



Improving Healthcare  
for the Common Good



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

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

FINAL REPORT  
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## Comprehensive Evaluation Summary

Over the past twenty years, state and federal policy-makers have promoted Medicaid Managed Care as a way of improving access to quality health care for Medicaid beneficiaries while at the same time controlling or containing steadily rising health care expenditures under the traditional fee-for-service delivery system. Managed care organizations (MCOs) accomplished this by offering beneficiaries office-based medical homes with a focus on primary care, patient education and numerous care management programs. In this way, MCOs could reduce reliance on hospital emergency rooms and unnecessary inpatient stays. While most states have focused their Medicaid managed care programs on relatively low cost families and children, states are increasingly planning expansions to their Medicaid managed care programs to cover more of their high-cost populations. By 2010, close to 70 percent of the country's 60 million Medicaid beneficiaries were enrolled in some form of managed care. As a result of the Patient Protection and Affordable Care Act (ACA), expanded Medicaid eligibility and the desire to bring more of the high-cost beneficiaries under the managed care umbrella will inevitably fuel further growth of Medicaid managed care.<sup>1</sup>

The Centers for Medicare and Medicaid Services (CMS) oversees the development and administration of the Medicaid managed care programs pursuant to the Social Security Act (Part 1915<sup>2</sup> and Part 1932(a))<sup>3</sup>, the Balanced Budget Act of 1997 and Title 42<sup>4</sup>, Part 438 of the Code of Federal Regulations (CFR)<sup>5</sup>.

One of the requirements of federal regulation (42 C.F.R. §438.200 et seq.) is that all states contracting with a managed care organization (MCO) or prepaid inpatient health plan (PIHP) have a written strategy for assessing and improving the quality of managed care services provided to Medicaid enrollees. This written strategy is referred to as the "State Quality Strategy." States are requested to obtain input from beneficiaries and other key stakeholders and to make the document available for public comment before final adoption. CMS provides a toolkit to assist states in developing their Quality Strategy, including an outline format for states to follow.

At a minimum, State Quality Strategies must include:

- MCO contract provisions that incorporate the standards of Part 438, subpart D;
- Procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO;
- Procedures that identify the race, ethnicity and primary language spoken of each enrollee;
- Procedures used to regularly monitor and evaluate the MCO's compliance with Part 438, subpart D;
- Arrangements for annual, external independent reviews of quality outcomes and timeliness of and access to services;
- Appropriate use of intermediate sanctions;
- An information system that supports initial and ongoing operation and review of the State's quality strategy; and

- Standards for access to care, structure and operations, and quality measurement and improvement.

This comprehensive evaluation summary is a result of 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, September, 2012,<sup>6</sup> approved by CMS September 20, 2012.

### **Background – Medicaid Managed Care in Kentucky**

In December 1995, Kentucky was granted approval under Section 1115 waiver authority to establish a statewide Medicaid managed care program that would be phased into different regions over time as described in state regulations. The waiver initially established health care partnerships of medical providers in both public and private sectors who would together provide comprehensive medical services to Medicaid beneficiaries living in designated regions. Two partnerships were eventually implemented in two regions of the state (Regions 3 and 5). Kentucky is divided into eight total regions – Region 3 is composed of Jefferson County and 15 surrounding counties and Region 5 is Fayette and 20 surrounding counties. In 1999, the Region 5 partnership notified the Department for Medicaid Services (DMS) that it was withdrawing from the managed care program and, by fall of 2000, the state had stopped plans to implement a statewide risk-based managed care program.

The remaining partnership, through University Health Care (UHC, and operating as Passport Health Plan, PHP), continued contracting with DMS to provide Medicaid managed care services to Medicaid beneficiaries in Region 3. Medicaid beneficiaries in the rest of the state were enrolled in a primary care management system which allowed enrollees to choose or be assigned a primary care provider who was responsible for providing primary care services and authorizing referrals to other specialty care.

More than a decade later and faced with increasing Medicaid health care expenditures and a growing eligible population, like many other states across the country, the state of Kentucky began to explore ways to more effectively manage health care costs while maintaining or improving access and quality. Kentucky once again looked to risk-based managed care as a solution and in 2011, initiated a procurement process to contract with MCOs that could provide services statewide. By July 2011, three additional managed care organizations were awarded contracts – 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.

Thus, in a very short time span, the state of Kentucky transitioned from one MCO in one region of the state, to four MCOs – two providing Medicaid services statewide; one providing services statewide except for Region 3, and one providing services only in Region 3. They phased in all populations (except waiver program enrollees) and all services including behavioral health and prescription drugs. This extremely aggressive timeline was challenging to all stakeholders – the

state, the MCOs, the providers, and the enrollees. The ability of the state to oversee the expanded program was tested and is still in the process of transition. New plans are adjusting to the Kentucky Medicaid environment, providers and beneficiaries are adjusting to managed care versus fee-for-service Medicaid. This theme of newness and transition will be evident throughout this evaluation.

A little more than a year after implementation, Kentucky Spirit Health Plan notified DMS that they would stop providing managed care services to Medicaid beneficiaries as of July 5, 2013. The state was successful in procuring a new contract with Humana – CareSource and the transition of health plan enrollees is now underway. Due to this recent development, Humana – CareSource, with just 16,068 enrollees in September, 2013, will not be included in this report. Table 1 below describes the Medicaid managed care program in Kentucky as reviewed in this summary.

Table 1. List of MCOs

MCO	Current Enrollment 9/16/2013	Service Area
CoventryCares of Kentucky	262,836	Statewide
Passport Health Plan	125,452	Region 3 – 16 counties
WellCare of Kentucky	282,831	Statewide

### Core Program Goals

In Kentucky’s original Quality Strategy, approved in 2004, DMS’ goal to improve the health status of Medicaid recipients, established a set of Medicaid Managed Care Performance Measures consistent with Healthy Kentuckians 2010 Goals<sup>7</sup>, which was the state’s version of the national preventive agenda, Healthy People 2010. Other Performance Measures were derived from the Healthcare Effectiveness Data and Information Set (referred to as HEDIS®)<sup>8</sup>, and from collaboration with Passport Health Plan and the state’s external quality review organization (EQRO). Kentucky’s strategy, approved in 2012, includes a subset of these measures and encompasses access, timeliness and quality of care provided to recipients enrolled in managed care as they relate to four program goals:

- Improve preventive care for adults;
- Improve care for chronic illness;
- Improve behavioral health care for adults and children; and
- Improve access to a medical home.

Table 2. Core Program Goals and Performance Measures

Goal	Performance Measures
Improve preventive care for adults	Increase performance on: Colorectal Cancer Screening Breast Cancer Screening Cervical Cancer Screening
Improve care for chronic illness	Increase performance on: Comprehensive Diabetes Care Cholesterol Management for Patients with Cardiovascular Conditions
Improve behavioral health care for adults and children	Increase performance on: Antidepressant Medication Management Follow-up After Hospitalization for Mental Illness
Improve access to a medical home	Increase performance on: Adults Access to Preventive/Ambulatory Services Children and Adolescents Access to Primary Care Change Performance on Outpatient and ED Visits

Benchmarks used to measure improvement are from the NCOA’s Quality Compass<sup>9</sup> Medicaid which presents HEDIS® data submitted to NCOA by Medicaid plans throughout the nation. These standardized measures allow states to make