMS on obtaining clarification on the requirement to offer sufficient alternate sites for 24 hour care and appropriate incentives to members to reduce unnecessary Emergency Room visits. The policy for member outreach and education has been drafted and is in the internal approval process. It will be submitted to DMS. Outcome and Monitoring: DMS has clarified that Telehealth does not meet this requirement. In Kentucky, there are no 24 hour urgent care centers. We continue to work with DMS on other available alternatives.

IPRO Recommendation	MCO Response
out-patient, intensive out-patient, substance abuse residential, case management, mobile crisis, residential crisis stabilization, assertive community treatment and peer support services. In the event there are less than five (5) qualified Mental Health and Substance Abuse providers for both adults and children in a particular Medicaid Region, the fifty (50%) percent shall not apply to that Medicaid Region. <u>Recommendation for Anthem</u> The draft Policy and Procedure Access and Availability-KY should be finalized and implemented. In addition, Anthem should provide evidence of monitoring J. The Department shall notify the Contractor and all other MCOs on contract with the Department when more than five (5%) percent of Emergency Room visits in a Medicaid Region, in a rolling three (3) month period, are determined to be a non-emergent visit. The Contractor shall provide sufficient alternate sites for twenty-four (24) hour care and appropriate incentives to Members to reduce unnecessary Emergency Room visits so that the determination of non-emergent visits are reduced to no more than two (2%) percent in a rolling three (3) month period for that Medicaid Region. The	DMS has not yet begun providing the reports to the MCOs that show when non-emergent visits are reduced to no more than 2% in a rolling 3 month period. Future Actions/Plans: The policy for member outreach and education is pending internal approval and will be submitted to DMS, as noted above.

IPRO Recommendation	MCO Response
Contractor and all other MCOs shall provide such alternate sites or incentives based upon the number of their respective members in the Medicaid Region. <u>Recommendation for Anthem</u> Anthem should develop a policy and procedure detailing the MCO's process for addressing non-emergent visits.	
The Contractor shall have programs and processes in place to address the preventive and chronic physical and behavioral healthcare needs of its population. The Contractor shall implement processes to assess, monitor, and evaluate services to all subpopulations, including but not limited to, the on-going special conditions that require a course of treatment or regular care monitoring, Medicaid eligibility category, type of disability or chronic conditions, race, ethnicity, gender and age. <u>Recommendation for Anthem</u> The MCO should ensure that members in need of a PCP or assistance with other issues, such as substance use, as per HRA responses are identified and assisted. The procedure for identifying members with these needs, including needs indicated on mailed-in HRAs, should be included in policies and	Initial Plan of Action: • The Health Risk Assessment (HRA) policy is approved and has been implemented. The finalized policy including all IPRO suggestions was submitted to DMS in February 2016 with our corrective action response to the 2015 audit. • The Health Risk Assessment (HRA) policy addresses the HRA timeframes, which are outreach within the first week of receipt by the Plan of the 834 Enrollment File, with the mailing of a paper HRA that the member is instructed to complete and return in the pre-paid mailer. As each HRA is returned to the Plan, it is entered into the Case Management System. Within 30 days after enrollment, a file is created of all new enrollees without an HRA in the system; the file goes to an external vendor who then proceeds to make IVR calls to the members. If a pregnant member is identified by the enrollment file, the same process occurs. In addition, if a member is identified by the enrollment file, on the HRA, via claim review or personal notification as pregnant, then our maternal outreach vendor begins outreach with a much more detailed prenatal High Risk OB screener. Depending upon the member's answers regarding prenatal history, current conditions or issues with this pregnancy, the member is automatically sent to either an "Urgent" or "High" OB queue; from that queue the OB Case Manager makes contact attempts within 24 hours (Urgent) or 48 hours (High). This process has been implemented. • The HRA policy addresses member outreach for HRA completion and the process has been implemented. Date of Implementation: 7/1/2015 When and how was this accomplished: • The policy was updated with the recommendations and approved in July 2015. It was submitted to DMS as noted above. · The policy includes language that is specific regarding timeframes for notifying the member of the need to complete an HRA (Member Welcome Packet) and mailing the HRA to each new member, as well as the initiation of the IVR member contact to complete the HRA. • A revised HRA will offer assistance to members in making the first PCP appointment. • Currently the Member Handbook, provided to all newly enrolled members, does state that the member may call Member Services for help in making an initial PCP appointment. Outcome and Monitoring: The HRA has been revised to reflect the language: "A question on the HRA asks if the member would like assistance with

IPRO Recommendation	MCO Response
procedures. The Contractor shall conduct initial health screening assessments including mental health and substance use disorders screenings, of new Members who have not been enrolled in the prior twelve (12) month period, for the purpose of assessing the Member's needs within ninety (90) days of Enrollment. If the Contractor has a reasonable belief a Member is pregnant, the Member shall be screened within thirty (30) days of Enrollment, and if pregnant, referred for appropriate prenatal care. <u>Recommendation for Anthem</u> The MCO should ensure timely outreach (prior to 90 days) to facilitate timely HRA completion. To identify barriers to timely completion of HRAs, it would be helpful to document outreach timeframes for completed HRAs to evaluate whether earlier outreach results in more timely completion. Similarly, tracking of refusals would allow for better evaluation of completion rates to inform improvement initiatives. The Contractor agrees to make all reasonable efforts to contact new Members in person, by telephone, or by mail to have	making their initial appointment with their PCP." All members will be offered assistance to make an initial appointment with their PCP by means of the revised HRA, regardless of the means by which it is completed. The HRA policy was updated and submitted to the Policy and Procedures Committee on 3/18/2016. Once approved, it will be submitted to DMS. Future Actions/Plans: A revised HRA is in development. It has been approved by DMS, and is targeted to go into production by 7/1/16. The new HRA will have more focused referrals to either Physical Health or Behavioral Health Case Management queues, based upon a point system related to how the member answers questions. The first question asks female members if they are pregnant, as this is a help in identifying members who are pregnant and should complete the High Risk OB Screener. It also asks questions regarding recent hospitalizations or ER visits, and asks members if they have Special Healthcare Needs. It focuses on Behavioral Health(BH) questions as well, such as depression, BH diagnoses and Substance Use Disorder. Each answer has a point value that when completed can determine if the member will be queued to Case Management, and at what level, High or Low. Finally, this revised Assessment has added the following: 17. May we help you make an appointment with your primary care provider (PCP)? Name and contact number of PCP: If the answer is Yes, this will automatically trigger a referral to the Case Management system queue to assist.

IPRO Recommendation	MCO Response
Members complete the initial health screening questionnaire which includes the survey instrument for both substance use and mental health disorders. <u>Recommendation for Anthem</u> Anthem should ensure timely outreach to members to facilitate timely completion of HRAs. Anthem should ensure that substance use problems identified by HRAs are assessed and addressed as needed. Information to be collected shall include demographic information, current health and behavioral health status to determine the Member's need for care management, disease management, behavioral health services and/ or any other health or community services. <u>Recommendation for Anthem</u> Anthem should ensure that issues identified in submitted HRAs are addressed or further assessed. The MCO should ensure that there is a mechanism to document referral to or contact by case management so that appropriate follow up is ensured. Members shall be offered assistance in arranging an initial visit to their PCP for a baseline medical assessment and other	

IPRO Recommendation	MCO Response
preventive services, including an assessment or screening of the Members potential risk, if any, for specific diseases or conditions, including substance use and mental health disorders. <u>Recommendation for Anthem</u> The MCO should ensure mechanisms to identify members that are not accessing PCPs, either because they do not have an identified PCP or do not work well with assigned PCP. Members indicating an issue with their PCP on the HRA, regardless of how the HRA is submitted, should have follow up for their concerns.	

Table 56: CoventryCares of Kentucky Response to Recommendations Issued in 2015 Technical Report

IPRO Recommendation	MCO Response
In the domain of quality, IPRO recommends that CoventryCares of Kentucky: · Address all compliance domains and elements that were found less than fully compliant, with a particular focus on areas with minimal and non-compliance designations and all elements requiring corrective action; · work to improve the rates for HEDIS measures which fell below the NCQA national averages and the HK PM rates that fell below the statewide aggregate rate, particularly those that have ranked below average for more than one reporting period; · evaluate the root causes and initiate improvement strategies for the declines in member satisfaction with network providers and the health plan, as demonstrated by current performance on the Adult and Child CAHPS 5.0; · consider working with DMS and the other Kentucky Medicaid MCOs to examine the reasons for providers' low rates for board-certification to determine if	Initial Plan of Action – § Compliance – Review all elements that did not receive a full compliance rating, address with each responsible department § HEDIS - Create tip sheets for providers for both behavioral and physical health noting suggested ICD-9 & ICD-10 codes per HEDIS measure technical specifications to aid in administrative hits. Tip sheets also provided and emphasize anchor dates such as a child's 2 year birthday being the final day they could be compliant for a specific immunization, PPC postpartum visits having to be 21-56 days after the birth, etc.; Begin regular calls with corporate HEDIS leadership to review current and future processes of HEDIS measures for our HEDIS project overall, outreach to membership, available assets from corporate in regarding technical and outreach resource availability, etc.; Increase reminder calls to members for routine visits in the non-HEDIS season; Hire a Prevention and Wellness Coordinator to assist in training all departments but with a main focus on Case Management and Member Services. Trainings will include HEDIS measures and specifications as well as best practice advice in positive member encounters. § CAHPS - Begin monthly calls with corporate HEDIS leadership, as well as other plans in similar regions, to review current and future processes based on improvements of CAHPS reports; Move Member Services on-site here in Kentucky vs. being outsourced in Houston; Implemented a Service Review Committee that addresses areas of member satisfaction; Compare grievance and appeals reports against our CAHPS ratings to review for any correlations of issues; Hire a Prevention and Wellness Coordinator to assist in training all departments but with a main focus on Case Management and Member Services who deal with membership directly. § Provider Low Rates- Will work with DMS to determine whether providers within our provider network have board certifications that were not disclosed to us during their initial credentialing as well as ask if this is specific to our MCO vs. others in the state. § PIPs - We received a CAP for both the ED and AMM PIPs, which were the first two PIPs of our plan. Initial plan was to work with DMS/IPRO in providing reports on action plans for improvement as well as monthly calls to discuss each PIP in detail to gain a greater understanding on issues of formatting our PIPs up to and including better uses of resources for greater impacts for our membership. When and how was this accomplished? § Compliance - A clear and solid plan has been developed to address weaknesses that have been identified in the Quality Management Access Committee (QMAC) delivery. Specific and intentional recruitment of QMAC Committee Members began in March 2016. Roles and responsibilities; as well as the one year time commitment, have been clearly defined and will be reviewed at each meeting. To make attendance consistent, and therefore more effective, Aetna Better Health of Kentucky will utilize WebEx or Conference Call technology to enable members to attend at least 3 meetings remotely and one required meeting physically in a 12 month timeframe. Agenda items have been identified and included in a template that will be used at each meeting. These include but are not limited to: Definition of QMAC, Roles and Responsibilities, QI Program Description, Work Plan, evaluation or points of interest to members and committee members, grievance and appeals process, Community Outreach functions, Local programming, Review of Member Handbook, Discussion and Committee feedback and

IPRO Recommendation	MCO Response
this issue is specific to CoventryCares of Kentucky or is a regional/statewide norm; and · implement corrective actions to improve the methodological soundness and success of each of the current PIPs.	other member materials. Four QMAC meetings per year will be held across the Commonwealth. Regions will be paired geographically § HEDIS – Tip sheets were completed in the 3rd Quarter 2015, submitted for review, and revised in the 4th Quarter to include the corresponding ICD-10 codes which were activated on October 1st and sent out to providers via fax blast. Also included was a postpartum spreadsheet which allows quick review of a baby's birth date to determine the 21-56 day window necessary for a compliant postpartum visit; Weekly calls with corporate HEDIS leadership in the 3rd Quarter and continue to the present, although less frequently due to the time requirements of the HEDIS project. Advice provided on outreach to membership as well as preparation for the HEDIS project began with the first call; Increased outreach to members began in the 2nd Quarter after the HEDIS season had completed. Non-compliant members were generated monthly in targeted measures that needed improvement; Our Prevention and Wellness Coordinator was hired in the 2nd Quarter and additional trainings to staff began in the 3rd Quarter on topics such as a full HEDIS overview with a focus on how their department directly impacts HEDIS, diabetes, heart disease, motivational interviewing of members, etc. § CAHPS – Monthly calls began in the 3rd Quarter with a focus on the barriers that we face with members that could affect scoring from member service issues like first call resolutions, outstanding and friendly customer service, showing empathy on the phone in difficult situations up to reviewing what benefits/incentives that we provide our members; The hiring process for on-site Member Services began in the 2nd Quarter and they were up and running in the 4th Quarter; the Service Review Committee was implemented in the 1st quarter 2016 and membership contains health plan leadership with representation from all departments and will allow for a venue to continuously compare grievance and appeals reports against our CAHPS ratings to review for any correlations of issues; Our Prevention and Wellness Coordinator was hired in the 2nd Quarter and additional trainings to staff began in the 3rd Quarter on topics such as motivational interviewing of members, positive interactions, empathetic but direct assistance, etc. § PIPs – The scoring sheets and CAP details were provided by IPRO/DMS in the early spring and action plans, reports and monthly calls were completed through the early summer. Outcome and Monitoring – § Compliance – Quarterly meetings have been established to review compliance in all elements where we did not receive a full compliance rating. § HEDIS – Outreach numbers increased last year over previous years and the Prevention and Wellness trainings have been very well received. Currently the HEDIS project is still ongoing with 2015 results being available mid-June. Things that were proposed and later approved on the corporate HEDIS calls include 7 new incentives for members for receiving corresponding HEDIS treatments to reviewing our vision benefits to potentially include eye glasses (still under review) to increase visits to the eye doctor and DRE's for diabetics § CAHPS – Currently awaiting results which will be available summer 2016, but per internal data call answer timeliness is down and 1st call issue resolution was trending up since bringing Member Services on location here in Kentucky. § PIPs – The lessons learned from the CAP in reviewing the scoring sheets, formatting and getting the additional feedback from IPRO/DMS were invaluable. When the CAP responsibilities had completed, our focus turned to

IPRO Recommendation	MCO Response
	improving, and in some cases re-working, our PIPs to provide a better product on all 8 reports due last fall. Some of our main improvements were in the flow of information throughout the PIP, ensuring information from section to section were in line with one another as well as having a greater understanding of what is truly being requested in each section. With the lessons learned in 2015, no CAPs were required on our PIPs for 2016, although we acknowledge there is still much work to be done to get them up to the standards that we all expect. Future Actions/Plans – § Compliance – Continue to work with IPRO/DMS and in interdepartmental workgroups to ensure improvements in compliance in all elements. § HEDIS – Continue regular corporate calls, evaluating outreach methods to membership and trainings for all departments that could possibly affect the HEDIS measures and rates. § CAHPS – Continue regular calls with corporate to analyze and improve methods and customer service to membership § Provider Low Rates- Outreach to DMS to identify whether this MCO's provider network has the same amount of board certified providers as other MCOs throughout the commonwealth. § PIPs - – Now that our PIPs have been "cleaned up", our focus is on analyzing and improving the quality of our data, our interventions, process measures, assessment of barriers, etc. We believe that our collaborative relationships have improved with IPRO/DMS as well as interdepartmentally within the plan over the past few years and look to continue this progress as we proceed with our current and future PIPs.
In the domain of access to/timeliness of care, IPRO recommends that CoventryCares of Kentucky: · address all compliance domains and elements that were found less than fully compliant, with a particular focus on areas with minimal and non-compliance designations and all elements requiring corrective action, particularly Health Risk Assessment; · work to improve the rates for HEDIS measures which fell below the NCQA national averages and HK	Initial Plan of Action – § Health Risk Assessment - CM dept to add demographic questions to the HRQ that is sent to members § HEDIS – Create tip sheets for providers for both behavioral and physical health noting suggested ICD-9 & ICD-10 codes per HEDIS measure technical specifications to aid in administrative hits. Tip sheets also provided and emphasize anchor dates such as a child's 2 year birthday being the final day they could be compliant for a specific immunization, PPC postpartum visits having to be 21-56 days after the birth, etc.; Begin regular calls with corporate HEDIS leadership to review current and future processes of HEDIS measures for our HEDIS project overall, outreach to membership, available assets from corporate in regarding technical and outreach resource availability, etc.; Increase reminder calls to members for routine visits in the non-HEDIS season; Hire a Prevention and Wellness Coordinator to assist in training all departments but with a main focus on Case Management and Member Services. Trainings will include HEDIS measures and specifications as well as best practice advice in positive member encounters. § PIPs – We received a CAP for both the ED and AMM PIPs, which were the first two PIPs of our plan. Initial plan was to work with DMS/IPRO in providing reports on action plans for improvement as well as monthly calls to discuss each PIP in detail to gain a greater understanding on issues of formatting our PIPs up to and including better uses of resources for greater impacts for our membership for greater access/timeliness of care; Increase collaboration between Quality and Case Management for HEDIS specification and the importance of travel assistance and timeliness of care. Provide Case Managers tip sheets and PPC date spreadsheet. When and how was this accomplished? –

IPRO Recommendation	MCO Response
PM rates that fell below the statewide aggregate rate, particularly those that have ranked below average for more than one reporting period or declined from the prior reporting period and focusing on HEDIS measures for well-care visits for children and adolescents; and · implement corrective actions to improve the methodological soundness and success of each of the current PIPs.	§ Health Risk Assessment - CM added demographic questions to the HRQs given to members. CM began utilizing the updated HRQ on 2/1/2016. § HEDIS – Tip sheets were completed in the 3rd Quarter 2015, submitted for review, and revised in the 4th Quarter to include the corresponding ICD-10 codes which were activated on October 1st; Weekly calls with corporate HEDIS leadership in the 3rd Quarter and continue to the present, although less frequently due to the time requirements of the HEDIS project. Advice provided on outreach to membership as well as preparation for the HEDIS project began with the first call; Increased outreach to members began in the 2nd Quarter after the HEDIS season had completed. Non-compliant members were generated monthly in targeted measures that needed improvement; Our Prevention and Wellness Coordinator was hired in the 2nd Quarter and additional trainings to staff began in the 3rd Quarter on topics such as a full HEDIS overview with a focus on how their department directly impacts HEDIS, diabetes, heart disease, motivational interviewing of members, etc. § PIPs – The scoring sheets and CAP details were provided by IPRO/DMS in the early spring and action plans, reports and monthly calls were completed through the early summer; Tip sheets and trainings were provided to Case Management and other departments that work with members directly during the 4th Quarter to stress the importance of receiving routine exams on topics such as diabetes, what qualifies as a "compliant" visit including date ranges that are necessary. Outcome and Monitoring – § Health Risk Assessment - All members who were unable to be reached by phone are mailed an HRQ with a cover letter § HEDIS – Outreach numbers increased last year over previous years and the Prevention and Wellness trainings have been very well received. Currently the HEDIS project is still ongoing with 2015 results being available mid-June. § PIPs – The lessons learned from the CAP in reviewing the scoring sheets, formatting and getting the additional feedback from IPRO/DMS were invaluable. When the CAP responsibilities had completed, our focus turned to improving, and in some cases re-working, our PIPs to provide a better product on all 8 reports due last fall. Some of our main improvements were in the flow of information throughout the PIP, ensuring information from section to section were in line with one another as well as having a greater understanding of what is truly being requested in each section. With the lessons learned in 2015, no CAPs were required on our PIPs for 2016, although we acknowledge there is still much work to be done to get them up to the standards that we all expect; Results are yet to be available, but feedback from Case Managers and other staff has been positive in their understanding of the HEDIS project/rates, our PIPs and their roles. Future Actions/Plans – § Health Risk Assessment - To continue using the updated HRQ with the demographic information and mail a HRQ and cover letter to members who were unable to be reached. § HEDIS – Continue regular corporate calls, evaluating outreach methods to membership and trainings for all departments that could possibly affect the HEDIS measures and rates. § PIPs – Now that our PIPs have been "cleaned up", our focus is on analyzing and improving the quality of our data,

IPRO Recommendation	MCO Response
	our interventions, process measures, assessment of barriers, etc. We believe that our collaborative relationships have improved with IPRO/DMS as well as interdepartmentally within the plan over the past few years and look to continue this progress as we proceed with our current and future PIPs; Continue to assess barriers, training topics and possible improvements in interdepartmental collaborations.

Table 57: Humana-CareSource Response to Recommendations Issued in 2015 Technical Report

IPRO Recommendation	MCO Response
In the domain of quality, IPRO recommends that Humana-CareSource: · address any areas of less than full compliance with special attention to elements that require corrective action;	Initial Plan of Action – Substantial compliance was noted in the areas of: · Inform and involve the QI Committee in the development, implementation, and monitoring of the corrective action plans. *Response*: Humana-CareSource presented the overall findings of the annual compliance review to the QI Committee for input and monitoring. · Implement steps targeted at health improvement for selected performance measures. *Response:* Analysis of results and interventions for HK performance measures were included in the 2015 QI Work Plan and quarterly updates. · For all reportable effectiveness of care and access/availability of care measures, the contractor shall stratify each measure by eligibility category, race, ethnicity, gender and age. *Response:* Humana-CareSource included the results of the data stratification, analysis and planned actions in the 2015 QI Evaluation. · Humana-CareSource should include the commitment to development of best practices in its QI Program Description. *Response:* Humana-CareSource included the commitment to development of best practices in its 2015 QI program Description. · All survey results must be reported to the department and upon request disclosed to members. *Response:* Humana-CareSource has added the information that survey results will be disclosed to members upon request in the 2015 QI Program Description. When and how was this accomplished? See Responses above Outcome and Monitoring – These items will be included in the listed documents in future version. Future Actions/Plans – These items will be included in the listed documents in future version. Initial Plan of Action – Minimal compliance was noted for: · "Review of member education materials prepared by the Contractor, other than the Member Handbook, was not found in the QMAC meeting minutes. Response: Humana-CareSource added review of member education materials to the QMAC meetings. When and how was this accomplished? – At the QMAC meeting held on 6/23/15 the New Member Guide (KY-MMED-935) was reviewed with attendees and feedback requested. Going forward, all functions outlined in the QMAC Charter will be addressed at the QMAC throughout the year and documented in the QMAC minutes.

IPRO Recommendation	MCO Response
	Additionally, a new QI policy (Development of Member Educational Material consistent with Clinical Guidelines) has been developed that includes review by the QMAC committee. Outcome and Monitoring – Review of member educational material was added to the agenda for QMAC meetings. Future Actions/Plans – Continue to monitor QMAC meetings for inclusion and review of member educational material. Initial Plan of Action – Minimal compliance was noted for: · "Responsibilities of the QMAC Committee shall include providing review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data." Response: Humana - CareSource added the review and comment on the Grievance and Appeals process to the QMAC meetings. This requirement was also added to the 2016 committee charter. When and how was this accomplished? During the QMAC meeting held on 3/24/15, the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data were reviewed. During the QMAC meeting held on 6/23/15, the committee approved the revised QMAC charter which increased the QMAC meeting schedule to four meetings per year with a minimum of three required. This was done to allow ample meeting time to address all of the functions outlined in the charter at least once per year. Outcome and Monitoring – Annually the Grievance and Appeals process and review of aggregate Grievance and Appeals data occurs. Future Actions/Plans – Continue to monitor QMAC meetings for inclusion of the Grievance and Appeals process and review of aggregate Grievance and Appeals data.
· Work to improve rates for HEDIS measures that were below the NCQA national averages, with particular attention on metrics for preventive and screening and care for diabetes;	Initial Plan of Action – A comprehensive HEDIS improvement plan was put into place and activities related to improving these rates were outlined and included in the QI work plan. When and how was this accomplished? Beginning in 1st quarter 2015 specific interventions around preventive screenings and diabetes care were developed. These included: · Development of the Clinical Practice Registry (CPR) for use by providers. The registry allows providers to see gaps in care for their members related to preventive screenings and other HEDIS measures. The display is color coded in Red = overdue, Yellow = due soon, and Green = compliant, for each member on the provider's panel. Provider Relations trains providers on access to the portal and the CPR. · In June 2015 a certified Diabetes educator was hired to provide care management for high risk diabetes

IPRO Recommendation	MCO Response
· Based on the CAHPS 5.0 survey results, conduct a root-cause analysis to determine the reasons for lack of member satisfaction with network providers and the MCO and initiate interventions directed toward improvement; and	members. This RN provides care management services, diabetes education, assistance with appointments and other types of assistance the member may need. · In September 2015 a Performance Improvement Project was proposed and approved later in the year by KDMS/IPRO with the aim of reducing the percentage of members with HbA1c >9. The PIP began 1st quarter 2016 with the first pilot including 4 providers: 1 single practitioner and 1 group practice in a rural setting and the same in an urban setting. · An EPSDT Program Manager was hired third quarter to provide program development and oversight of the EPSDT Program. This includes well child measures, dental and lead screenings. · An Eliza interactive call campaign for members delinquent in well child care and diabetes screenings was initiated in second quarter 2015. · During fourth quarter 2015, members with multiple care gaps were identified and outreached to by disease and care managers. · Birthday cards with needed preventive measures are sent to adult men and women, and adolescents, in their birth month. Dental postcard reminders are sent to members twice a year and preventive care reminders are included in member newsletters. Outcome and Monitoring – A monthly HEDIS dashboard report was created to measure progress towards member action to obtain preventive care. From HEDIS MY 2013 to 2014, improvement was noted in 6 of the 7 diabetes measures. For preventive and screening measures HEDIS MY 2013 to 2014, improvement was noted in all WCC measures, childhood immunizations Combo 3 and lead screening. A decline was noted in 2 of the 3 adolescent immunization measures. Future Actions/Plans – Two quality improvement coordinators and two quality improvement specialist were recently added to the Quality Department. These staff will be used to develop and execute additional intervention. Initial Plan of Action – A comprehensive CAHPS improvement plan was put into place and activities related to improving these rates were outlined and included in the QI work plan. When and how was this accomplished? A multidisciplinary team was formed in second quarter 2015 to review the 2015 CAHPS results and the following interventions were planned: · Make on-line Health Risk Assessment available. (Completed 4th quarter 2015) · Workgroup reviewing 'Find a Doc' tool functionality for enhancements and improvement (In-progress) · Workgroup considering changes to web-site to improve ease of navigation (In-progress) · Provider engagement representatives to conduct outreach to providers to discuss access and availability issues. (On-going) · Secret Shopper Survey conducted to identify issue related to access and availability. (4th quarter 2015) · Implement Phase II of Member IVR. Phase 2 will add two new member self-service functions: changing address

IPRO Recommendation	MCO Response
· Initiate interventions directed at improving the HK measure rates for Prenatal Screening/Counseling.	and requesting ID card replacements (In-progress) Outcome and Monitoring – Improvement was noted in 8 of 9 composite results for adult s from CAHPS 2014 to 2015. Improvement was noted in 5 of 9 composite results for Child CAHPS 2014 to 2015. Future Actions/Plans – A condensed survey is being sent to members in Fall 2016 to measure member satisfaction, this will be done annually to allow HCS to be proactive with any negative trends in satisfaction prior to the annual CAHPS survey in the spring. A team is analyzing member complaints and grievances to identify opportunities to improve member satisfaction. Initial Plan of Action – The Quality Improvement Department met to discuss the HK (State Specific Measures) measures and to develop plans/intervention to increase the rates. Activities related to improving these rates were outlined and included in the QI work plan. Medical record review for compliance with Clinical Practice Guidelines for Postpartum depression screening and family planning was completed in the Fall of 2015. When and how was this accomplished? – A perinatal case manager was hired 3rd quarter 2014 to begin development of a perinatal program. A perinatal program utilizing perinatal case managers was developed in 2nd qtr. 2015. The annual medical record review for compliance with CPG's included 2 measures for postpartum care: 1) family Planning education, and 2) screening for postpartum depression. Outcome and Monitoring – For HK measures for prenatal Screening/Counseling, improvement was noted in all measures from MY 2014 to 2015. Future Actions/Plans – Educate provider who were non-compliant with medical record review requirements. Medical record review will be repeated Fall 2016 for measurement of improvement.
In the domain of access to/timeliness of care, IPRO recommends that Humana-CareSource: · address any areas of less than full compliance with special attention to elements that require corrective action;	Initial Plan of Action – Substantial compliance was noted in the areas of: · Appointments for counseling and medical services shall be available as soon as possible within a maximum of 30-days. *Response:* Humana-CareSource has initiated the process for revising the most current member handbook to include the appointment time frames for counseling and medical services. The revised 2015 Provider Manual will be provided at the annual compliance review. Policy NO-32 was approved at the P&P committee in January 2016. · The network shall include mental health and substance abuse providers for both adults and children in no fewer number than 50% of the mental health and substance abuser providers enrolled in the Medicaid Program … *Response:* Policy NO-27 which included the updated language was approved by the P&P Committee in December 2015. When and how was this accomplished? See Responses above

IPRO Recommendation	MCO Response
· Work to improve rates for HEDIS and HK measures that were below the NCQA national averages or the statewide aggregate rate, with particular attention on metrics for children and adolescent's access to PCPs and well-care visits for both the general member population and CSHCNs; and	Outcome and Monitoring – These items will be included in the listed documents in future version. Future Actions/Plans – These items will be included in the listed documents in future version. Initial Plan of Action – Minimal compliance was noted in the area of: · Access. Regulatory language pertaining to counseling and medical services was found to be missing from the documentation. Response: An update to the family planning section of the 2015 member handbook was initiated for approval. An update to the 2015 provider manual was also initiated. This language will also be included in the future 2016 Member Handbook and Provider Manual. When and how was this accomplished? – Updates to Member Handbook and Provider Manual for 2015 were initiated for approval, and inclusion of language in the 2016 updated manuals. Outcome and Monitoring – Handbook review process will include these requirements each review cycle. Future Actions/Plans – This language will be included in the 2016 Member Handbook and Provider Manual. Initial Plan of Action – The Quality Improvement Department met to discuss the HEDIS and HK (State Specific Measures) measures and to develop plans/intervention to increase the rates. Activities related to improving access to PCPs and well-care visit rates were outlined and included in the QI work plan. When and how was this accomplished? – · Development of the Clinical Practice Registry (CPR) for use by providers. The registry allows providers to see gaps in care for their members related to preventive screenings and other HEDIS measures. The display is color coded in Red = overdue, Yellow = due soon, and Green = compliant, for each member on the provider's panel. Provider Relations trains providers on access to the portal and the CPR. · An EPSDT Program Manager was hired 3rd quarter to provide program development and oversight of the EPSDT Program. This includes well child measures, dental and lead screenings. · An Eliza interactive call campaign for members delinquent in well child care was initiated in 2nd quarter 2015. · Geoaccess mapping occurs quarterly to determine if there are any noted gaps in member access. Outcome and Monitoring – The following activities are utilized to monitor rates: · Geoaccess monitoring is performed quarterly. · A monthly HEDIS dashboard report was created to measure progress towards member action to obtain preventive care. Future Actions/Plans – · Exploring telemedicine as a member option to improve access.

IPRO Recommendation	MCO Response
· Move ahead with the PIP focused on improving rates for HEDIS Postpartum Visits.	· Exploring options for Value-Based Reimbursement that will improve access to care. · Exploring member incentives that will encourage members to seek preventive care. Initial Plan of Action – Proposed PIP was submitted September 2014 and approved by Kentucky Department of Medicaid. When and how was this accomplished? – Activities associated with the Postpartum PIP were initiated during 1st quarter 2015. The following actions were initiated: · Member newsletter article two times annually on prenatal and/or postpartum care. · Perinatal case managers review the Health Risk Assessment to identify barriers to care and specific needs of the pregnant member to decrease any barriers related to postpartum care. · Redesigned Babies First Program implemented 3rd quarter 2015. Program was redesigned to a claims based debit card process. Education was provided to members regarding this change via the member web site, member newsletters and the member handbook. Outcome and Monitoring – Activities to monitor postpartum outcomes include: · A monthly HEDIS dashboard report was created to measure progress towards members getting their postpartum care. Future Actions/Plans – · Develop targeted member material specific to preconception and interconception care. · Develop targeted mailing material specific to the adolescent member, to address the unique needs of this population.

Table 58: Passport Health Plan Response to Recommendations Issued in 2015 Technical Report

IPRO Recommendation	MCO Response
In the domain of quality, IPRO recommends that Passport Health Plan: · address areas requiring corrective action in the compliance domain, Quality Measurement and Improvement; (1) · focus efforts on rates for HEDIS measures that perform below the NCQA national average, especially those that ranked below average for more than one (1) reporting period; (2) · conduct barrier analyses and implement strategies to improve member satisfaction for adults; and (3) · review and implement the EQRO recommendations for each of the PIPs, particularly those related to indicators for the asthma and psychotropic drugs PIPs, where the plan was not able to report baseline rates. (4)	Initial Plan of Action – (1) Areas requiring corrective action When and how was this accomplished? Outcome and Monitoring – Future Actions/Plans – Initial Plan of Action – (2) HEDIS measures below national averages Passport Health Plan routinely monitors our HEDIS scores during the measurement period in order to identify areas that appear to lag below performance targets and evaluate whether alternative strategies to improve performance should be considered and/or implemented. Based on HEDIS 2015 final rates the following measures fall below the NCQA Medicaid Quality Compass 50th percentile: · Cervical Cancer screening · Breast Cancer screening · Appropriate Treatment of Children with URI * · Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis * · Asthma Medication Management 75% · Controlling Hypertension · Diabetes- HbA1c control, eye exams, nephropathy · Anti-Rheumatic Therapy for Patient with Rheumatoid Arthritis · Adherence to Antipsychotic medication · Diabetes Monitoring for People with Diabetes and Schizophrenia * · Initiation & Engagement of Alcohol and Drug Dependence Treatment * *means below the 50th for two measurement periods When and how was this accomplished? Passport Health Plan currently utilizes several strategies to develop and evaluate interventions across the company to improve HEDIS measures including but not limited to : · Multidisciplinary HEDIS workgroup · Call Effectiveness reporting · Interim HEDIS reports · Care Gap reporting · HEDIS Team meetings to deep dive into individual measures · QI workplan · Quality medical and behavioral committee recommendations and feedback

IPRO Recommendation	MCO Response
	· HEDIS strategy and planning sessions · Monthly Clinical Focus · Pharmacy Consultant outreach Outcome and Monitoring – Passport Health Plan utilizes our HEDIS certified software (Inovalon HEDIS Advantage) to produce monthly interim reports in order to evaluate progress of all HEDIS measures. Future Actions/Plans – The analysis of our HEDIS results is an ongoing process that includes the following either in the planning or implementation stage: · Expansion of the Embedded Case Management program to increase face to face member interventions and collaborative care planning · Business Intelligence/analytic capabilities · Provider collaborations/pilot projects to facilitate collaborative care planning · Member engagement/value added benefits · Biannual HEDIS strategic planning · Benchmarking against both mid-year and annual Quality Compass rates · Provider Recognition Program · Provider Cap adjustments · Patient Center Medical Home Projects · Provider Recoupment related to inappropriate antibiotic prescribing * · Direct telephonic outreach to members with both diabetes and schizophrenia to assist in scheduling diabetes recommended testing * · Adding additional resources via the website for drug and alcohol dependence resources in order to allow members ease in finding providers anonymously * · Develop collaborative projects with behavioral health vendor * * specific projects for those that have been below the 50th percentile for more than two measurements periods Initial Plan of Action – (3) CAHPS survey- Adults Passport Health Plan analyzes the results of both the child and adult member surveys in order to constantly improve member satisfaction When and how was this accomplished? While formal member satisfaction is measured once a year during the CAHPS process, Passport Health Plan utilizes intermittent member surveys of programs and of our customer service in order to provide timely feedback and

IPRO Recommendation	MCO Response
	opportunities for improvement. Outcome and Monitoring – Passport Health Plan utilizes detailed reporting from our accredited vendor, Morpace, to evaluate trends and areas for potential improvement. Rates and trends are shared with the multi-disciplinary CAHPS workgroups as well as QI committees requesting feedback and recommendations. Future Actions/Plans – Interventions are still in the development stage to improve member satisfaction for implementation in the last 6 months of the year, in order to have the most impact. Initial Plan of Action – (4) PIPs Passport Health Plan recognizes the need for continued growth and development in relation performance improvement projects. Passport Health Plan continues to participate in the IPRO/DMS and PIP LC Technical Assistance meetings. In addition to participation in the meetings, Passport Health Plan has completed the suggested readings and mock PIP project assignments. When and how was this accomplished? – The mock PIP project and assignment meetings are ongoing. Passport Health Plan has begun work on the physical health PIP proposal for 2016 utilizing the education and feedback given during the mock pilot meetings. Outcome and Monitoring – The Quality Department has several techniques to monitor and evaluate each of the PIPs including: · Bimonthly meetings with QI and the Project leader · Quarterly summary reports for each active PIP · QI workplan · Quality medical and behavioral committee recommendations and feedback Future Actions/Plans – Passport Health Plan continues to focus efforts on improving both our processes and analytics of our active PIPs as well as our 2016 PIP proposals including: · Expansion of the QI team including staff with strong analytical experience · Increased internal collaboration during the development and evaluation stage of each PIP · Increased frequency of reporting regarding interventions and goals · Increased Provider feedback during Quality committees · Continued self-study of best practices · Identification of available resource talent within Passport Health Plan
Review and implement In the	Initial Plan of Action – (1) Not fully compliant

IPRO Recommendation	MCO Response
domain of access to/timeliness of care, IPRO recommends that Passport Health Plan: · address all areas that were not fully compliant, focusing on elements requiring corrective action in the compliance domains EPSDT, Care Management, and Behavioral Health Services and continue to work towards increasing the rates of HRA completion; (1) · continue working to improve rates for HEDIS measures that perform below the NCQA national average; and (2) · although the PIP, "Reduction of Emergency Room Care Rates" is completed, since ED utilization is an ongoing challenge, it would be beneficial to conduct a barrier analysis, evaluate the intervention strategy and add new interventions or modify existing interventions. (3)	EPSDT- Passport Health Plan corrected the Periodicity schedule link immediately following the onsite visit. All regions have been included in the EPSDT chart audits and audits are under way at this time. Care Management- Passport Health Plan corrected the policy 10.1 as per IPRO recommendations. Passport Health Plan approved the CC 4.05 immediately following the onsite visit. Behavioral Health- Passport Health Plan has updated the policy UM 62.27 to reflect the contract requirement of 100% of calls are answered and do not receive a busy signal. Policies have been updated to reflect the receipt and routing of emergency calls. HRA- Passport Health Plan made the suggested corrections to policy CC 2.0 to clarify the attempts of HRA completion for new members. Passport Health Plan participated in the request for information regarding development of a MCO HRA and offered assistance in development, if needed. When and how was this accomplished? EPSDT- EPSDT chart audits are being conducted at this time in all Regions Care Management- N/A Behavioral Health-Passport Health Plan monitors the member telephone lines in order to verify compliance with 80% of the calls are answered within 30 seconds HRA- Passport Health Plan tracks both new members, outreach attempts, successful completion via an excel spreadsheet Outcome and Monitoring – EPSDT- Monthly tracking of audit results are reviewed by the QI department and quarterly with QI committees Care Management- N/A Behavioral Health-Monthly reports of call timeliness HRA- Passport Health Plan continues to monitor HRA outreach attempts and completion rates on a monthly basis. Future Actions/Plans- EPSDT- The EPSDT program is continuing to evaluate all program options available to combine all of the aspects of EPSDT outreach Investigate additional opportunities to increase home visit outreach in collaboration with departments of health Care Management- Passport Health Plan is investigating and evaluating program options available to make ease of tracking and reporting more efficient regarding Foster Care/Guardianship members Behavioral Health-Passport Health Plan continues to monitor the call timeliness reports and will issue a corrective action, if needed, with the vendor HRA- Passport Health Plan continues to evaluate program options to make reporting of the HRA process more robust Initial Plan of Action – (2) HEDIS below national averages In our analysis of HEDIS 2015 final rates in the domain of Access/Availability of Care, Passport Health Plan performs well based on QC. There are two overall measures where improvement in warranted: · Call Answer Timeliness · Initiation & Engagement of Alcohol and Drug Dependence Treatment When and how was this accomplished? Passport Health Plan currently utilizes several strategies to develop and evaluate interventions across the company to improve HEDIS measures including but not limited to :

IPRO Recommendation	MCO Response
	· Multidisciplinary HEDIS workgroup · Call Effectiveness reporting · Interim HEDIS reports · Care Gap reporting · HEDIS Team meetings to deep dive into individual measures · QI workplan · Quality medical and behavioral committee recommendations and feedback · HEDIS strategy and planning sessions · Monthly Clinical Focus Outcome and Monitoring – Passport Health Plan utilizes our HEDIS certified software (Inovalon HEDIS Advantage) to produce monthly interim reports in order to evaluate progress of all HEDIS measures. Call Timeliness is monitored daily by both our Member and Provider service departments. Future Actions/Plans The analysis of our HEDIS results is an ongoing process that includes the following either in the planning or implementation stage: · Provider collaborations/pilot projects to facilitate collaborative care planning · Member engagement/value added benefits · Biannual HEDIS strategic planning · Benchmarking against both mid-year and annual Quality Compass rates · Provider Recognition Program · Provider Cap adjustments · Patient Center Medical Home Projects · Integrated Care Projects Initial Plan of Action – (3) Reduction of ER Usage Based upon the high utilization of the emergency room for non-urgent / avoidable diagnosis, Passport Health Plan developed several initiatives including: · E.R. Navigators at High Volume Facilities: Passport Health Plan associates physically located in hospitals conduct interviews, identify barriers to care, educate and discharge plan for members who are more at risk for adverse outcomes, frequent ER utilizers and are using the ER for non-emergent, non-urgent or avoidable conditions · E.R. Coordinators: Upon receipt of a daily utilization report from facilities, Passport Health Plan members are contacted telephonically to inquire as to why the ER was used, educate them on available resources, inform them of the Lock-in program · ER Lock-In When and how was this accomplished? –

IPRO Recommendation	MCO Response
	These 3 programs have impacted over 3,500 members. In 2014 alone, the ER Navigators intervened in approximately 700 member visits, of which 46% are Expansion members. For members where the ER Navigator intervened, there was a subsequent decrease in ER visits by 71% post intervention. Passport Health Plan ER Coordinators spoke to 946 members in 2014. Outcome and Monitoring – Ongoing analysis of data to identify trend in ER utilization occurs monthly, quarterly and on an annual basis including year over year trends. Data analysis of the Emergency Room include: · Utilization rates (total claims paid, visits and dollars PMPM) by Category of Aid · Analysis of top facilities · Analysis of barriers to care (i.e. miles from PCP vs. ER) · Urgent vs. non urgent diagnosis · High utilizers · Member analysis at the PCP level · Claims analysis by age – region and COA Future Actions/Plans – Passport Health Plan continues to evaluate additional interventions aimed at reduction of ER such as: · Expansion of ER programs outside of Region 3 · Expansion of ER Navigators hours during weekend and nights · Hardin County Chronic Care project · ULP Chronic Care project

Table 59: WellCare of Kentucky Response to Recommendations Issued in 2015 Technical Report

IPRO Recommendation	MCO Response
In the domain of quality, IPRO recommends that WellCare of Kentucky: · Continue to work on improving rates for HEDIS and HK measures related to preventive and screening services;	Initial Plan of Action – WellCare of Kentucky has multiple ongoing interventions aimed at improving performance on all HEDIS and Healthy Kentuckians measures, including those related to preventive and screening services. These interventions include one-on-one case management, disease management, distribution of provider care gap reports, targeted phone calls and mailings to members identified as needing HEDIS services, provider visits, and a member incentive program for diabetic eye exams. Additionally, WellCare of Kentucky's Quality Improvement department includes 9 regional Clinical HEDIS Practice Advisor (CHPA) positions, which were added in 2014. The CHPAs' primary responsibility is the improvement of HEDIS rates as they work individually with providers to improve HEDIS and Healthy Kentuckians rates. In addition, WellCare of Kentucky implemented a Pay for Performance program in 2015. At the completion of each HEDIS season, the QI team analyzes HEDIS and Healthy Kentuckians outcomes for root cause analysis, identification of barriers, and development of interventions for implementation. When and how was this accomplished? - Throughout 2015 CHPAs worked with provider offices to educate providers and staff about HEDIS requirements, appropriate medical record documentation and the use of Electronic Medical Record (EMR) systems to capture all data needed to demonstrate HEDIS compliance, and claims coding for services rendered during member visits using HEDIS -accepted codes. CHPAs distributed HEDIS toolkits to providers during onsite provider visits to educate providers on HEDIS and Healthy Kentuckians measure specifications. In July 2015, following the receipt of final HEDIS results for measurement year 2014, WellCare of Kentucky performed a detailed analysis of NCQA Accreditation measures falling below or just meeting the 50th percentile to identify barriers and potential interventions targeted at specific measures. During 2015, WellCare of Kentucky continued distributing care gap reports to PCPs to notify them of members on their panel in need of screenings; in addition, in 2015 WellCare of Kentucky began distributing OB/GYN care gap reports to OB/GYNs to specifically target female members with care gaps for cervical cancer screening, breast cancer screening, and chlamydia screening. WellCare of Kentucky also had a Pay for Performance program in 2015 that targeted the following HEDIS measures: Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Adolescent Well Visits; Childhood Immunization Status – Combo 2 and Combo 10; Comprehensive Diabetes Care – HbA1c Testing and HbA1c <9%; and Chlamydia Screening. WellCare of Kentucky also continued to alert provider offices of members in need of preventive services when office staff checked member eligibility through WellCare of Kentucky's secure provider portal. WellCare of Kentucky also continued to alert customer service representatives when members who called in to the MCO were in need of preventive services so customer service can assist with making appointments. During 2015, WellCare of Kentucky also began offering car seat safety checks and provided childhood immunization educational materials at those events. Interventions aimed at better data collection included the collection of medical records and lab results for eligible members and the entering of results of medical record abstraction into a pseudoclaims database so this information could be used for HEDIS 2016. WellCare of Kentucky also launched a member incentive program for diabetic eye exams in 2015 that provided a $10 gift card to members who received an eye exam for diabetic retinopathy. Outcome and Monitoring – WellCare of Kentucky monitors HEDIS rates monthly to identify areas in need of greater intervention. WellCare of Kentucky anticipates that HEDIS 2016 rates will show an improvement over HEDIS 2015. HEDIS rates for WellCare of Kentucky and for individual providers are monitored on a monthly basis. Providers are also distributed their individual HEDIS rates and care gap reports monthly so they can track their progress and open

IPRO Recommendation	MCO Response
	opportunities. Additionally, the CHPAs are assessed against performance goals for their work and outcomes with individual provider groups. Member and provider interventions aimed at improving HEDIS measure performance are included in the QI Work Plan, which is updated quarterly. Member and provider interventions are also reported to the MCO's quality committees. Future Actions/Plans – Following receipt of final HEDIS 2016 rates, WellCare of Kentucky will conduct an analysis of HEDIS 2015 data to identify barriers and potential interventions. Based on this analysis, WellCare of Kentucky will continue interventions already in place and/or develop new member and provider interventions as needed. WellCare of Kentucky will continue to work individually with providers to improve HEDIS rates. Additionally, in 2016 WellCare of Kentucky has added two new positions to the QI Department for HEDIS Care Gap Coordinators, whose responsibilities will include directly outreaching members with care gaps to provide education and assistance with making appointments; these positions will be located within the Kentucky market. Additionally, in 2016 WellCare of Kentucky has launched a new member incentive program, the Healthy Rewards Program, which provides a reloadable debit card and incentives ranging from $10 to $60 in value for the completion of the following preventive visits and screenings: Well Child Visits 0-15 Months, Well Child Visits 3-6 Years, Adolescent Well Care Visit, Prenatal Care Visits (6 or more), Postpartum Care Visit (diaper incentive), Diabetes Eye Exam, Diabetes HbA1c Test, Cervical Cancer Screening, Mammogram, Annual Adult Health Screening, and Preventive Dental Visit.
· take action to increase risk screening and counseling for adolescents and pregnant women;	Initial Plan of Action – WellCare of Kentucky has multiple ongoing interventions aimed at improving performance on all HEDIS and Healthy Kentuckians measures, including those related to preventive and screening services for adolescents and pregnant women. These interventions include one-on-one case management, disease management, distribution of provider care gap reports, targeted phone calls and mailings to members identified as needing HEDIS services, and provider visits. Additionally, WellCare of Kentucky's Quality Improvement department includes 9 regional Clinical HEDIS Practice Advisor (CHPA) positions, which were added in 2014. The CHPAs' primary responsibility is the improvement of HEDIS rates as they work individually with providers to improve HEDIS and Healthy Kentuckians rates. In addition, WellCare of Kentucky implemented a Pay for Performance program in 2015. At the completion of each HEDIS season, the QI team analyzes HEDIS and Healthy Kentuckians outcomes for root cause analysis, identification of barriers, and development of interventions for implementation. When and how was this accomplished? - Throughout 2015 CHPAs worked with provider offices to educate providers and staff about HEDIS requirements, appropriate medical record documentation and the use of Electronic Medical Record (EMR) systems to capture all data needed to demonstrate HEDIS compliance, and claims coding for services rendered during member visits using HEDIS -accepted codes. CHPAs distributed HEDIS toolkits to providers during onsite provider visits to educate providers on HEDIS and Healthy Kentuckians measure specifications, including the risk screening and counseling requirements for adolescents and pregnant women. Providers are educated that adolescents should be screened and/or counseled for substance use, tobacco use, sexual activity, and depression. Providers are educated that pregnant women should be screened and/or counseled for tobacco use, alcohol use, substance use, prescription/over the counter medication use, nutrition, prenatal and postpartum depression, and domestic violence. In July 2015, following the receipt of final HEDIS results for measurement year 2014, WellCare of Kentucky performed a detailed analysis of NCQA Accreditation measures falling below or just meeting the 50th percentile to identify barriers and potential interventions targeted at specific measures. During 2015, WellCare of Kentucky continued distributing care gap reports to

IPRO Recommendation	MCO Response
	PCPs to notify them of members on their panel in need of screenings. WellCare of Kentucky also had a Pay for Performance program in 2015 and one of the measures targeted was Adolescent Well Visits. WellCare of Kentucky also began a Postpartum Care PIP that includes provider education regarding postpartum depression screening and supplies providers with the Edinburgh Postnatal Depression Scale for use as a screening tool. WellCare of Kentucky also provides case management services to pregnant members through our vendor, Alere. Members receive periodic risk assessments for the identification of women at risk of preterm birth and other pregnancy-related complications. Risk assessments are then used to stratify participants into acuity-based risk levels and provided with educational materials and/or ongoing clinical support from case managers. Risk assessments include assessment of medical and obstetrical history, as well as current conditions including but not limited to smoking, alcohol use, substance use, and domestic violence, and education provided includes pregnancy wellness, signs and symptoms of high-risk conditions, nutrition, medication, and lifestyle behaviors such as smoking and alcohol/substance use. Outcome and Monitoring – Risk screening and counseling for adolescents and pregnant women are monitored via the annual Healthy Kentuckians rates. WellCare of Kentucky monitors rates monthly to identify areas in need of greater intervention. WellCare of Kentucky anticipates that 2016 rates will show an improvement over 2015. Providers are also distributed their individual rates and care gap reports monthly so they can track their progress and open opportunities. Additionally, the CHPAs are assessed against performance goals for their work and outcomes with individual provider groups. Member and provider interventions aimed at improving HEDIS measure performance are included in the QI Work Plan, which is updated quarterly. Member and provider interventions are also reported to the MCO's quality committees. Future Actions/Plans – Following receipt of final 2016 rates, WellCare of Kentucky will conduct an analysis of 2015 data to identify barriers and potential interventions. Based on this analysis, WellCare of Kentucky will continue interventions already in place and/or develop new member and provider interventions as needed. WellCare of Kentucky will continue to work individually with providers to improve rates. Additionally, in 2016 WellCare of Kentucky has added two new positions to the QI Department for HEDIS Care Gap Coordinators, whose responsibilities will include directly outreaching members with care gaps to provide education and assistance with making appointments; these positions will be located within the Kentucky market. Additionally, in 2016 WellCare of Kentucky has launched a new member incentive program, the Healthy Rewards Program, which provides a reloadable debit card and incentives ranging from $10 to $60 in value for the completion of the certain preventive visits and screenings, including Adolescent Well Care Visits, Prenatal Care Visits (6 or more), and Postpartum Care Visit (also includes diaper incentive). Members who complete an Adolescent Well Care Visit are eligible to receive a $20 reloadable debit card. Members who complete 6 or more Prenatal Care Visits are eligible to receive a $50 reloadable debit card. Members who complete a Postpartum Care Visit 21-56 days after the birth are eligible to receive a $20 gift card and 6 packs of diapers. Through the provision of incentives for members to attend these visits, coupled with provider education regarding the appropriate screenings that should occur during these visits, WellCare of Kentucky anticipates improvement in risk screening and counseling rates for adolescents and pregnant women.
· work to improve HEDIS measure rates that fall below the NCQA national averages, particularly for	Initial Plan of Action – WellCare of Kentucky has multiple ongoing interventions aimed at improving performance on all HEDIS measures, including those related to cardiovascular care, appropriate testing and antibiotic use for children with acute respiratory illnesses, and behavioral health care measures. These interventions include one-on-one case management, disease management, distribution of provider care gap reports, targeted phone calls and mailings to

IPRO Recommendation	MCO Response
measures related to cardiovascular care, appropriate testing and antibiotic use for children with acute respiratory illnesses, and some behavioral health care measures;	members identified as needing HEDIS services, and provider visits. Additionally, WellCare of Kentucky's Quality Improvement department includes 9 regional Clinical HEDIS Practice Advisor (CHPA) positions, which were added in 2014. The CHPAs' primary responsibility is the improvement of HEDIS rates as they work individually with providers to improve HEDIS and rates. At the completion of each HEDIS season, the QI team analyzes HEDIS and Healthy Kentuckians outcomes for root cause analysis, identification of barriers, and development of interventions for implementation. WellCare of Kentucky targeted education to providers and members regarding appropriate testing for children with pharyngitis, appropriate antibiotic use for children with acute respiratory illness, and high blood pressure. WellCare of Kentucky also had several PIPs as defined below related to behavioral health care. When and how was this accomplished? - Throughout 2015 CHPAs worked with provider offices to educate providers and staff about HEDIS requirements, appropriate medical record documentation and the use of Electronic Medical Record (EMR) systems to capture all data needed to demonstrate HEDIS compliance, and claims coding for services rendered during member visits using HEDIS -accepted codes. CHPAs distributed HEDIS toolkits to providers during onsite provider visits to educate providers on HEDIS and Healthy Kentuckians measure specifications. In July 2015, following the receipt of final HEDIS results for measurement year 2014, WellCare of Kentucky performed a detailed analysis of NCQA Accreditation measures falling below or just meeting the 50th percentile to identify barriers and potential interventions targeted at specific measures. WellCare of Kentucky educated members regarding appropriate testing for pharyngitis, antibiotic use for URI, and controlling high blood pressure through targeted member mailings and member newsletter articles. WellCare of Kentucky conducted targeted outreach to providers with 10 or more members diagnosed with pharyngitis and prescribed antibiotics who did not receive a strep test per claims. WellCare of Kentucky also conducted targeted outreach to providers who prescribed antibiotics for URI and/or were not billing for all diagnosed symptoms. WellCare of Kentucky conducted disease management activities with members identified as having high blood pressure and educated providers on taking a second blood pressure reading when the initial reading is higher than recommended levels. WellCare of Kentucky PIPs related to behavioral health that were active in 2015 include Follow-Up after Mental Health Hospitalization and Antipsychotic Medication Use in Children and Adolescents. WellCare of Kentucky also submitted a PIP proposal in September 2015 for a PIP on the topic Management of Physical Health Risks in the SMI Population. Outcome and Monitoring – WellCare of Kentucky monitors HEDIS rates monthly to identify areas in need of greater intervention. WellCare of Kentucky anticipates that HEDIS 2016 rates will show an improvement over HEDIS 2015. HEDIS rates for WellCare of Kentucky and for individual providers are monitored on a monthly basis. Providers are also distributed their individual HEDIS rates and care gap reports monthly so they can track their progress and open opportunities. Additionally, the CHPAs are assessed against performance goals for their work and outcomes with individual provider groups. Member and provider interventions aimed at improving HEDIS measure performance are included in the QI Work Plan, which is updated quarterly. Member and provider interventions are also reported to the MCO's quality committees. PIP outcomes are monitored on an annual basis and reports are submitted to IPRO and DMS annually by September 1. Future Actions/Plans – Following receipt of final HEDIS 2016 rates, WellCare of Kentucky will conduct an analysis of HEDIS 2015 data to identify barriers and potential interventions. Based on this analysis, WellCare of Kentucky will continue interventions already in place and/or develop new member and provider interventions as needed. WellCare of

IPRO Recommendation	MCO Response
	Kentucky will continue to work individually with providers to improve HEDIS rates. Additionally, in 2016 WellCare of Kentucky has added two new positions to the QI Department for HEDIS Care Gap Coordinators, whose responsibilities will include directly outreaching members with care gaps to provide education and assistance with making appointments; these positions will be located within the Kentucky market. Additionally, in 2016 WellCare of Kentucky has launched a new member incentive program, the Healthy Rewards Program, which provides a reloadable debit card and incentives ranging from $10 to $60 in value for the completion of the following preventive visits and screenings: Well Child Visits 0-15 Months, Well Child Visits 3-6 Years, Adolescent Well Care Visit, Prenatal Care Visits (6 or more), Postpartum Care Visit (diaper incentive), Diabetes Eye Exam, Diabetes HbA1c Test, Cervical Cancer Screening, Mammogram, Annual Adult Health Screening, and Preventive Dental Visit. In addition, interventions for the Antipsychotic Medication Use in Children and Adolescents PIP continue in 2016, and interventions for the Management of Physical Health Risks in the SMI Population PIP begin in 2016.
· address all areas that were found less than fully compliant, with special attention to the domains Behavioral Health Services and Health Risk Assessment; and	Initial Plan of Action – Following the 2015 Annual Compliance Audit findings, WellCare of Kentucky enacted a Corrective Action Plan for the domain of Behavioral Health addressing the minimal findings for contract requirements related to the Behavioral Health hotline. WellCare of Kentucky also enacted internal action plans to address all areas found less than fully compliant, including actions to address two areas found substantially compliant in the domain of Health Risk Assessment, one area found substantially compliant in the domain of Behavioral Health, and one area found substantially compliant in the domain of Pharmacy Benefits. When and how was this accomplished? - As part of the Corrective Action Plan for the domain of Behavioral Health, WellCare of Kentucky updated the documents and call scripts governing calls to the Behavioral Health hotline to clarify that members are never placed on hold, continued to report average hold time for the Behavioral Health hotline quarterly on the QI Work Plan as "0" as calls to the hotline are never placed on hold, and discussed the absence of space to report the metric "average hold time" on the Report #11 template with DMS. WellCare of Kentucky also developed training materials and provided training to Behavioral Health hotline staff regarding the various Programs, Provider Networks, and Service Areas related to Kentucky Medicaid, updated the Health Integrated vendor contract to include the requirement of ongoing training related to Kentucky-specific resources, and updated Policy C6C2-121 Behavioral Health Customer Service Requirements to specifically address training of subcontractors on Kentucky Medicaid-specific Programs, Provider Networks, and Service Areas. WellCare of Kentucky addressed the substantial finding in the domain of Behavioral Health by updating the contract with the hotline vendor, Health Integrated, to explicitly state that there is no maximum call duration limit imposed and all calls will be of sufficient length to ensure adequate information is provided to callers to the Behavioral Health hotline. These corrective actions were completed by the end of 2015. WellCare of Kentucky addressed the substantial findings in the domain of Pharmacy Benefits by revising the Preferred Drug List policy to include coverage for all drugs for which a federal rebate is available and has been provided by DMS. This revision took place on 3/16/2015 during IPRO's onsite review. WellCare of Kentucky began addressing the substantial findings in the domain of Health Risk Assessment immediately after final findings were received in July 2015. HRA file review revealed that the process for identification of new members for HRA outreach was excluding new members who were retroactively enrolled, and WellCare of Kentucky initiated an IT process revision that was completed and became active in February 2016. Retroactively enrolled members are now included on the file of new members sent to WellCare of Kentucky's HRA vendor, Eliza. WellCare of Kentucky also initiated a corporate-wide program to standardize one HRA for

IPRO Recommendation	MCO Response
	use across all markets, which would address IPRO's recommendation to have a standardized version of the HRA across formats (paper and telephonic). The adoption of a standardized HRA required approval from all WellCare of Kentucky markets and this process is ongoing. WellCare of Kentucky also added an offer of assistance in scheduling a PCP visit to the Member Handbook per IPRO's recommendation. Additionally, the process for distributing the unable to contact letters for the HRAs that was implemented in response to the 2014 Annual Compliance Audit recommendations became fully automated in 2015. Outcome and Monitoring – WellCare of Kentucky provided documentation evidencing the changes made in response to the 2015 Annual Compliance Audit to IPRO for the 2016 Annual Compliance Audit. Final findings for the 2016 Annual Compliance Audit have been received and indicate improvement in most areas addressed following the 2015 Annual Compliance Audit, including full compliance with Behavioral Health elements previously found minimally compliant. The domain of Health Risk Assessment continues to need improvement. The HRA files reviewed onsite by IPRO during the 2016 Annual Compliance review contained members who became active with WellCare of Kentucky between July 1 and September 30, 2015 but who were retroactively enrolled by DMS and had eligibility dates that occurred prior to that enrollment span. Because the process of referring new members had not yet been updated to include retroactively enrolled members, these members were not included on the file for HRA outreach and had not received an HRA. The corrective action addressing the inclusion of retroactively enrolled members on the file for HRA outreach was deployed in February 2016 and documentation was supplied to IPRO during the 2016 Annual Compliance Review in January 2016 as evidence that this corrective action was in process. Retroactively enrolled members are now included on the file of new members sent to WellCare of Kentucky's HRA vendor, Eliza, and WellCare of Kentucky expects this issue to be resolved for the 2017 Annual Compliance Review. Future Actions/Plans – WellCare of Kentucky has received the final findings and recommendations from IPRO for the 2016 Annual Compliance Audit and will execute improvements for all areas with a finding of less than Full compliance.
· Consider working with DMS and the other MCOs to examine the reasons for low rates for board-certification to determine if this issue is specific to WellCare of Kentucky or is a regional/statewide norm.	Initial Plan of Action – WellCare of Kentucky monitored a quarterly internal Provider Board Certification report, identified internal data issues, and evaluated external data to determine statewide norms of board certification. WellCare of Kentucky believes discrepancies with our internal data are causing the issue with low rates of board certification. When and how was this accomplished? - The final internal data source for generating WellCare of Kentucky's board certification rates is our claims production system, Xcelys, which is populated through our credentialing software, Cactus. This is our intake repository during the credentialing process and data is entered from The Council of Affordable Quality Healthcare (CAQH) manually. WellCare of Kentucky currently produces and monitors a quarterly internal report showing the board certification status of all participating providers. WellCare of Kentucky's Network Integrity team coordinated with WellCare of Kentucky's Credentialing team to compile a list of providers with inconsistent internal data regarding board certification status and to verify providers' board certification status against external data sources. Outcome and Monitoring – WellCare of Kentucky will correct any errors in its internal data regarding the board certification status of contracted providers. Following data correction, WellCare of Kentucky will perform a follow-up review to determine if our actions have improved our HEDIS board certification rate, and will compare that rate to the statewide rate to ensure our rate is in line with statewide norms. WellCare of Kentucky will continue to monitor the quarterly internal report on board certification to ensure the provider network maintains the highest percentage of board-certified providers.

IPRO Recommendation	MCO Response
	Future Actions/Plans – With Kentucky being an Any Willing Provider state, WellCare of Kentucky must offer an Agreement to any provider that requests participation in our network. WellCare of Kentucky's Network Development team will review the Provider Board Certification report and act upon any specialties that fall below a certain percentage to ensure we work to fill those gaps and maintain a quality network for our members. WellCare of Kentucky will also continue to correct identified internal data issues to ensure that board certification rates truly reflect the number of board-certified providers in WellCare of Kentucky's network. The Network Development team will partner with WellCare of Kentucky's Shared Services – Configuration team to update the board certification status in our internal systems for those providers that have been verified as truly board-certified but who currently have inconsistent information documented in WellCare of Kentucky's system.
In the domain of access to/timeliness of care, IPRO recommends that WellCare of Kentucky: · work to improve HEDIS measure rates which fall below the NCQA national averages, particularly related to access/timeliness of behavioral health service and continue the PIP focused on Follow-up After Hospitalization for Mental Illness, evaluating and modifying the intervention strategy where needed;	Initial Plan of Action – WellCare of Kentucky has multiple ongoing interventions aimed at improving performance on all HEDIS measures, including those related to behavioral health service. These interventions include one-on-one case management, disease management, distribution of provider care gap reports, targeted phone calls and mailings to members identified as needing HEDIS services, and provider visits. Additionally, WellCare of Kentucky's Quality Improvement department includes 9 regional Clinical HEDIS Practice Advisor (CHPA) positions, which were added in 2014. The CHPAs' primary responsibility is the improvement of HEDIS rates as they work individually with providers to improve HEDIS and rates. At the completion of each HEDIS season, the QI team analyzes HEDIS and Healthy Kentuckians outcomes for root cause analysis, identification of barriers, and development of interventions for implementation. WellCare of Kentucky's PIP focused on Follow-up After Hospitalization for Mental Illness continued in 2015. When and how was this accomplished? – Throughout 2015 CHPAs worked with provider offices to educate providers and staff about HEDIS requirements, appropriate medical record documentation and the use of Electronic Medical Record (EMR) systems to capture all data needed to demonstrate HEDIS compliance, and claims coding for services rendered during member visits using HEDIS -accepted codes. CHPAs distributed HEDIS toolkits to providers during onsite provider visits to educate providers on HEDIS and Healthy Kentuckians measure specifications. In July 2015, following the receipt of final HEDIS results for measurement year 2014, WellCare of Kentucky performed a detailed analysis of NCQA Accreditation measures falling below or just meeting the 50th percentile to identify barriers and potential interventions targeted at specific measures. As part of the FUH PIP, WellCare of Kentucky targeted outreach to facilities with 10 or more mental health admissions with a re-admission rate of 8% or higher to provide coaching on discharge planning and coordination of care. WellCare of Kentucky also targeted outreach to all CMHCs to review HEDIS FUH requirements and provide a Behavioral Health HEDIS toolkit. WellCare of Kentucky also improved our process by which Case Managers are notified of discharges by Utilization Management, speeding up the timeframe for member outreach by Case Management. Outcome and Monitoring – WellCare of Kentucky monitors HEDIS rates monthly to identify areas in need of greater intervention. WellCare of Kentucky anticipates that HEDIS 2016 rates will show an improvement over HEDIS 2015. HEDIS rates for WellCare of Kentucky and for individual providers are monitored on a monthly basis. Providers are also distributed their individual HEDIS rates and care gap reports monthly so they can track their progress and open opportunities. Additionally, the CHPAs are assessed against performance goals for their work and outcomes with individual provider groups. Member and provider interventions aimed at improving HEDIS measure performance are included in the QI Work Plan, which is updated quarterly. Member and provider interventions are also reported to the

IPRO Recommendation	MCO Response
	MCO's quality committees. PIP outcomes are monitored on an annual basis and reports are submitted to IPRO and DMS annually by September 1. Future Actions/Plans – Following receipt of final HEDIS 2016 rates, WellCare of Kentucky will conduct an analysis of HEDIS 2015 data to identify barriers and potential interventions. Based on this analysis, WellCare of Kentucky will continue interventions already in place and/or develop new member and provider interventions as needed. WellCare of Kentucky will continue to work individually with providers to improve HEDIS rates. Additionally, in 2016 WellCare of Kentucky has added two new positions to the QI Department for HEDIS Care Gap Coordinators, whose responsibilities will include directly outreaching members with care gaps to provide education and assistance with making appointments; these positions will be located within the Kentucky market. In addition, interventions for the Antipsychotic Medication Use in Children and Adolescents PIP continue in 2016, and interventions for the Management of Physical Health Risks in the SMI Population PIP begin in 2016. Following the receipt of HEDIS 2016 rates and the final rates for the FUH PIP, WellCare of Kentucky will evaluate the intervention strategy used for the FUH PIP and determine whether to continue the PIP interventions or implement a modified strategy for improving performance in this area.
· Implement the planned PIP focusing on Postpartum Care, evaluating and modifying the intervention strategy where necessary as the PIP progresses;	Initial Plan of Action –The Postpartum PIP's performance goals include: increasing the HEDIS rate for Postpartum Care, increasing the Healthy Kentuckians rate for Postpartum Depression Screening, decreasing the 30-day re-admission rate post-delivery, and decreasing the 60-day re-admission rate post-delivery. Planned interventions targeted barriers of member knowledge of the importance and timing of the postpartum visit (21-56 days after delivery) and provider knowledge of the timing, appropriate documentation of the postpartum visit, and appropriate screening for postpartum depression. When and how was this accomplished? – WellCare of Kentucky submitted the baseline report for the Postpartum Care PIP to DMS and IPRO on September 1, 2015. Interventions implemented by September 1, 2015 included: the addition of Clinical HEDIS Practice Advisors (CHPAs) to educate providers regarding HEDIS and Healthy Kentuckians guidelines for postpartum care; a comprehensive maternal case management program via WellCare of Kentucky's vendor Alere; member outreach conducted post-delivery by WellCare of Kentucky's Postpartum Discharge Planning Program; member education regarding postpartum visits via articles in the member newsletter; the provision of the Edinburgh Postnatal depression scale to providers via WellCare of Kentucky's provider website. Outcome and Monitoring – Baseline rates for the PIP were reported in the baseline report submitted on September 1, 2015 and are from measurement year 2014. The baseline rate for HEDIS postpartum care was 51.41%. The baseline rate for Healthy Kentuckians Postpartum Depression Screening was 30.22%. The 30-day Re-admission Rate Post-Delivery was 1.65%, and the 60-Day Re-admission Rate Post-Delivery was 2.15%. Quarterly PIP workgroup meetings are held to discuss the progress of the PIP. Interim rates will be measured during HEDIS 2016. Future Actions/Plans – WellCare of Kentucky will submit the interim report for the Postpartum Care PIP to DMS and IPRO by September 1, 2016. Following HEDIS 2016, WellCare of Kentucky will evaluate the interim rates for the PIP's performance measures and will continue current interventions or modify the intervention strategy as necessary.
· address all compliance areas found less than fully compliant, particularly for the domain Behavioral	Initial Plan of Action — Following the 2015 Annual Compliance Audit findings, WellCare of Kentucky enacted a Corrective Action Plan for the domain of Behavioral Health addressing the minimal findings for contract requirements related to the Behavioral Health hotline. WellCare of Kentucky also enacted internal action plans to address all areas found less than fully compliant, including actions to address two areas found substantially compliant in the domain of

IPRO Recommendation	MCO Response
Health Services; and	Health Risk Assessment, one area found substantially compliant in the domain of Behavioral Health, and one area found substantially compliant in the domain of Pharmacy Benefits. When and how was this accomplished? – As part of the Corrective Action Plan for the domain of Behavioral Health, WellCare of Kentucky updated the documents and call scripts governing calls to the Behavioral Health hotline to clarify that members are never placed on hold, continued to report average hold time for the Behavioral Health hotline quarterly on the QI Work Plan as "0" as calls to the hotline are never placed on hold, and discussed the absence of space to report the metric "average hold time" on the Report #11 template with DMS. WellCare of Kentucky also developed training materials and provided training to Behavioral Health hotline staff regarding the various Programs, Provider Networks, and Service Areas related to Kentucky Medicaid, updated the Health Integrated vendor contract to include the requirement of ongoing training related to Kentucky-specific resources, and updated Policy C6C2-121 Behavioral Health Customer Service Requirements to specifically address training of subcontractors on Kentucky Medicaid-specific Programs, Provider Networks, and Service Areas. WellCare of Kentucky addressed the substantial finding in the domain of Behavioral Health by updating the contract with the hotline vendor, Health Integrated, to explicitly state that there is no maximum call duration limit imposed and all calls will be of sufficient length to ensure adequate information is provided to callers to the Behavioral Health hotline. These corrective actions were completed by the end of 2015. WellCare of Kentucky addressed the substantial findings in the domain of Pharmacy Benefits by revising the Preferred Drug List policy to include coverage for all drugs for which a federal rebate is available and has been provided by DMS. This revision took place on 3/16/2015 during IPRO's onsite review. WellCare of Kentucky began addressing the substantial findings in the domain of Health Risk Assessment immediately after final findings were received in July 2015. HRA file review revealed that the process for identification of new members for HRA outreach was excluding new members who were retroactively enrolled, and WellCare of Kentucky initiated an IT process revision that was completed and became active in February 2016. Retroactively enrolled members are now included on the file of new members sent to WellCare of Kentucky's HRA vendor, Eliza. WellCare of Kentucky also initiated a corporate-wide program to standardize one HRA for use across all markets, which would address IPRO's recommendation to have a standardized version of the HRA across formats (paper and telephonic). WellCare of Kentucky also added an offer of assistance in scheduling a PCP visit to the Member Handbook per IPRO's recommendation. Additionally, the process for distributing the unable to contact letters for the HRAs that was implemented in response to the 2014 Annual Compliance Audit recommendations became fully automated in 2015. Outcome and Monitoring - WellCare of Kentucky provided documentation evidencing the changes made in response to the 2015 Annual Compliance Audit to IPRO for the 2016 Annual Compliance Audit. Final findings for the 2016 Annual Compliance Audit have been received and indicate improvement in most areas addressed following the 2015 Annual Compliance Audit, including full compliance with Behavioral Health elements previously found minimally compliant. The domain of Health Risk Assessment continues to need improvement. The HRA files reviewed onsite by IPRO during the 2016 Annual Compliance review contained members who became active with WellCare of Kentucky between July 1 and September 30, 2015 but who were retroactively enrolled by DMS and had eligibility dates that occurred prior to that enrollment span. Because the process of referring new members had not yet been updated to include retroactively enrolled members, these members were not included on the file for HRA outreach and had not received an HRA. The corrective action addressing the inclusion of retroactively enrolled members on the file for HRA outreach was deployed in February 2016 and documentation was supplied to IPRO during the 2016 Annual Compliance Review in January 2016 as

IPRO Recommendation	MCO Response
	evidence that this corrective action was in process. Retroactively enrolled members are now included on the file of new members sent to WellCare of Kentucky's HRA vendor, Eliza, and WellCare of Kentucky expects this issue to be resolved for the 2017 Annual Compliance Review. Future Actions/Plans – WellCare of Kentucky has received the final findings and recommendations from IPRO for the 2016 Annual Compliance Audit and will execute improvements for all areas with a finding of less than Full compliance.
· As recommended previously, consider initiating a PIP focused on improving rates for well-care visits for children and adolescents.	Initial Plan of Action – During 2015, WellCare of Kentucky had a Pay for Performance program that targeted the HEDIS measures: Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Adolescent Well Visits, and Childhood Immunization Status – Combo 2 and Combo 10. WellCare of Kentucky's HEDIS 2015 rates for Children and Adolescent's Access to Primary Care Practitioners met the 50th percentile for ages 12 – 24 months and 25 months – 6 years, and met the 75th percentile for 7 – 11 years and 12 – 19 years. WellCare of Kentucky chose not to implement a PIP aimed at increasing the rates of well-visits for children and adolescents in favor of implementing a PIP aimed at increasing the rate Annual Dental Visit HEDIS rate. WellCare of Kentucky's approach was to address well-child visits for children and adolescents via the Pay for Performance program, which is aimed at PCPs, while addressing dental care with a PIP to more effectively target dental providers. WellCare of Kentucky also continued all interventions aimed at improving HEDIS rates, including distribution of provider care gap reports, targeted phone calls and mailings to members identified as needing HEDIS services, and provider visits. Additionally, WellCare of Kentucky's Quality Improvement department includes 9 regional Clinical HEDIS Practice Advisor (CHPA) positions, which were added in 2014. The CHPAs' primary responsibility is the improvement of HEDIS rates as they work individually with providers to improve HEDIS and rates. At the completion of each HEDIS season, the QI team analyzes HEDIS and Healthy Kentuckians outcomes for root cause analysis, identification of barriers, and development of interventions for implementation. When and how was this accomplished? – Throughout 2015 CHPAs worked with provider offices to educate providers and staff about HEDIS requirements, appropriate medical record documentation and the use of Electronic Medical Record (EMR) systems to capture all data needed to demonstrate HEDIS compliance, and claims coding for services rendered during member visits using HEDIS -accepted codes. CHPAs distributed HEDIS toolkits to providers during onsite provider visits to educate providers on HEDIS and Healthy Kentuckians measure specifications. In July 2015, following the receipt of final HEDIS results for measurement year 2014, WellCare of Kentucky performed a detailed analysis of NCQA Accreditation measures falling below or just meeting the 50th percentile to identify barriers and potential interventions targeted at specific measures. Outcome and Monitoring – WellCare of Kentucky monitors HEDIS rates monthly to identify areas in need of greater intervention. WellCare of Kentucky anticipates that HEDIS 2016 rates will show an improvement over HEDIS 2015. HEDIS rates for WellCare of Kentucky and for individual providers are monitored on a monthly basis. Providers are also distributed their individual HEDIS rates and care gap reports monthly so they can track their progress and open opportunities. Additionally, the CHPAs are assessed against performance goals for their work and outcomes with individual provider groups. Member and provider interventions aimed at improving HEDIS measure performance are included in the QI Work Plan, which is updated quarterly. Member and provider interventions are also reported to the MCO's quality committees. Future Actions/Plans – Following receipt of final HEDIS 2016 rates, WellCare of Kentucky will conduct an analysis of HEDIS 2015 data to identify barriers and potential interventions. Based on this analysis, WellCare of Kentucky will

IPRO Recommendation	MCO Response
	continue interventions already in place and/or develop new member and provider interventions as needed. WellCare of Kentucky will continue to work individually with providers to improve HEDIS rates. Additionally, in 2016 WellCare of Kentucky has added two new positions to the QI Department for HEDIS Care Gap Coordinators, whose responsibilities will include directly outreaching members with care gaps to provide education and assistance with making appointments; these positions will be located within the Kentucky market. Additionally, in 2016 WellCare of Kentucky has launched a new member incentive program, the Healthy Rewards Program, which provides a reloadable debit card and incentives ranging from $10 to $60 in value for the completion of the certain preventive visits and screenings, including Well Child Visits 0-15 Months, Well Child Visits 3-6 Years, and Adolescent Well Care Visit.

Appendix A – Medicaid Managed Care Compliance Monitoring

Objectives

Each annual detailed technical report must contain data collected from all mandatory EQR activities. Federal regulations at 42 CFR 438.358, delineate that a review of an MCO's compliance with standards established by the State to comply with the requirements of § 438.204(g) is a mandatory EQR activity. Further, for plans that were in operation prior to the current review, the evaluation must be conducted within the previous three-year period, by the State, its agent or the EQRO.

DMS annually evaluates the MCOs' performance against contract requirements and State and federal regulatory standards through its EQRO contractor. In an effort to prevent duplicative review, federal regulations allow for use of the accreditation findings, where determined equivalent to regulatory requirements.

A full review of all requirements was conducted for the following MCOs: CoventryCares of Kentucky, and WellCare of Kentucky. All domains listed were evaluated for compliance to contractual requirements and standards, as were any corresponding files. Humana-CareSource and Passport Health Plan underwent partial reviews including: standards subject to annual review; initial review of applicable contract changes; and standards previously rated as less than fully compliant.

The annual compliance review for the period calendar year January 2015 – December 2015, conducted in January 2016, addressed contract requirements and regulations within the following domains:

- Behavioral Health Services
- Case Management/Care Coordination
- Enrollee Rights: Enrollee Rights and Protections
- Enrollee Rights: Member Education and Outreach
- EPSDT
- Grievance System
- Health Risk Assessment
- Medical Records
- Pharmacy Benefits
- Program Integrity
- QAPI: Access
- QAPI: Access – Utilization Management
- QAPI: Measurement and Improvement
- QAPI: Measurement and Improvement – Health Information Systems
- QAPI: Structure and Operations – Credentialing
- QAPI: Structure and Operations – Delegated Services

Data collected from the MCOs, either submitted pre-onsite, during the onsite visit or in follow-up, was considered in determining the extent to which the health plan was in compliance with the standards. Further descriptive information regarding the specific types of data and documentation reviewed is provided in the section "Description of Data Obtained" listed below and in this report located under subpart, "Compliance Monitoring."

Technical Methods of Data Collection

In developing its review protocols, IPRO followed a detailed and defined process, consistent with the CMS EQRO protocols for monitoring regulatory compliance of MCOs. For each set of standards reviewed, IPRO prepared standard-specific tools with standard-specific elements (i.e., sub-standards). The tools include the following:

- statement of state and MCO contract requirements and applicable state regulations,
- prior results,
- reviewer compliance determination,

- descriptive reviewer findings and recommendations related to the findings,
- review determinations, and
- suggested evidence.

In addition, where applicable (e.g., member grievances), file review worksheets were created to facilitate complete and consistent file review.
Reviewer findings on the tools formed the basis for assigning preliminary and final designations. The standard designations used are shown in Table 60.

Table 60: Medicaid Managed Care Compliance Monitoring Standard Designations

Standard Designations	
Full Compliance	MCO has met or exceeded requirements.
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas.
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action.
Non-compliance	MCO has not met the requirements.
Not Applicable (N/A)	Statement does not require a review decision; for reviewer information purposes.

Pre-Onsite Activities – Prior to the onsite visit, the review was initiated with an introduction letter, documentation request, and request for eligible populations for all file reviews.

The documentation request is a listing of pertinent documents for the period of review, such as policies and procedures, sample contracts, program descriptions, work plans and various program reports.

The eligible population request requires the MCOs to submit case listings for file reviews. For example, for member grievances, a listing of grievances for a selected quarter of the year; or, for care coordination, a listing of members enrolled in care management during a selected quarter of the year. From these listings, IPRO selected a random sample of files for review onsite.

IPRO began its "desk review," or offsite review, when the pre-onsite documentation was received from the plan.

Prior to the review, a notice was sent to the MCOs including a confirmation of the onsite dates, an introduction to the review team members, onsite review agenda and list of files selected for review.

Onsite Activities – The onsite review commenced with an opening conference where staff was introduced and an overview of the purpose and process for the review and onsite agenda were provided. Following this, IPRO conducted a review of the additional documentation provided onsite, as well as the file reviews. Staff interviews were conducted to clarify and confirm findings. When appropriate, walkthroughs or demonstrations of work processes were conducted. The onsite review concluded with a closing conference, during which IPRO provided feedback regarding the preliminary findings, follow-up items needed and the next steps in the review process.

Description of Data Obtained

As noted in the Pre-Onsite Activities, in advance of the review, IPRO requested documents relevant to each standard under review, to support the health plan's compliance with federal and State regulations and contract requirements. This included items such as: policies and procedures; sample contracts; annual QI Program Description, Work Plan, and Annual Evaluation; Member and Provider Handbooks; access reports; committee descriptions and minutes; case files; program monitoring reports; and evidence of monitoring, evaluation, analysis and follow-up. Additionally, as reported above under Onsite Activities, staff interviews, demonstrations, and walkthroughs were conducted during the onsite visit. Supplemental documentation was also requested for areas where IPRO deemed it necessary to support

compliance. Further detail regarding specific documentation reviewed for each standard for the 2015 review is contained in the Compliance Monitoring section of this report and in the full compliance reports for each MCO.[33]

Data Aggregation and Analysis

Post-Onsite Activities – As noted earlier, each standard reviewed was assigned a level of compliance ranging from Full Compliance to Non-compliance. The review determination was based on IPRO's assessment and analysis of the evidence presented by the health plan. For standards where the plan was less than fully compliant, IPRO provided a narrative description of the evidence reviewed, and reason for non-compliance. The plan was provided preliminary findings and 20 business days to submit a response and clarification of information for consideration. No new documentation was accepted with the response. The MCOs could only clarify documentation that had been submitted previously, pre-onsite or during the onsite review. IPRO reviewed the MCO responses and prepared the final compliance determinations. In accordance with the DMS/MCO contract, DMS issued a Corrective Action Plan (CAP) request and/or Letter of Concern (LOC), where applicable, and the MCOs are required to submit written corrective action plans to address any findings rated "Minimal" or "Non-compliant."

[33] The complete compliance report for each MCO is available on the DMS Managed Care Oversight - Quality Branch Reports web page at: http://chfs.ky.gov/dms/pqomcoqbreports.htm.

Appendix B – Validation of Performance Improvement Projects

Objectives

Medicaid MCOs implement PIPs to assess and improve processes of care and, as a result, improve outcomes of care. The goal of the PIP is to achieve significant and sustainable improvement in clinical and non-clinical areas. A mandatory activity of the EQRO under the BBA is to review the PIP for methodological soundness of design, conduct and report to ensure real improvement in care and confidence in the reported improvements.

PIPs were reviewed according to the CMS protocol described in the document *Validating Performance Improvement Projects: a Protocol for Use in Conducting Medicaid External Quality Review Activities*. The first process outlined in this protocol is assessing the methodology for conducting the PIP. This process involves the following ten elements:

- review of the selected study topic(s) for relevance of focus and to the MCO's enrollment,
- review of the study question(s) for clarity of statement,
- review of selected study indicator(s), which should be objective, clear and unambiguous and meaningful to the focus of the PIP,
- review of the identified study population to ensure it is representative of the MCO enrollment and generalizable to the plan's total population,
- review of sampling methods (if sampling was used) for validity and proper technique,
- review of the data collection procedures to ensure complete and accurate data was collected,
- assessment of the improvement strategies for appropriateness,
- review of the data analysis and interpretation of study results,
- assessment of the likelihood that reported improvement is "real" improvement, and
- assessment of whether the MCO achieved sustained improvement.

Following the review of the listed elements, the review findings are considered to determine whether or not the PIP findings should be accepted as valid and reliable. In addition to validating and scoring the PIPs, IPRO provided ongoing technical assistance to the MCOs as part of its EQR tasks.

Technical Methods of Data Collection

IPRO's methodology for validation of the PIPs was based on CMS's *Validating Performance Improvement Projects: a Protocol for Use in Conducting Medicaid External Quality Review Activities*. A reporting template was designed by IPRO in order to collect the information and data necessary to review the projects. An assessment of each project in progress was conducted using tools developed by IPRO, approved by DMS, and consistent with the CMS EQR protocol for PIP validation. Each PIP submitted by the MCOs was reviewed using this methodology, and each of the ten protocol elements was considered.

Description of Data Obtained

Each PIP was validated using the MCOs' PIP project reports. Additional detail on the projects and technical assistance was provided during conference calls and onsite interviews of MCO staff during the compliance reviews in January 2016.

Data Aggregation and Analysis

At the proposal and baseline report phases, a narrative summary review was produced, detailing project strengths and opportunities for improvement for each element applicable to the project at the time of the review. Overall credibility of results was assessed at the baseline report phase. At Interim and final re-measurement phases of the project, a scored review and validation was conducted to assess overall credibility of results. Review elements were assessed using a scale of Met, Partially Met, and Not Met. Each element was weighted and assigned a point value, adding to a total of 80 points for the interim phase and 100 points for the final phase. Additional state-specific review elements to address contract requirements, such as methods to maintain member confidentiality; member involvement in the project; and dissemination of findings were included in the review tool. These items were scored "Met" or "Not Met".

A summary report of the findings, strengths and opportunities for improvement for each PIP in progress during the period of report is documented in this Technical Report.[34]

[34] The full PIP reports for each of the MCOs submitted at the time of the final re-measurement are available on the DMS Managed Care Oversight - Quality Branch Reports web page at: http://chfs.ky.gov/dms/pqomcoqbreports.htm.

Appendix C – Validation of Performance Measures

Objectives

Medicaid MCOs calculate PMs to monitor and improve processes of care. As per the CMS Regulations, validation of PMs is one of the mandatory EQR activities. The methodology for validation of PMs was based on CMS *Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities* (updated 2012). This protocol was derived from protocols and tools commonly used in the public and private sectors for auditing PMs.

The primary objectives of the PM validation process are to assess 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) into a data repository or set of consolidated files for use in constructing MCO 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.

Technical Methods of Data Collection

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

- 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;
- Conduct statistical testing of results;
- Procedures used to determine the measure denominators from the HEDIS denominator base, and how additional criteria were applied (where applicable);
- Medical record abstraction staff qualifications, training and inter-ʳater reliability testing;
- 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 medical record review and administrative validation);
- HEDIS 2015 *Interactive Data Submission System (IDSS)* report for the Medicaid product line;
- HEDIS 2015 *Final Audit Report,* for the Medicaid Product Line; and
- Table of measures including measure/numerator name, denominator value, numerator value and rate.

IPRO's methodology for performance measure validation included the following:

- Information Systems (IS) Capabilities – an assessment of data capture, transfer and entry methods, ongoing encounter data validation, and review of the IS assessment from the MCOs' annual HEDIS Compliance Audits.
- Denominator Validation – an assessment of sampling guidelines and methods.
- Data Collection Validation – an assessment of the MCOs' medical record review process, sampling and data abstraction.
- Numerator Validation – a review of member-level data for adherence to established specifications.

Several of the PMs are derived directly from HEDIS, including: Adult BMI Assessment, Weight Assessment and Counseling for Nutrition and Physical Activity for Children and 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 an NCQA-licensed audit organization as part of MCOs' annual HEDIS

Compliance Audits. Therefore, in accordance with the CMS EQRO provisions for non-duplication of activities, IPRO did not address those measures in its validation process. Rather, the focus was validating the State-specific measures.

Description of Data Obtained

As described under Technical Methods of Data Collection, IPRO requested documentation related to programming and queries, medical record data collection, and data entry and verification.

A medical record review (MRR) validation was conducted to ensure that the medical record abstraction performed by the MCOs met the measure specifications and that the abstracted medical record data was accurate. IPRO's MRR validation process 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 via medical record documentation.

In addition to the medical record review validation, an administrative validation is conducted to ensure that data analysis performed by the MCOs met the measure specifications and that the claims/encounter data were accurate. IPRO selected a sample of members identified by the MCOs as having numerator positive events via claims/encounter data for administrative validation. IPRO's administrative validation process included a review of 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.

Data Aggregation and Analysis

The findings from the validation activities were tabulated to determine whether the MCOs made any errors that may have significantly biased the final reported rates. The maximum amount of bias allowed for the final rates to be considered reportable is +/- five (5) percentage points. If the results indicated that a reported rate for a particular measure was materially biased, the measure was designated "Not Reportable" or "NR". If the data collection and measure calculation processes were found to be unbiased, the measure was designated "Reportable" or "R". If an MCO was not able to report a measure due to the lack of eligible population or a denominator less than 30, the measure was designated "Not Applicable" or "N/A".

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

Managed Care Program Progress Report
IPRO/DMS Contract Year
7/1/2015–6/30/2016

FINAL JULY 2016

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Table of Contents

Background and Introduction 3
Compliance with State and Federal Standards 10
Compliance Review Findings 11
Program Integrity 13
Health Risk Assessment 13
Care Management/Coordination 13
Enrollee Rights and Responsibilities 14
Quarterly Desk Audit Tables 14
Provider Network Access 15
Compliance with Access Standards 15
Access and Availability Survey of Dental Providers 15
Board Certification 15
Access and Utilization – HEDIS 2015 16
Consumer Satisfaction with Access – CAHPS Health Plan Survey 5.0H 2015 16
Quality Assessment and Performance Improvement 17
Health Information Systems 17
Credentialing 17
Delegation 17
Utilization Management 17
Quality Measurement and Improvement 17
Performance Measurement 18
Kentucky Performance Measures – Reporting Year 2015 18
Quality Performance – HEDIS 2015 18
Consumer Satisfaction – CAHPS 2015 19
Quality Improvement 19
Performance Improvement Projects (PIPs) 19
Focused Clinical Studies 21
Early and Periodic Screening, Diagnosis and Treatment 23
Kentucky Medicaid Managed Care Early Periodic Screening, Diagnostic and Treatment Services (EPSDT) Review for 2015, Draft Report June 2016 23
Summary of Program Progress – Strengths and Opportunities for Improvement 24
Strengths 24
Opportunities for Improvement 25
Recommendations 26

List of Tables

Table 1: Medicaid Enrollment Between June 29, 2015 and June 6, 2016 5
Table 2: Standard Designations for Compliance Review 11
Table 3: Overall Compliance Determinations by Review Category – 2016 12
Table 4: CAHPS 2015 5.0H Adult and Child Satisfaction Survey – Access Measures 16
Table 5: PIP Project Status 2013–2016 20

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Background and Introduction

The Commonwealth of Kentucky's report, Strategy for Assessing and Improving the Quality of Managed Care Services, outlines a strategy for quality oversight that is aligned with federal regulations and pursuant to the Social Security Act (Part 1915[1] and Part 1932(a)[2]), the Balanced Budget Act of 1997 and Title 42,[3] Part 438 of the Code of Federal Regulations (CFR).[4]

According to the Social Security Act (42 CFR Part 1932(a)) all states that contract with Medicaid managed care organizations (MCOs) to provide Medicaid services are required to provide for an external independent quality review. The Balanced Budget Act of 1997 further described mechanisms states should use in monitoring Medicaid MCO quality. In early 2003, the Centers for Medicare and Medicaid Services (CMS) issued a final rule defining the requirements for external quality review (EQR) and state quality monitoring[5] which include three mandatory external review activities and five optional activities. In July 2016, CMS revised the requirements and issued a final rule for Medicaid and Children's Health Insurance Program (CHIP) managed care and EQR. However, states are not required to implement the new requirements related to EQR until July 2018. The Cabinet for Health and Family Services (CHFS), Department for Medicaid Services (DMS) is responsible for administering and overseeing the Kentucky Medicaid Managed Care (MMC) Program. DMS contracts with an external quality review organization (EQRO), the Island Peer Review Organization (IPRO), to conduct the three mandatory review activities as well as many of the optional activities. The Kentucky EQR work plan includes the following review activities:

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

In addition to the mandatory and optional activities listed in federal regulation, Kentucky also contracts with their EQRO to validate patient level claims, conduct individual case reviews, pharmacy reviews, an annual Early Periodic Screening, Diagnostic and Treatment Services (EPSDT) review and an annual progress report. Technical assistance and presentations are provided as needed. The role of external quality review in Kentucky MMC is documented in the *Quality Companion Guide.* Prepared by the EQRO, this document is intended to assist MCOs in carrying out quality improvement activities and includes background information on EQR regulations and the role of the EQRO, instructions and time lines related to compliance review, PIP validation and PM validation.

The purpose of this Progress Report is to summarize information from the external quality review activities that describe the status and progress that has occurred in Kentucky's MMC Program during the contract period of July 1, 2015 through June 30, 2016. Key reports referenced while preparing this Progress Report include the following:

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[1] http://www.ssa.gov/OP_Home/ssact/title19/1932.htm
[2] http://www.govtrack.us/congress/bills/105/hr2015
[3] http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=b4058b30e1d1a47b9abd147b7dced4cc&rgn=div5&view=text&node=42:4.0.1.1.8&idno=42#PartTop
[4] 42 CFR Part 438.
[5] For the most recent EQR protocols, refer to http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

- Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services, September 2012
- 2016 External Quality Review Technical Report for MCO contract year(s) 2013–2015
- Quality Companion Guide Final Version, July 2015
- 2016 MCO Compliance Review findings
- Quarterly Desk Audit Reports, 4th Quarter 2015
- A Member's Guide to Choosing a Medicaid Health Plan 2015[6]
- Kentucky Medicaid Management Information System (MMIS) Encounter Data Validation Report, May 2016
- Validation of Managed Care Provider Network Submissions: Audit Report, January 2016
- Web-Based Provider Directory Validation Study, January 2016
- Validation of Performance Measures Report, April 2016
- Access and Availability Survey - Dental Services, February 2016
- Focused Study: Emergency Department Visits for Non-traumatic Dental Problems Among the Adult Kentucky Medicaid Managed Care Behavioral Health Subpopulation, May 2016
- Focused Study: Prenatal Smoking, July 2016

Managed Care Organizations

During the state fiscal year July 1, 2015 through June 30, 2016, five MCOs served the Medicaid population in Kentucky: Anthem Blue Cross and Blue Shield (BCBS) Medicaid; Coventry Health and Life Insurance Company (doing business as (dba) CoventryCares of Kentucky); Humana-CareSource; Passport Health Plan; and WellCare of Kentucky, Inc.

As a result of the Patient Protection and Affordable Care Act (ACA), March 2010, Medicaid eligibility was expanded in Kentucky and as of July 2015, all five MCOs were contracted to enroll members statewide.

Enrollment/Regions

Enrollment in Kentucky's MMC Program steadily increased over the past year. On June 29, 2015, 1,162,413 Medicaid beneficiaries were enrolled in MMC and as of June 6, 2016, there were 1,229,921 enrolled, an increase of 5.8%. During this period, enrollment in Aetna Better Health decreased by approximately 7%, while enrollment in the other four plans increased. Anthem BCBS Medicaid and Passport Health Plan saw the highest percent increases in enrollment, 43.9%[7] and 13.6% respectively. WellCare of Kentucky continues to have the largest enrollment with 438,798 members (Table 1).

[6] http://www.chfs.ky.gov/NR/rdonlyres/7BD9A46D-6710-4915-8163-4394F8F36EFF/0/2016MembersGuidetoChoosingaMedicaidHealthPlan.pdf (English), Accessed June 13, 2016. http://www.chfs.ky.gov/NR/rdonlyres/7E4290C1-5F2C-411B-9D21-99AB4074B023/0/2016MembersGuidetoChoosingaMedicaidHealthPlanSpanishrevised.pdf (Spanish), Accessed June 13, 2016.

[7] Note that the large increase (43.9%) in Anthem Blue Cross and Blue Shield Medicaid's enrollment is not surprising, since the MCO began participating in the Kentucky Medicaid managed care program in mid-2014 and expanded their service area and age groups served thereafter.

Table 1: Medicaid Enrollment Between June 29, 2015 and June 6, 2016

MCO	Enrollment 6/29/2015	Enrollment 6/6/2016	Percent Change	Percent of Total Medicaid Enrollment	Service Area
Anthem BCBS Medicaid	71,696	103,190	+43.9%	7.6%	Statewide
CoventryCares of Kentucky	293,370	272,680	-7.1%	20.0%	Statewide
Humana-CareSource	115,980	127,362	+9.8%	9.3%	Statewide
Passport Health Plan	253,536	287,891	+13.6%	21.1%	Statewide
WellCare of Kentucky	427,831	438,798	+2.6%	32.2%	Statewide
Managed Care Total	1,162,413	1,229,921	+5.8%	90.2%	Statewide
Fee-for-Service	121,576	134,213	+10.4%	9.8%	Statewide
Total Medicaid	1,283,989	1,364,134	+6.2%	100.0%	Statewide

MCO: managed care organization; BCBS: Blue Cross and Blue Shield

Responsibility for Program Monitoring

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

The DMS Division of Program Quality and Outcomes (DPQ&O) measures, analyzes and reports health outcomes of Kentucky Medicaid members and the MCOs' compliance with all federal and state regulations and contract provisions. The DPQ&O consists of three branches: the Disease and Case Management Branch, the Managed Care Oversight – Quality Branch, and the Managed Care Oversight – Contract Management Branch.

The Disease and Case Management Branch reviews MCO and FFS disease and case management programs; oversees the EPSDT benefit; coordinates state fair hearings for Medicaid service denials; and coordinates disenrollment for cause requests.

The Managed Care Oversight – Quality Branch oversees the EQRO's measurement of the MCOs' quality outcomes; monitors the EQRO's contract compliance; reviews and analyzes the Healthcare Effectiveness Data and Information Set (HEDIS®) scores and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results, and works with the EQRO to monitor the quality and effectiveness of care provided by the MCOs.

The Managed Care Oversight – Contract Management Branch reviews the MCOs' activities to monitor compliance with all applicable regulations and contract provisions; ensures that the MCOs consistently provide reliable health care to Kentucky's MMC members; and issues corrective action plans when an MCO is found in violation of a contract provision(s).

Benefits

Kentucky's MMC Program offers a comprehensive benefit plan for enrollees.[8] Enrollee benefit information is made available to new enrollees as they become eligible and to all enrollees during the open enrollment period. Information regarding benefits is provided on the DMS Medicaid website, Member Information page. The Kentucky Medicaid

[8] http://chfs.ky.gov/NR/rdonlyres/82416E1B-5D96-4FF7-AB27-0CB231416771/0/YourKYMedicaidBenefitPlan.pdf, Accessed June 22, 2016.

Member Handbook[9] also provides an overview of the benefits members are entitled to receive through the Kentucky Medicaid Benefit Plan.

As of January 1, 2014, all Medicaid beneficiaries were provided with the same benefit plan. The Benefit Plan covers basic medical services including acute inpatient hospital services; outpatient hospital/ambulatory surgical centers; laboratory, diagnostic and radiology services; physician office visits; preventive services; EPSDT services; emergency ambulance and hospital emergency room services; occupational, physical and speech therapy; hospice, chiropractic, hearing and vision services; prosthetic devices; and durable medical equipment. Also included in the benefit package are behavioral health services; dental services; maternity services; prescription drugs; home healthcare; substance abuse treatment; family planning; podiatry services; and end-stage renal disease treatment and transplants. While a number of services require a small co-payment, some people covered by Medicaid are exempt, including non-KCHIP (children not in Kentucky's Children's Health Insurance Program), children under 19 years who are in foster care, pregnant women, Native Americans, as well as people receiving hospice care and home care. Services exempt from co-payment include family planning, preventive care, and services provided by American Indian Health Services providers. While the Benefit Plan sets co-payments and limits for each benefit category, the Medicaid MCOs may opt to augment the benefits and/or services by reducing or eliminating co-payments and offering additional services such as member rewards and gift incentives, free mobile phone service, and 24-hour nurse advice lines, to name a few.[10]

Data Systems Validation

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

The EQRO is responsible for validating encounter data, provider network data and MCO-reported Kentucky PMs.

Encounters

Encounters are defined as professional face-to-face transactions between an enrollee and a provider and are submitted to DMS weekly or at least monthly. All five MCOs submitted encounters during this review period.

The EQRO receives a final extracted file from DMS each month for further processing and then prepares a monthly data validation report summarizing each MCO's submission. The report format consists of two parts, a file validation report and an intake report. Each section presents data for all MCOs in aggregate and for each MCO separately. The validation report presents the number and percent of missing data and the number and percent of invalid data for each encounter variable. A separate validation table is created by encounter type including inpatient, outpatient, professional, home health, long-term care, dental and pharmacy. The intake report presents the number of encounters submitted to Kentucky MMIS and includes encounter volume reports by place of service.

Monthly Encounter Data Validation Report

According to the Intake Report portion of the Monthly Encounter Data Validation Report prepared for June 2016, for the period between May 2015 and May 2016, the average number of encounter records per month was 10.5 million. Total encounter records ranged from a high of 15.4 million in June 2015 to a low of 6.5 million in September 2015. Additionally, the total number of monthly encounter records received declined from 12.4 million to 9.2 million between May 2015 and May 2016. This could be due to normal fluctuations. Several variables continued to show a high proportion of missing data elements including inpatient diagnosis codes 4 and above, inpatient procedure codes, inpatient surgical International Classification of Diseases, Revision 9 (ICD-9) codes 2 and above, performing provider key,

[9] http://www.chfs.ky.gov/NR/rdonlyres/A9BEAC84-BAEE-4FA1-9B84-CDD5CB390667/0/OpenEnrollment2016Master.pdf, Accessed June 22, 2016.

[10] http://www.chfs.ky.gov/NR/rdonlyres/A9BEAC84-BAEE-4FA1-9B84-CDD5CB390667/0/OpenEnrollment2016Master.pdf, Accessed June 22, 2016.

procedure modifier codes, referring provider key, and all outpatient surgical ICD-9 codes. For May 2016, several key elements of provider-related information were missing, including national provider identification (NPI) number (51.4% of records), provider license number (44.0% of records) and taxonomy (51.7% of records).

Encounter Data Validation Study-MCO Discrepancy Report

Accurate capture of MCO encounters is beneficial to DMS for future data collaborations, health care quality improvement studies and assessing measures of MCO performance. In order to confirm the accuracy of MCO encounter claims submitted to DMS, IPRO performs a data validation annually to ensure that DMS's data warehouse captures all data submitted by the MCOs. IPRO is conducting the data validation study for State Fiscal Year (SFY) 2016. IPRO requested the following from DMS: the most current file specifications sent to MCOs for encounter, dental and pharmacy data submissions, any updates to the data submission process since IPRO's prior review, and documentation of internal queries and edit checks applied to files received. IPRO reviewed the documentation and then requested that each of the Kentucky MCOs submit to IPRO the encounter data that were submitted to the state for the three month period, July–September 2015. An analysis and comparison of records and dates of service was conducted between the MCOs' and DMS data warehouse contents for encounter, dental and pharmacy data. Discrepancy reports were created for and provided to each of the MCOs. The MCOs were asked to provide responses with the reasons for the differences in the State MMIS system. Currently, the MCOs are preparing the responses.

Provider Network

Kentucky MCOs each maintain a provider network database that requires continual updates and submission to DMS on at least a monthly basis. MCOs use the data to populate printed provider directories and on-line provider query tools for members and potential members. Each MCO uses their provider network database to create and submit required GeoAccess reports to DMS. In September 2015 and again in March 2016, IPRO completed two audits of the Kentucky MCOs' provider network submissions and concurrent validations of the MCOs' web-based provider directories.

Validation of Managed Care Provider Network Submissions

For the Provider Network validation, two surveys were performed during the year. A sample of providers was randomly selected from each MCO's electronic provider directory files. Surveys were sent to 100 primary care providers and 100 specialists from each MCO to validate the information contained in the MCOs' provider directories. Information to be validated included elements such as name, provider license number, NPI, specialty(ies), language(s) spoken. The overall response rate was 58.1% in September 2015 and 60.6% in March 2016. In both audits, the providers' responses validated that some information in the Managed Care Assignment Processing System (MCAPS) data system was correct while other information required correction. For the September 2015 survey, a total of 206 of 456 providers (45.2%) returned a survey noting at least a revision to at least one element was necessary. For the March 2016 survey, a total of 219 of 467 providers (46.9%) returned a survey noting at least a revision to at least one element was necessary. Survey items where a substantial percentage of MCO data were missing included: provider license number, secondary specialty, Spanish and other languages spoken. IPRO sent plan-specific reports to each of the MCOs that included a list of revisions needed and a list of incorrect provider addresses. The MCOs were asked to update their provider directory files with the correct information.

Based on the findings from the Provider Network Validation studies, the EQRO made the following recommendations:

- MCOs should improve the accuracy and completeness of critical fields in the provider directory data files, especially fields relating to license number, phone number, address, and languages.
- DMS should consider enhancing the MCAPS provider file data dictionary with more specific definitions for the data elements.
- DMS should consider adding data elements to the directory that collect information about wheelchair access, hours at site and provider's usage of EMRs.
- DMS should consider removing the field "Spanish" and incorporating it into the Language field.
- DMS should consider recording "Secondary Specialty" on the same row as "Primary Specialty" instead of on separate rows.

Web-Based Provider Directory Validation

The Provider Web Directory Validation was performed to ensure that enrollees receive accurate information when they access the MCOs' web-based provider directories. The objectives of this study were two-fold: 1) to determine if all

providers included in the MCOs' electronic provider directory files are listed in the web-based provider directories, and 2) to ensure that provider information published in the MCO's' web directories is consistent with the information reported in the provider directory files and/or the provider network validation responses.

This study used provider directory files from September 2015 submitted by the MCOs. A random sample of 50% of providers who responded to the Provider Network Validation Study was drawn. Of those, no more than 50 providers from each MCO (25 primary care providers [PCPs] and 25 specialists) were chosen for audit. Overall, 97% of the PCPs and 77% of the specialists were found in the MCO online web directories. The accuracy of the web directory data was evaluated by comparing the information published in the MCO web directories to both the MCOs' provider directory files and the provider validation survey responses. If the web-based data matched either the provider directory files or the provider's survey response, the information was considered to be accurate. The overall accuracy rate of the provider information published in the web directories was determined to be 80% for PCPs and 88% for specialists.

One study limitation in the methodology for the web-based provider directory validation was that the study sample included only providers who responded to the Provider Network Survey and, therefore, excluded a portion of the full provider population in the MCAPS. Additionally, IPRO recommended that the web-based directory validation should also include a measure to indicate whether the web directory information is more consistent with the MCAPS file or the provider network survey responses. This would allow DMS to target data improvement to the appropriate source.

A second web directory validation was initiated in March 2016. This study used provider directory files from February 2016 submitted by the MCOs. A random sample of 50% of providers who responded to the Provider Network Validation Study was drawn. Of those, no more than 50 providers from each MCO (25 PCPs and 25 specialists) were chosen for audit. Overall, 97% of the PCPs and 79% of the specialists were found in the MCO online web directories. The accuracy of the web directory data was evaluated by comparing the information published in the MCO web directories to both the MCOs' provider directory files and the provider validation survey responses. If the web-based data matched either the provider directory files or the provider's survey response, the information was considered to be accurate. The overall accuracy rate of the provider information published in the web directories was determined to be 68% for PCPs and 83% for specialists.

Quality Performance

Quality performance data is the basis for quality assurance and improvement activities. MCOs contract with a certified HEDIS audit organization to conduct an NCQA-approved audit prior to submitting HEDIS data to DMS. Additionally, MCOs are required to contract with an NCQA-certified vendor to administer the CAHPS survey. Complete HEDIS 2015 and CAHPS 2015 data files were successfully submitted by CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky in June 2015 for services provided in the 2014 measurement year (MY). Since Anthem BCBS Medicaid was a new plan in 2014, the MCO submitted only a partial set of measures. DMS elected not to rotate any of the HEDIS measures selected for rotation by NCQA. DMS is reviewing the possibility of HEDIS measure rotation for future submissions.

Validation of Reporting Year 2015 Kentucky Medicaid Managed Care Performance Measures

The Kentucky Medicaid MCO contract requires annual reporting of DMS-designated PMs, including both HEDIS and state-specific PMs, that reflect Healthy Kentuckians 2010 and Healthy Kentuckians 2020 goals and health care priorities. Together, the measures address 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 and children with special health care needs [CSHCN]). IPRO validated the MCO-reported PMs for reporting year (RY) 2015 based on the CMS protocol: *Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities (updated 2012)*. The performance validation methodology included an information systems capabilities assessment; denominator validation; data collection validation; and numerator and rate validation.

After the validation was completed, each of the measures and specifications were reviewed for necessary clarifications, revisions and improvements for the RY 2016 measure set. The MCOs' feedback, lessons learned from calculating the measures, the results of the PM validation findings, and DMS priorities were considered. All RY 2016 measure

specifications were updated as necessary, including dates, diagnosis and procedure codes and applicable HEDIS specification updates.

MCO Performance Annual Health Plan Report Card

The Annual Health Plan Report Card is a document in which IPRO summarized HEDIS 2015 quality performance data. It is Kentucky's consumer-friendly document entitled "A Member's Guide to Choosing a Medicaid Health Plan." The guide was included in mailings sent during the open enrollment period and is also available in both English and Spanish on the DMS MMC webpage.[11] A similar guide will be developed for the 2017 open enrollment period using HEDIS 2016 and CAHPS 2016 data.

MCO Performance Dashboard

The MCO Performance Dashboard is a quality performance dashboard that pictorially presents national, statewide and MCO-specific performance on selected quality and satisfaction measures using graphs and charts. IPRO updated the dashboard using HEDIS 2015 data and the most recent version is posted on the internet.[12] The dashboard content is comprehensive, clearly displayed, user-friendly, and simple to navigate, allowing the user to obtain information quickly and easily.

[11] http://www.chfs.ky.gov/NR/rdonlyres/7BD9A46D-6710-4915-8163-4394F8F36EFF/0/2016MembersGuidetoChoosingaMedicaidHealthPlan.pdf (English), Accessed June 13, 2016. http://www.chfs.ky.gov/NR/rdonlyres/7E4290C1-5F2C-411B-9D21-99AB4074B023/0/2016MembersGuidetoChoosingaMedicaidHealthPlanSpanishrevised.pdf (Spanish), Accessed June 13, 2016.

[12] http://ky.mco.ipro.org/

Compliance with State and Federal Standards

On behalf of DMS, IPRO annually evaluates MCO performance against contract requirements and state and federal regulatory standards. In an effort to prevent duplicative review, federal regulations allow for use of the NCQA accreditation findings to deem regulatory compliance, where accreditation standards are determined equivalent to federal regulatory requirements. Currently, three of the five Kentucky MCOs are accredited by NCQA: CoventryCares of Kentucky, Passport Health Plan and WellCare of Kentucky. The newer MCOs, Anthem BCBS Medicaid and Humana-CareSource, have been preparing for accreditation and anticipate meeting the contract requirements for accreditation within three years. Since the Kentucky contract contains specific domains and requirements that are not addressed by the NCQA accreditation reviews, the state prefers to use a deeming policy based on prior MCO performance rather than deeming based on accreditation.

The annual compliance review for the contract year January 2015–December 2015 was conducted in January 2016. Two MCOs (Humana-CareSource and Passport Health Plan) received partial reviews, based on findings of compliance in the previous year. The three remaining MCOs received full reviews, i.e., an assessment of all domains and requirements. Data were collected from the MCOs prior to the survey (pre-onsite documentation submission), during the onsite review, and in follow-up (post-onsite documentation submission). All data and information submitted are considered in determining the extent to which the health plan is in compliance with the standards.

Contract requirements and regulations were addressed within the following domains (in order of review tool number):

1. Quality Measurement and Improvement
2. Grievance System
3. Health Risk Assessment (HRA)
4. Credentialing and Recredentialing
5. Access

5a. Utilization Management (UM)

6. Program Integrity
7. EPSDT
8. Delegation
9. Health Information Systems
10. Case Management/Care Coordination

12a. Enrollee Rights

12b. Member Outreach

13. Medical Records
15. Behavioral Health Services
16. Pharmacy Services

Reviewer findings for each domain formed the basis for assigning preliminary and final review designations. The standard designations used are listed in Table 2.

Table 2: Standard Designations for Compliance Review

Standard Designations for Compliance		Points
Full Compliance	MCO has met or exceeded the standard.	3
Substantial Compliance	MCO has met most requirements of the standard, but may be deficient in a small number of areas.	2
Minimal Compliance	MCO has met some requirements of the standard, but has significant deficiencies requiring corrective action.	1
Non-compliance	MCO has not met the standard and requires corrective action.	0
Not Applicable	The standard does not apply to the MCO.	N/A

Each element within a review domain receives one of the determinations listed in Table 2 and a corresponding score for each determination (3 points for full compliance; 2 points for substantial compliance; 1 point for minimal compliance; and 0 points for non-compliance). The numerical score for each review domain is then calculated by adding the points achieved for each element and dividing by the total number of elements. Thus, an MCO may have some elements within a domain determined minimally compliant or non-compliant, but when averaged with other elements found to be fully or substantially compliant, the overall finding for that domain may indicate substantial compliance. The overall compliance determination is assigned as follows:

- Full Compliance: point range of 3.0
- Substantial Compliance: point range of 2.0–2.99
- Minimal Compliance: point range of 1.0–1.99
- Non-compliant: point range of 0–0.99
- Not Applicable: N/A

As with the prior compliance reviews, DMS directed that any elements found less than compliant in the prior review (2015) and the current review (2016) should be scored minimally compliant and any elements found less than compliant for the two (2) prior years (2014 and 2015) and the current review (2016) should be scored non-compliant.

Compliance Review Findings

Table 3 summarizes the 2016 annual compliance review findings for each category reviewed. The MCOs receive preliminary findings and are permitted to submit responses for further review. The final findings are sent to both the MCOs and DMS. The DMS Corrective Action Plan and Letter of Concern Committee (CAP/LOC Committee) reviews the findings. The Division of Program Quality and Outcomes, Managed Care Oversight Quality Branch and the Managed Care Oversight Contract Management Branch work together to determine which domains and elements will require a letter of concern (LOC) and/or a corrective action plan (CAP) request for each MCO. The CAP/LOC Committee issues the LOCs and CAP requests to the MCOs. In general, the MCOs must provide a CAP for all elements deemed minimally compliant or non-compliant.

Table 3: Overall Compliance Determinations by Review Category – 2016

Tool #/ Review Area[1]	Anthem BCBS Medicaid		CoventryCares of Kentucky		Humana-CareSource		Passport Health Plan		WellCare of Kentucky	
	Point Average	Compliance Deter-mination	Point Average	Compliance Deter-mination	Point Average	Compliance Deter-mination	Point Average	Compliance Deter-mination	Point Average	Compliance Deter-mination
1. QI/MI	2.47	Substantial	2.74	Substantial	2.99	Substantial	2.98	Substantial	3.00	Full
2. Grievances	2.43	Substantial	2.68	Substantial	2.75	Substantial	3.00	Full	2.93	Substantial
3. HRA	1.83	Minimal	2.71	Substantial	3.00	Full	3.00	Full	2.57	Substantial
4. Credentialing/ Recredentialing	2.60	Substantial	2.92	Substantial	3.00	Full	2.71	Substantial	2.99	Substantial
5. Access	2.17	Substantial	2.82	Substantial	2.33	Substantial	2.50	Substantial	2.91	Substantial
5a. UM	2.90	Substantial	3.0	Full	3.00	Full	3.00	Full	3.00	Full
6. Program Integrity	2.08	Substantial	2.74	Substantial	3.00	Full	3.00	Full	2.89	Substantial
7. EPSDT	2.14	Substantial	3.00	Full	3.00	Full	2.50	Substantial	3.00	Full
8. Delegation	3.00	Full	2.92	Substantial	N/A	N/A	N/A	N/A	2.79	Substantial
9. Health Information Systems	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
10. Care Management	1.67	Minimal	2.79	Substantial	3.00	Full	3.00	Full	2.91	Substantial
12a. Enrollee Rights	2.83	Substantial	2.87	Substantial	2.67	Substantial	3.00	Full	3.00	Full
12b. Member Outreach	3.00	Full	3.00	Full	N/A	N/A	N/A	N/A	3.00	Full
13. Medical Records	1.92	Minimal	2.95	Substantial	N/A	N/A	3.00	Full	3.00	Full
15. Behavioral Health Services	1.29	Minimal	2.94	Substantial	2.83	Substantial	3.00	Full	2.92	Substantial
16. Pharmacy Services	2.86	Substantial	2.72	Substantial	2.60	Substantial	3.00	Full	2.85	Substantial
# Elements Requiring Corrective Action/# of Elements Reviewed (% Requiring Corrective Action)[1]	54/240 (22.5%)		33/759 (4.3%)		2/131 (1.5%)		0/136 (0%)		3/726 (0.4%)	

[1] The number (#) of elements reviewed for each domain and in total varies by MCO according to their applicability; N/A – Not applicable (deemed due to prior Full Compliance)
BCBS: Blue Cross and Blue Shield; QI/MI: Quality Assessment and Performance Improvement/Measurement and Improvement; HRA: Health Risk Assessment; UM: Utilization management; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment; N/A: not applicable.

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In 2016, the Health Information Systems domain was not reviewed for any of the MCOs since all were deemed fully compliant in prior reviews. The evaluation of this review area includes, but is not limited to, a review of policies and procedures for claims processing; claims payment and encounter data reporting; timeliness and accuracy of encounter data; timeliness of claims payments; and methods for meeting Kentucky Health Information Exchange (KHIE) requirements.

Passport Health Plan achieved full compliance for nine domains; both WellCare of Kentucky and Humana-CareSource attained full compliance for six domains; Aetna Better Health for three domains; while Anthem BCBS Medicaid earned full compliance for two domains.

Across all MCOs, the majority of review requirements (57%) exhibited substantial compliance, meaning that most requirements of the standards were met, but there were a small number of deficiencies identified. Many of the deficiencies noted were omissions or lack of clarity in the MCO policies and procedures, Provider Manuals, and/or Member Handbooks.

Only Anthem BCBS Medicaid received category-level determinations of less than substantial compliance; with four domains earning minimal compliance. None of the five MCOs received a category-level designation of non-compliance.

The number and proportion of elements reviewed eligible for corrective action (rating of minimal or non-compliance) ranged from a high of 22.5% (54 of 240 elements) for Anthem BCBS Medicaid to a low of 0% for Passport Health Plan. Of all elements reviewed for all five MCOs, 4.6% received minimal or non-compliant ratings that could require a CAP.

Program Integrity

Maintaining program integrity includes guarding against fraud, abuse and deliberate misuse of Medicaid program benefits; ensuring that Medicaid enrollees receive necessary quality medical services; and ensuring that providers and recipients are in compliance with federal and state Medicaid regulations. In determining MCO compliance with federal and state regulations for program integrity, the EQRO's 2016 Compliance Review included, but was not limited to, an evaluation of MCO policies and procedures, training programs, compliance with Annual Disclosure of Ownership (ADO) and financial interest provisions and a file review of program integrity cases.

Overall compliance determinations for the Program Integrity domain varied. Both Passport Health Plan and Humana-CareSource achieved full compliance; while Anthem BCBS Medicaid, Aetna Better Health and WellCare of Kentucky earned substantial compliance. Anthem BlueCross BlueShield Medicaid and Aetna Better Health were required to prepare CAPs for elements found minimally compliant or non-compliant. No CAPs were required for the other three MCOs.

Health Risk Assessment

Evaluation of the HRA domain included, but was not limited to, examination of MCO policies and procedures and a review of initial health screenings and MCO-initiated outreach to new members. The findings revealed that for this domain, Passport Health Plan and Humana-CareSource both achieved full compliance; Aetna Better Health and WellCare of Kentucky earned substantial compliance; while Anthem Blue Cross Blue Shield Medicaid was found to be in minimal compliance with the standards for HRA. All MCOs faced challenges in obtaining completed initial health risk assessments for newly enrolled members. Areas where compliance was lacking included: no documentation of assistance with PCP linkage and initial appointment scheduling and lack of referral to case management for needs identified in the HRA. All MCOs, except Humana-CareSource and Passport Health Plan, were required to submit at least one CAP.

Care Management/Coordination

Care coordination is a key component of managed care and is based on the assurance that all enrollees have an ongoing source of primary care 24 hours a day, 7 days a week as well as access to all necessary care and services. The MCO plays a unique role in identifying individuals with special healthcare needs (including chronic physical, developmental, behavioral, neurological or emotional conditions) and offering care coordination through case management. MCOs identify enrollees in need of care coordination via HRAs completed for new enrollees and tracking indicators of need

using encounter data algorithms to identify high risk diagnosis codes, high utilization, repeated use of emergency rooms, frequent inpatient stays, and hospital readmissions.

The compliance domain Care Management and Coordination closely examines coordination of care efforts between the MCOs and Kentucky's Department of Community Based Services (DCBS) and the Department of Aging and Independent Living (DAIL). MCOs require access to baseline information from DCBS and DAIL to enable timely and appropriate member referrals and for MCO case managers to ensure enrollee access to needed services. The service plans maintained by DCBS and DAIL are a key source of this baseline information. Ongoing communication with DCBS/DAIL staff is also essential to coordinate the most appropriate services and address individual member's needs. The DMS Division of Program Quality and Outcomes, Disease and Case Management Branch has been working to facilitate communication between the state agencies and the MCOs, including convening collaborative workgroups and tracking MCO access to service plans.

The 2016 overall compliance determinations for Care Management and Coordination revealed that Humana-CareSource and Passport Health Plan achieved full compliance; Aetna Better Health and WellCare of Kentucky earned substantial compliance, while Anthem BCBS Medicaid was found minimally compliant. For the purposes of the 2015 and 2016 annual reviews, DMS designated the requirements related to service plans not applicable for the MCOs since the service plans are under the domain of DCBS and DAIL. The sole requirement for the MCOs was to demonstrate efforts to obtain service plans for their enrolled DCBS and DAIL members. Obtaining service plans, especially accurate and complete service plans has been an historical challenge for all MCOs. All MCOs demonstrated efforts to obtain service plans and to meet regularly with DCBS and DAIL. Opportunities for improvement identified by this review included: the need to develop and implement policies and procedures that ensure access to care coordination for all DCBS clients; improve tracking and analyzing performance indicators for DCBS clients and implementing corrective actions when warranted; and the need for policies and procedures that better address Pediatric Interface and school-based services.

Enrollee Rights and Responsibilities

MCO Member Services is responsible for providing information to enrollees and responding to enrollee questions, problems and complaints. Member Services educates and assists enrollees to select or change their primary care provider. Member Services is also responsible for providing written information, such as a Member Handbook; explaining covered services; and providing instructions on how to access services. State and federal regulations call for cultural awareness and sensitivity in communicating with members and handling member grievances, cultural issues and program integrity. Kentucky Medicaid MCOs conduct ongoing monitoring of Member Services' functions by tracking the content and efficiency of calls including returned calls, call resolution, repeat callers and call abandonment rates. MCOs that utilize a subcontracted call center service must conduct careful vendor oversight and reporting.

The 2016 Compliance Review evaluation of the Enrollee Rights and Responsibilities domain included an assessment of policies and procedures for member rights and responsibilities, PCP changes and Member Services functions. For the Enrollee Rights domain, Passport Health Plan and WellCare of Kentucky achieved full compliance, while the remaining three MCOs, Anthem BCBS Medicaid, Aetna Better Health and Humana-CareSource earned substantial compliance. Humana-CareSource was required to submit one CAP and no CAPs were required of the remaining MCOs.

Quarterly Desk Audit Tables

While DMS remains committed to conducting compliance reviews on an annual basis, in an effort to streamline the compliance review process for the MCOs, the EQRO initiated periodic desk audits of selected MCO statutory reports submitted to DMS on a quarterly basis. As a result, the EQRO is able to review quarterly report data concurrent with submission by the MCOs, rather than reviewing all the statutory report data in conjunction with the annual compliance review. IPRO is able to conduct these quarterly reviews by creating and completing Desk Audit Tables that address each MCO upon receipt of the MCO quarterly reports from DMS, concurrent with each MCO's quarterly submission to DMS. The desk audits address each of the following review areas:

- Access and Availability
- Continuity and Coordination (Case Management/Care Coordination)
- Coverage and Authorization of Services (UM)
- Enrollee Rights
- Grievance System

Provider Network Access

Kentucky Medicaid MCOs are required to maintain and monitor a network of appropriate providers and assure that there is adequate provider capacity that is sufficient in number, mix of specialty and geographic distribution. The MCOs conduct ongoing reviews of provider credentials and assure that enrollees receive timely access to services within designated time and travel parameters. Progress in meeting these contract provisions is described using compliance review findings along with access and availability survey findings, HEDIS Access and Availability measures, HEDIS Use of Services measures and CAHPS member satisfaction survey results.

Compliance with Access Standards

The EQRO's Annual Compliance Review assessment of access included, but was not limited to a review of policies and procedures for direct access services, provider access requirements, program capacity reporting, evidence of monitoring program capacity and provider compliance with hours of operation and availability.

Findings from the 2016 Compliance Review related to provider network access indicated that all five MCOs received an overall rating of substantial compliance. WellCare of Kentucky, Passport Health Plan and Humana-CareSource had no elements requiring a corrective action plan, while Aetna Better Health and Anthem BCBS Medicaid had four and one elements requiring corrective action, respectively.

Access and Availability Survey of Dental Providers

During CY 2016, DMS and IPRO collaborated to design and conduct a dental provider access and availability survey using a "secret shopper" methodology. All five Kentucky Medicaid MCOs participated in the survey: Anthem BCBS Medicaid, CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan, and WellCare of Kentucky. A random sample of 220 dentists was selected from each MCO's dental network.

The telephone survey was fielded between November and December 2015. Time was allowed for initial phone calls and recalls after obtaining updated phone numbers for some providers. The methodology consisted of several different dental appointment request scenarios depending on the type of dental provider and for an adult or child/adolescent member. Scenarios for both routine and urgent needs were used. The contract requirements for timely appointments are 21 days for a routine service and 48 hours for an urgent need. The telephone surveyors made up to four attempts to contact a live person at each provider office. If a live person was not reached, the surveyor did not leave a telephone number call-back.

Key findings included the following:

- Overall, dental providers were contacted for 92.4% of routine calls and 88.2% of urgent calls.
- Dental providers were reached and appointments were scheduled within the required timeframes for 35.2% of routine calls and 31.6% of urgent calls (i.e., 21 days and 48 hours, respectively).

When the survey was completed, each of the MCOs received a plan-specific summary report of dental providers who could not be contacted and those who could not provide an appointment within the required timeframe. MCOs were asked to review the reports and submit responses for files instances where providers who could not be reached and/or appointments that could not be made timely. IPRO reviewed the responses and submitted a report to DMS.

Board Certification

Rates for the HEDIS 2015 Board Certification measure illustrate the percentage of physicians in an MCO's provider network who are board certified as of the last day of the MY (December 31, 2014) for the following specialties - family medicine, internal medicine, obstetrics/gynecology(OB/GYN), pediatrics, geriatrics and other specialties. Four of the five Kentucky Medicaid MCOs reported this measure for RY 2015 – CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan, and WellCare of Kentucky. Anthem Blue Cross and Blue Shield Medicaid did not report this measure in 2015.The board certification rates for family medicine physicians, OB/GYNs, pediatricians, and geriatricians were below the HEDIS 2015 national NCQA Quality Compass™ average for all MCOs. The rates for internists and other physicians were above the NCQA average rate only for CoventryCares of Kentucky.

Access and Utilization – HEDIS 2015

HEDIS Access/Availability of Care and Utilization measures indicate the percentages of children, adolescents, and adults who access their PCP for preventive visits, outpatient services, dental services, and alcohol and other drug (AOD) dependence treatment. Timeliness and adequacy of prenatal and postpartum services, well-child visits, adolescent well-care visits and MCO call answer timeliness is also assessed.

Performance related to access and availability was a statewide area of strength. Measures for which Kentucky's HEDIS 2015 weighted statewide average met or exceeded the HEDIS 2015 national Medicaid 50th percentile included the following:

- Adult Access to Preventive/Ambulatory Health Services: Total Rate;
- Children and Adolescents' Access to Primary Care Practitioners (all age groups);
- Annual Dental Visit (all age groups);
- Prenatal and Postpartum Care: Timeliness of Prenatal Care; and
- Frequency of Ongoing Prenatal Care: 81%+ of Expected Visits.

Although strong performance was demonstrated for some measures of access, opportunities for improvement remain. The HEDIS 2015 weighted statewide rate for Well-Child Visits in the First 15 Months of Life (≥ 6 Visits); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Adolescent Well-Care Visits; Call Answer Timeliness; and Initiation and Engagement of AOD Dependence fell short of the national Medicaid 50th percentile.

Consumer Satisfaction with Access – CAHPS Health Plan Survey 5.0H 2015

Each of the five MCOs is required by DMS to conduct annual adult and child member satisfaction surveys. The CAHPS 5.0H Adult survey was sent to a random sample of members ages 18 years and older as of December 31, 2015 and continuously enrolled for at least five of the last six months of 2015. The child and adolescent CAHPS 5.0H satisfaction survey was sent to the parent/guardian of randomly sampled members ages 17 years and younger as of December 31, 2015 and continuously enrolled for at least five of the last six months of 2015.

Table 4 highlights CAHPS 5.0H 2015 measures related to access from the adult and child satisfaction surveys: Getting Care Quickly; Getting Needed Care; Doctor is Available When Needed; and Satisfaction with Customer Service. For both the adult and child surveys, the Kentucky statewide average was above the 2015 NCQA national Medicaid average for all four measures.

Table 4: CAHPS 2015 5.0H Adult and Child Satisfaction Survey – Access Measures

Measure	Anthem BCBS Medicaid	Coventry-Cares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	Statewide Average 2015
Adult Survey						
Get Care Quickly[1]	85.26%	81.48%	83.10%	81.55%	83.18%	83.0 %↑
Get Needed Care[1]	84.68%	83.27%	86.32%	83.21%	84.53%	84.4 %↑
Adult Doctor Available[2] (Q4)	88.61%	84.67%	87.58%	84.72%	83.49%	85.9 %↑
Customer Service[1]	89.17%	88.70%	96.36%	89.87%	90.56%	90.8% ↑
Child Survey						
Get Care Quickly[1]	90.90%	94.65%	87.84%	92.08%	89.75%	91.2 %↑
Get Needed Care[1]	83.58%	86.60%	81.32%	89.42%	88.25%	87.2 %↑
Child Doctor Available[2] (Q4)	91.84%	95.33%	91.76%	93.93%	88.73%	92.4 %↑
Customer Service[1]	86.16%	87.25%	91.52%	90.88%	85.40%	88.3 %↑

[1] These indicators are composite measures.
[2] Note: for measures that call for respondents to answer with "Always," "Usually," "Sometimes" or "Never" the Medicaid rate is based on responses of "Always" or "Usually."
↑ Arrow indicates Kentucky statewide average > 2015 NCQA Quality Compass national Medicaid average.[13]

[13] National Committee for Quality Assurance Quality Compass™, Medicaid CAHPS®2015.

Quality Assessment and Performance Improvement

Quality Assessment and Performance Improvement (QAPI) is addressed in the EQRO's annual compliance review and includes, but is not limited to, a process review of each MCO's Health Information Systems, credentialing and delegation procedures, UM, Quality Improvement (QI) Program Description, Annual QI Evaluation, QI Work Plan and QI committee structure and function. In addition to processes and procedures, the EQRO reviews MCO performance including a compilation and analysis of the Medicaid MCOs' quality performance and satisfaction data. IPRO validated MCO PIPs, completed two focused clinical studies and conducted two additional focused clinical studies during the contract period. This section of the Progress Report outlines and describes the various quality assessment and improvement activities undertaken as part of Kentucky's MMC Program.

Health Information Systems

As stated prior, the domain addressing the MCOs' Health Information Systems was not reviewed in 2016 because all MCOs were deemed due to full compliance in previous years.

Credentialing

Kentucky Medicaid MCOs are responsible for ongoing review of network provider performance and credentials. As part of the 2016 Compliance Review, the EQRO assessed MCO written policies and procedures regarding the selection and retention of providers in their network. Providers, including individuals and facilities, must be validly licensed and/or certified to provide services in the state, and may also be accountable to a governing body for review of credentials for physicians, dentists, advanced registered nurse practitioners and vision care providers.

The 2016 Compliance Review findings for Credentialing/Recredentialing demonstrated that one MCO achieved full compliance (Humana-CareSource) while the remaining four MCOs earned substantial compliance.

Delegation

With the approval of DMS, MCOs may execute subcontracts for the performance of administrative functions or the provision of services to members. The Kentucky Medicaid MCOs enlisted subcontractors for a variety of purposes, including for example, HEDIS data collection, claims processing, call center functions, and behavioral health, dental and vision provider networks. MCOs are required to provide written notification regarding all subcontracts to DMS quarterly and within ten days of termination of a subcontract.

The 2016 compliance evaluation of this domain comprised a review of subcontractor contracts and oversight, including subcontractor reporting requirements, pre-delegation evaluations and annual, formal evaluations. No review was required for Humana-CareSource and Passport Health Plan due to findings of full compliance ratings for this domain in prior years. Anthem BCBS Medicaid achieved an overall determination of full compliance for the Delegation domain, while Aetna Better Health and WellCare of Kentucky each earned substantial compliance.

Utilization Management

A comprehensive UM program regularly reviews services for medical necessity and routinely monitors and evaluates the appropriateness of care and services. Each MCO's UM program must have mechanisms in place to ensure consistency in applying clinical review criteria and protocols. The EQRO review included an evaluation of UM policies and procedures, UM committee meeting minutes and a review of a sample of UM files. Four of the five MCOs earned full compliance for the UM domain, the exception was Anthem BCBS Medicaid, with an overall rating of substantial compliance. No MCOs had elements requiring a CAP.

Quality Measurement and Improvement

The 2016 Compliance Review findings revealed that WellCare of Kentucky achieved full compliance for all Quality Measurement and Improvement standards, while Anthem BCBS Medicaid, CoventryCares of Kentucky, Humana-CareSource and Passport Health Plan each earned substantial compliance ratings. Of the four MCOs rated substantially compliant; Humana-CareSource, Passport Health Plan, and WellCare of Kentucky required no CAPs, while Aetna Better Health and Anthem BCBS Medicaid required 9 and 15 CAPs, respectively.

Performance Measurement

Kentucky Medicaid PMs are derived from three annual data submissions to DMS: Kentucky PMs; HEDIS data, and the CAHPS consumer satisfaction results.

Kentucky Performance Measures – Reporting Year 2015

Kentucky PMs, submitted annually to DMS, are validated by the EQRO according to the CMS protocol for PM validation. The performance validation methodology includes an information system capabilities assessment; denominator validation; data collection validation; and numerator validation. A final report is prepared, which includes all validation findings and a designation of reportable/not reportable for each of the measures.

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

- Performance was very good for documentation of height and weight for both children and adolescents and adults, with rates above 75% for both.
- Only approximately 24% of adults and 39% of children and adolescents had a healthy weight for height reported. It should be noted; however, that this measure is 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 approximately 30%.
- The rate for cholesterol screening for adults was fair, at 58.71%.
- Adolescent screening and counseling rates ranged from a low of 34.32% (screening/counseling for sexual activity) to a high of 61.35% (screening/counseling for tobacco), with screening/counseling for alcohol/substance use and depression falling in between (44.54% and 36.76%, respectively).
- For screening and counseling during the perinatal period, screening for tobacco was most often found (55.58%), followed by screening for alcohol use (51.88%) and substance use (49.54%).
    - Of the 312 (34.40%) women identified as tobacco users, only 61.25% had evidence of intervention.
    - Of the 59 (8.06%) women identified as alcohol users, only 22.43% had evidence of intervention.
    - Of the 93 (10.68%) women identified as substance users, only 61.92% had evidence of intervention.
- Prenatal assessment/counseling for nutrition was found in 31.37% of records and counseling for use of prescription and/or over-the-counter medications was reported 50.98% of the time.
- There is a substantial opportunity for improvement in screenings for domestic violence and depression. Rates were 25.16% for prenatal domestic violence screening, 33.98% for prenatal depression screening, and slightly higher at 39.42% for postpartum depression screening.
- Access to dental care for CSHCN, as indicated by the HEDIS Annual Dental Visits measure, was fair for the total CSHCN population ages 2-21, at 59.22%, and ranged from a low of 52.84% for the SSI population to a high of 70.85% for the foster population.
- Related to well-child visits for CSHCN, performance ranged from 45.24% for adolescent well-care visits to 71.17% for well-child visits for children 3–6 years of age.
- All rates for access to care for CSHCN exceeded 90%. The rate was highest for those 12–24 months of age (98.04%), followed by 7–11 years of age (94.72%), 25 months–6 years of age (92.98%) and 12–19 years of age (92.44%).
- The rate for 6 or more well-visits in the first 15 months of life was 47.57%.
- The CMS-416 EPSDT dental services measures were reported for the first time in RY 2015. The rate for receipt of any dental service was 47.29% and the rate for preventive services was 40.13%. The aggregate rate for sealants on a permanent molar for children 6 and 11 years of age was very low, 5.02% and ranged from 1.80% to 5.49% across the five MCOs.

Quality Performance – HEDIS 2015

DMS requires the MCOs to report HEDIS measure rates for the following domains: Board Certification, Effectiveness of Care, Access/Availability of Care and Use of Services. All five MCOs (Anthem BCBS Medicaid, CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky) successfully submitted audited HEDIS data in June 2015 for services provided in MY 2014. This was the first year of reporting for Anthem BCBS Medicaid.

HEDIS 2015 results for Board Certification, Access and Use of Services were summarized previously, in the Provider Network Access section of this report. Results for the Effectiveness of Care measures are summarized below.

HEDIS Effectiveness of Care measures evaluate how well a health plan provides preventive screenings and care for members with acute and chronic illnesses, including: respiratory illnesses, cardiovascular illnesses, diabetes, behavioral health and musculoskeletal conditions. In addition, medication management measures are included.

A review of HEDIS 2015 Effectiveness of Care rates for the Kentucky MCOs revealed that many of the weighted statewide average rates compared favorably with HEDIS 2015 Medicaid Quality Compass 50th percentile including the following:

- Adult BMI Assessment,
- Immunizations for Adolescents, including Meningococcal, Tetanus, Diphtheria, Pertussis/Tetanus, Diphtheria booster (Tdap/Td) and Combination #1,
- Use of Appropriate Medications for People with Asthma (Ages 5–11 Years, 12–18 Years, and Total),
- Follow-up Care for Children Prescribed ADHD Medication (Initiation and Continuation/Maintenance Phases),
- Annual Monitoring for Patients on Persistent Medications (ACE Inhibitors, Diuretics, Total),
- Medication Management for People with Asthma: 75% Compliance (all age groups and Total), and
- Comprehensive Diabetes Care:
  1. HbA1c Testing,
  2. Poor HbA1c Control (> 9.0%),
  3. HbA1c Control (< 8.0% and < 7.0%), and
  4. Medical Attention for Nephropathy.

Opportunities for improvement were identified by weighted statewide averages below the national Medicaid Quality Compass 10th percentile benchmark for the following measures:

- Appropriate Treatment for Children with Upper Respiratory Infection,
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, and
- Use of Imaging Studies for Low Back Pain.

Consumer Satisfaction – CAHPS 2015

Statewide, the survey findings indicated that 73.8% of adults were satisfied overall with their healthcare in the managed care program and 78.4% were satisfied with their health plan. Statewide rates for these survey items were above the 2015 national Medicaid average. The child survey results demonstrated that 84.8% were satisfied overall with their child's healthcare and 83.5% were satisfied with their health plan; however, both rates fell just short of the CAHPS 2015 national Medicaid average.

Quality Improvement

Performance Improvement Projects (PIPs)

A protocol for conducting PIPs was developed by CMS to assist in the design and implementation of Medicaid performance improvement efforts. Additionally, federal MMC regulations require that all PIPs be validated according to CMS EQR protocols for PIP validation. In the Kentucky MMC Program, the EQRO is responsible for validating MCO PIPs. Each year, the MCOs initiate two new PIPs, each with baseline, interim and final measurements over a three-year duration; thus, in any given year, an MCO is likely to have two to six PIPs at various stages of activity in progress.

The EQRO's process for validating MCO PIPs begins with DMS approval of the PIP topic. Using a team of two reviewers, the EQRO evaluates the PIP proposals, including the topic selection, rationale, methodology, study indicators, and planned interventions. The MCOs receive written feedback and the findings are discussed via teleconferences. Subsequently, the EQRO follows all PIPs through each phase with written evaluations and discussions of the PIP progress and issues. Each PIP is assessed with a quantitative score at the interim and final re-measurement phases. The concurrent evaluation approach is a key method for validating the PIP results, but more importantly, it helps the MCOs to refine the indicators, methodology, and interventions prior to implementation. This allows the MCO identify and

address any issues early. The MCO benefits also from the perspective of multiple reviewers. The EQRO team is available for consultation at any time, should the MCO need assistance.

Initially, MCOs selected PIP topics based individually, usually based on HEDIS results. Subsequently, DMS initiated a contract requirement that MCOs conduct a PIP for one physical health and one behavioral health topic annually with each MCO selecting the specific topics. More recently, DMS has designated a collaborative, statewide topic. For 2015, the topic was use of antipsychotic medications for children and adolescents and for 2016, management of preventive care and physical health risks for people with serious mental illness (SMI). For the 2016 PIP, IPRO developed the PIP indicators and methodology and is assisting the MCOs with intervention development for this statewide improvement effort.

Table 5 presents a list of the Kentucky Medicaid MCOs' active PIP topics for 2012–2018.

Table 5: PIP Project Status 2012–2018

Plan	PIP Topic	Proposal Submitted	PIP Period
All-plans	Safe and Judicious Antipsychotic Medication Use in Children and Adolescents	2014	2015–2017
	The Effectiveness of Coordinated Care Management on Physical Health Risk Screenings in the Seriously Mentally Ill Population	2015	2016–2018
Anthem BCBS Medicaid	Reducing Avoidable Emergency Department Utilization	2014	2015–2017
	Increasing Annual Dental Visits	2015	2016–2018
Aetna Better Health Medicaid	Major Depression: Anti-Depressant Medication Management and Compliance	2012	2013–2015
	Decreasing Non-Emergent Inappropriate Emergency Department Use	2012	2013–2015
	Secondary Prevention by Supporting Families of Children with Attention Deficit Hyperactivity Disorder (ADHD)	2013	2014–2016
	Decreasing Avoidable Hospital Re-admissions	2013	2014–2016
	Increasing Comprehensive Diabetes Testing and Screening	2014	2015–2017
	Improving Postpartum Care	2015	2016-2018
Humana-CareSource	Untreated Depression	2013	2014–2016
	Emergency Department Use Management	2013	2014–2016
	Increasing Postpartum Visits	2014	2015–2017
	HbA1c Control	2015	2016–2018
Passport Health Plan	Reduction of Emergency Room Care Rates	2012	2013–2015[1]
	Reduction of Inappropriately Prescribed Antibiotics for Pharyngitis and Upper Respiratory Infections (URI)	2012	2013–2015[1]
	You Can Control Your Asthma! Development and Implementation of an Asthma Action Plan	2013	2014–2016
	Psychotropic Drug Intervention Program	2013	2014–2016
	Reducing Readmission Rates of Postpartum Members	2014	2015–2017
	Healthy Smiles	2015	2016–2018
WellCare of Kentucky	Utilization of Behavioral Health Medication in Children	2012	2013–2015
	Decreasing Inappropriate Emergency Department Utilization	2012	2013–2015
	Follow-up After Hospitalization for Mental Illness	2013	2014–2016
	Management of Chronic Obstructive Pulmonary Disease (COPD)	2013	2014–2016
	Postpartum Care	2014	2015–2017
	Pediatric Oral Health	2015	2016–2018

[1] Prior to 2012, Passport Health Plan was the sole Medicaid MCO and the contract required only one PIP annually.
[2] Final EQRO review of second re-measurement was sent to MCO 2/24/2015.
BCBS: Blue Cross and Blue Shield.

The EQRO's PIP reviews encompassed an evaluation of the study topic selection, indicators, methodology, interventions, data analysis and results as well as an overall impression of the PIPs' strengths and opportunities for improvement. Several recurring strengths were noted in the PIP review summaries including:

- strong project rationale supported by literature citations and/or national and statewide statistics and plan-specific data;
- selected topic demonstrates substantial opportunity for improvement;
- strong evidence of topic relevance to the plan or a public health issue;
- collaboration with external organizations;
- use of a multi-disciplinary teams for project implementation;
- interventions that address identified barriers; and
- multi-dimensional interventions targeting providers, members and the health plan.

The EQRO's role in validating the PIP also involved identification of opportunities for improvement, and the following were recurring comments in the PIP reviews:

- Indicators are not clearly defined or are not aligned with the study aims and objectives.
- The interventions do not directly target the indicator(s).
- A more active intervention strategy is needed as the proposed interventions are passive education activities such as mailings and website postings.
- Process measures should be used to track the progress of the major interventions.
- The intervention descriptions lack specifics, such as timeframes and logistics on implementation.

Anthem BCBS Medicaid did not have any PIPs at the interim or final phases that required scoring. They had two PIPs at the baseline phase that were submitted: Reducing Avoidable Emergency Department Utilization and Antipsychotic Medication Use in Children.

Aetna Better Health had two 2013 PIPs at the final measurement phase, Decreasing Non-Emergent/Inappropriate Emergency Department Utilization and Major Depression: Antidepressant Medication Management and Compliance. Both met the compliance requirements with recommendations and comments. Two PIPs were in the interim phase: Secondary Prevention by Supporting Families of Children with ADHD and Decreasing Avoidable Hospital Readmissions. Both of the PIPs met compliance requirements with recommendations. Aetna Better Health continues to meet with DMS and IPRO on a monthly basis.

Humana-CareSource had two PIPs in the interim phase of scoring: Untreated Depression and Emergency Dept: Use Management. Both PIPs met compliance.

Passport Health Plan's one 2014 PIP, Psychotropic Drug Intervention Program (PDIP), was at the interim phase during this contract year. The EQRO found that it met compliance requirements.

WellCare of Kentucky had two PIPs in the final phase: Utilization of BH Medicine in Children and Inappropriate ED Utilization. Both of these PIPs were found to be compliant. Two additional PIPs were in the interim phase. They are: Follow-up After Hospitalization for Mental Illness and Management of COPD. Both of these PIPs are currently compliant at this phase.

Focused Clinical Studies

During the contract year, the EQRO initiated and completed two focused clinical studies: 1) Emergency Department Visits for Non-traumatic Dental Problems Among the Adult Kentucky Medicaid Managed Care Behavioral Health Subpopulation, and 2) Prenatal Smoking.

Emergency Department Visits for Non-traumatic Dental Problems Among the Adult Kentucky Medicaid Managed Care Behavioral Health Subpopulation

Administrative encounter data for measurement year June 1, 2014–May 31, 2015 were utilized to assess relationships between the outcome of an emergency department (ED) visit for non-traumatic dental problems and the risk factors among the adult (aged 18 years and older) MMC behavioral health (BH) subpopulation.

The following outcomes were evaluated among the total adult BH subpopulation: any (one or more) ED visit(s) for non-traumatic dental problems: disorders of tooth development and eruption; diseases of hard tissues of teeth (dental caries); disease of pulp and periapical tissues; gingival and periodontal diseases; other diseases of teeth and supporting structures.

In addition, among the subset of the population with non-traumatic dental visits (NTDV), associations between risk factors and the outcome of multiple NTDVs (MNTDVs) were evaluated. The risk factors examined included demographic characteristics (age group, race, sex); specific BH conditions; chronic physical health conditions; member region of residence (rural non-Appalachian, urban non-Appalachian, and Appalachian county); MCO; access to PCPs, access to BH providers for outpatient visits; and access to outpatient dental visits by type (restorative, preventive/diagnostic without restorative care; pain/palliative care without restorative care; and no outpatient dental visits).

Key findings included the following:

- The majority of the BH MMC population with one or more NTDVs was between the ages of 18–37 years and resided in urban counties.
- Unmet dental needs and lack of access to outpatient dental care crossed geographic boundaries.
- Most Kentucky BH MMC members with an NTDV had no outpatient dental visits, yet the highest NTDV rate was among members with an outpatient dental visit for pain/palliative care without any restorative care.
- There was significant variability in the NTDV rate among Medicaid MCOs and among members with and without outpatient visits to PCPs and BH providers.

Prenatal Smoking

The aims of this focused clinical study included the following:

- assess smoking prevalence, member characteristics, and receipt of prenatal smoking cessation services among the Kentucky MMC population who delivered a singleton live or non-live birth;
- evaluate the relationships between smoking cessation benefit utilization and demographic, clinical and health care access characteristics;
- identify clinical, demographic and smoking-related factors that impact selected adverse perinatal outcomes; and
- profile provider prenatal and postpartum interventions relative to guidelines, including the 5 A's, MCO care coordination and case management of prenatal and postpartum interventions, whether or not smoking abstinence was achieved and, if it was achieved, whether it was achieved during the prenatal period or the postpartum period.

The study methodology comprised analyses of both administrative data and data abstracted from medical records. The administrative portion of the study examined the entire population of members who delivered a singleton live or stillborn infant, utilizing administrative claims/encounter data to evaluate disparities and associations. Smoking status was defined using ICD-9-Clinical Modification (ICD-9-CM) diagnosis codes across all settings of care during the 280 days prior to the delivery date.

The medical record portion of the study utilized a random sample of 500 members (424 member charts received) from the eligible aforementioned eligible population, stratified by smoking status and MCO (i.e., a population of smokers and nonsmokers from each of the five MCOs). The following data were abstracted from the medical records: provider documentation of the "5 A's" in the prenatal and postpartum outpatient records, MCO documentation of care coordination/case management prenatal and postpartum interventions for smoking cessation, and both prenatal and postpartum smoking abstinence outcomes from both provider and MCO charts.

Key findings included the following:

- The majority of members (89.97%) were assessed for smoking status during a prenatal visit; however, only 49.28% had an initial smoking assessment conducted at a first prenatal visit that occurred during the first trimester.
- Less than half (46.98%) of prenatal smokers were advised to quit at any prenatal visit, 22.15% were advised to quit during the first trimester and 16.11% during the second trimester.
- Only 2.01% of prenatal smokers were referred to the Kentucky quit line.

- There were 57 (38.36%) of 149 smokers who received perinatal provider counseling; Of these 57 smokers, medical record documentation indicated that a total of 5 members quit smoking during pregnancy; 2 quit smoking with abstinence from the first trimester through delivery, 1 abstained from the second trimester through delivery, and 2 abstained from the third trimester through delivery.

Early and Periodic Screening, Diagnosis and Treatment

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

Kentucky Medicaid Managed Care Early Periodic Screening, Diagnostic and Treatment Services (EPSDT) Review for 2015, Draft Report June 2016

The EQRO conducted a review of adherence to EPSDT protocol using MCO EPSDT data reports and review of a sample of complaints, grievances, denials and care management files. Other reports and data referenced included the Annual Compliance Review findings for the EPSDT domain, 2015 HEDIS (MY 2014 data) and Kentucky PMs (MY 2014 data), and MCO statutory reports (MY 2015). EPSDT programs for each of the five Kentucky Medicaid MCOs participating in 2015 were evaluated.

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

- Quarterly Report #24 – Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death,
- Annual Report #93 – EPSDT Annual Participation Report (as reported on CMS-416),
- Quarterly Report #17 – Quality Assessment and Performance Improvement Work Plan,
- Quarterly Report #85 – Quality Improvement Program Evaluation,
- Annual Report #94 – CAHPS Medicaid Child Survey,
- Annual Report #86 – Annual Outreach Plan,
- Quarterly Report #18: Monitoring Indicators, Benchmarks and Outcomes, and
- Quarterly Report #19, Performance Improvement Projects (PIPs).

Key findings included the following:

- Kentucky MCOs were compliant with contractual requirements to inform members about the availability of EPSDT services and facilitate utilization; most demonstrated a multi-faceted approach to member education, utilizing a variety of educational mailings, personalized postcards pre- and post-service due dates, telephonic outreach, website postings, and presentation at community and back-to-school events.
- Every MCO required PCPs to provide EPSDT services; four of five MCOs met all PCP network requirements for geographic access, member to PCP ratios, and appointment scheduling wait times.
- Four of five MCOs were fully compliant regarding provider education conducted via provider manuals, websites, newsletters, resource guides, tool kits, and on-site visits. A recurring issue is the development of educational materials for non-physician providers such as nurses, nurse practitioners and physician assistants.
- Four of five MCOs were compliant with monitoring provider delivery of EPSDT services through medical record review against Clinical Practice Guidelines, tracking provider-specific PM rates, and monitoring provider member panels for Care Gaps. With few exceptions, notably Passport Health Plan, MCO screening ratios by age group did not meet national averages and decreased with age, indicating primarily infants are receiving the expected number of screenings. A similar pattern was seen in participant ratios, indicating relatively more infants and toddlers received any screening services during the review period. HEDIS Access/Availability and Utilization of Care measures also demonstrated fewer PCP and well-care visits among adolescents compared to infants and toddlers.

Summary of Program Progress – Strengths and Opportunities for Improvement

This report described the status and progress of the Kentucky MMC Program's external quality review activities that have occurred over the past twelve-month contract period of July 1, 2015 through June 30, 2016. During the contract period, numerous strengths as well as opportunities for improvement have been identified and are highlighted below.

Strengths

Program Administration

- Kentucky's MMC Program is composed of five MCOs with capacity to serve Medicaid enrollment statewide. Enrollment has steadily increased over the past year from 1,162,413 as of June 29, 2015, to 1,229,921 as of June 6, 2016, an increase of 5.8%.
- With several leadership changes and increasing branch responsibilities for monitoring and quality improvement, DMS continues to vigorously apply staff resources and expertise in the development of their expanding MMC Program.
- Kentucky continues to have a contract in place for external quality review, including work plan activities for the annual technical report, the three mandatory quality review activities and several optional activities, such as conducting focused quality studies and validation of MCO submitted data files.
- There continues to be excellent lines of communication between the state, the MCOs and the EQRO.
- DMS applied for and received acceptance to participate in several CMS Affinity Group collaboratives and a SAMHSA Tobacco Policy Group collaborative, which offer opportunities to expand state resources through collaboration with other state and national participants.

Data Systems

- Data collection systems for all five Medicaid MCOs are in place including encounter data, provider network data, HEDIS and Kentucky PMs. All MCOs submitted data to DMS according to established timeframes.
- Each month the EQRO received a final extracted encounter file from DMS and created a monthly Encounter Data Validation Report summarizing the MCO submissions. DMS continues to work with the MCOs, the EQRO and appropriate divisions of DMS to review MCO progress in encounter data quality and completeness and to troubleshoot issues in need of improvement.
- MCOs commented that their communication with DMS regarding encounter data submissions continues to be positive and the monthly conference calls with DMS continue to be helpful.
- DMS continues to update their internet website to include MCO data reports and external quality review reports.
- The EQRO successfully completed four data validation reviews of the Kentucky MMC Program Provider Network, including two audits of Kentucky's Provider Network Submissions (September 2015 and March 2016) and two validations of MCO web-based provider directories in the same months.
- The overall accuracy rates of the provider information published in the web directories was found to be 97% for PCPs and 77% for specialists.
- Kentucky PMs, HEDIS and CAHPS data were successfully submitted by all MCOs in 2015 for services provided in the 2014 measurement year.
- The EQRO validated the Kentucky PMs for reporting year 2015 and compiled all MCO HEDIS audit findings.
- The EQRO summarized HEDIS 2015 quality performance data in Kentucky's consumer-friendly document entitled "A Members Guide to Choosing a Medicaid Health Plan." A copy of the guide is posted on the DMS website. A similar guide is also being developed with HEDIS and CAHPS 2016 data.

Compliance with State and Federal Standards

- An annual compliance review was successfully completed in January 2016 by the EQRO for the calendar year January 2015–December 2015 for all five MCOs. Anthem and WellCare of Kentucky had full reviews.
- The overwhelming majority of review areas for all plans (93%) exhibited overall substantial or full compliance.

- Health Information Systems was not reviewed for the five MCOs since they received full compliance ratings in the previous compliance review.

Provider Network Access

- The EQRO conducted a telephone survey of provider appointment availability for dental providers using the "secret shopper" methodology. Overall, dental providers were contacted for 92.4% of routine calls and 88.2% of urgent calls. Dental providers were reached and appointments were scheduled within the required timeframes for 35.2% of routine calls and 31.6% of urgent calls (i.e., 21 days and 48 hours, respectively).
- Overall, the adult and child CAHPS 2015 survey results showed strong consumer satisfaction with access to care under the Kentucky MMC Program, including ratings for Getting Care Quickly, Getting Needed Care, Customer Service and Doctor Availability.

Quality Assessment

- All five MCOs reported Kentucky PMs for reporting year 2015. The EQRO validated the Kentucky PMs for 2015.
- All five MCOs successfully submitted audited HEDIS data in June 2015 for services provided in the 2014 measurement year.
- Statewide results of the adult CAHPS 2015 survey indicated that 78.4% of adults were satisfied overall with their healthcare under managed which was above the 2015 national Medicaid average for overall satisfaction with healthcare. For the child survey, 82.5% of those surveyed were satisfied overall with their healthcare, falling just short of the CAHPS 2015 national Medicaid average.

Performance Improvement

- The EQRO reviewed all PIP proposals submitted by Kentucky Medicaid MCOs for 2015 and continues to validate all PIPs in progress though periodic conference calls with the MCOs.
- Validation findings for all completed PIP reviews indicated that the credibility of the PIP results is not at risk after the revisions suggested by the EQRO were addressed.
- The EQRO completed two related focused studies: 1) Emergency Department Visits for Non-traumatic Dental Problems among the Adult Kentucky Medicaid Managed Care Behavioral Health Subpopulation; and 2) Prenatal Smoking.

Opportunities for Improvement

Data Systems

- A monthly validation review of encounter data submissions continues to indicate a number of variables that consistently have a high percent of missing data elements including inpatient diagnoses codes 4 and above, inpatient procedure codes, inpatient surgical codes 2 and above, performing provider key, procedure modifier codes, referring provider key and outpatient surgical ICD-9 codes. Provider-related data was also missing several key elements including NPI, provider license number and taxonomy.
- The audits of MCO provider network submissions indicated that close to half of the returned surveys noted at least one revision.

Compliance with State and Federal Standards

- Anthem BCBS was required to submit 54 Corrective Action Plans (CAPs) for Minimal or Non-compliant elements, or 22.5% of total elements reviewed, followed by Aetna Better Health(4.3%), Humana-CareSource (1.5%), WellCare of Kentucky (.4%) and Passport Health Plan (0%).
- In preparing Quarterly Desk Audit Tables as part of the compliance review, there continues to be a lack of consistency in MCO interpretations of the data specifications for reporting, thus making comparisons across MCOs difficult. The EQRO provided suggestions for revising report language and instructions to improve reporting consistency.
- Of all elements reviewed for all five MCOs, 4.6% received minimal or non-compliant ratings requiring a corrective action plan. This is an overall improvement from last year's rate of 10.6%.
- Overall Anthem BCBS received minimal compliance determinations for HRA, Care Management, Medical Records and Behavioral Health Services.

Provider Network Access

- The Access and Availability Survey of dental providers reported that appointments were scheduled within the required timeframes for 35.2% of routine calls and 31.6% of urgent calls (i.e., 21 days and 48 hours, respectively).
- HEDIS 2015 statewide rates for Board Certification for all provider types fell below the HEDIS 2015 national NCQA Quality Compass 10th percentile rate.

Quality Assessment

- The process of summarizing selected quarterly report information across plans in the form of quarterly desk audits highlights the variability in the data reported and raises questions about how each of the MCOs are interpreting the questions. More data specification and interpretive guidance is needed, so that all MCOs are reporting consistently and a fair comparison can be made across plans.
- Reported EPSDT screening rates dropped from 83% in RY 2015 to 82% in RY 2015. The reported participation rate for EPSDT services in RY 2015 was 58%, well below the 80% standard set by CMS. Results of the EPSDT validation study and HEDIS and Healthy Kentuckians measures indicated opportunities for improvement in mental health, vision, hearing, and developmental screening; depression and behavioral risk screening for adolescents; BMI screening and nutrition/physical activity counseling; immunizations and lead screening. Oral health assessment was also found lacking in the validation study.

Performance Improvement

- As a result of the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity Clinical Focused Study, MCOs were encouraged to promote BMI percentile screening and universal prevention interventions for all MMC-enrolled children beginning in early childhood; to improve provider risk assessment, management and monitoring of overweight and obese enrollees; to ensure that resources for nutrition, physical activity and weight management are disseminated to network providers; and to educate members and families regarding cardiovascular and other health risks associated with overweight and obesity. It was further recommended that improvement efforts address obesity with a chronic care model that includes motivational interviewing, family involvement and engagement of all office staff in the care of at-risk children and adolescents.

Recommendations

Focusing on the strengths and opportunities for improvement identified for the Kentucky MMC Program between July 1, 2014 and June 30, 2015, the following key performance area recommendations are presented for DMS's consideration.

Data Systems

External quality review activities are strongly rooted in data quality including validations of performance data, encounter data and provider network data. The protocols for validating data require an assessment of multiple dimensions including:

- Validity and accuracy – does the data reflect the real world?
- Consistency – can the data be compared over time and between entities?
- Completeness – is there missing data?
- Timeliness – is the data available at the time needed?
- Relevance – does the data meet the users' needs?

The quality of data collected and maintained by the MCOs is of critical importance in measuring program progress and achievements and for targeting improvement efforts. Missing codes in encounter data submissions and inconsistent performance rates as identified in the Encounter Data Rate Benchmarking Study adversely impact the usefulness of the data. Data elements should be clearly defined and specified. Inconsistent provider information in MCO and DMS Medicaid provider datasets needs to be continually audited and improved. Recommendations from the Provider Network Audits should be implemented to improve the usability of the provider data. The monthly encounter data meetings between DMS and the MCOs are valuable in helping the MCOs resolve encounter data submission problems and should be continued.

Provider Network Access

HEDIS PMs and CAHPS satisfaction measures related to access were an area of strength for all five MCOs reviewed in this progress report; however, opportunities for improvement in the following HEDIS rates should be addressed:

- Board Certification for all provider specialties,
- Well-Child Visits in the First 15 Months of Life (6+ visits),
- Well-Child Visits in the Three to Six Years of Life,
- Adolescent Well-Care Visits, and
- Initiation of AOD Dependence Treatment: 18+ years and Total.

Quality Assessment and Performance Improvement

Using the national 2014 Medicaid Quality Compass as a benchmark, opportunities for improvement should be considered for the following HEDIS 2015 measures that fell below the national Medicaid 10th percentile:

- Cervical Cancer Screening,
- Appropriate Treatment for Children with Upper Respiratory Infection,
- Annual Monitoring for Patients on Persistent Medications (Digoxin), and
- Use of Imaging Studies for Low Back Pain.

Several Kentucky PMs which fell below 50% also offer opportunities for improvement:

- healthy weight for height for both adults and children,
- counseling for nutrition and physical activity for both adults and children/adolescents,
- adolescent screening for depression,
- screening for tobacco, alcohol use and substance use during the prenatal period,
- prenatal assessment/counseling for nutrition and prenatal counseling for use of prescription and/or over the counter medications, and
- prenatal screening for domestic violence, prenatal screening for depression and postpartum screening for depression.

With results from the Kentucky Behavioral Health Study and the Experience of Care Survey for Children with a Behavioral Health Condition, DMS may want to consider potential new measures that have been under review by NCQA such as, body mass index screening and follow-up for people with SMI; clinical depression screening and follow-up for people with alcohol or other drug dependence use; controlling high blood pressure for people with SMI; and follow-up after emergency department use for mental illness or AOD dependence.

Care Coordination

All MCOs faced challenges in obtaining health risk assessments. General issues identified were: lack of documentation of assistance with PCP linkage and/or referrals to case management for identified needs. Care management review findings further revealed the need to develop and implement policies and procedures to ensure access to care coordination for all DCBS clients and to track, analyze, report and implement corrective actions regarding care coordination of DCBS clients. As noted in prior years, each of the MCOs faced challenges related to obtaining complete service plans but all demonstrated efforts to obtain the plans and to meet with DCBS regularly. While there has been substantial improvement in care coordination and communications between state agencies and MCOs, DMS needs to continue efforts to coordinate and maintain those improved communications.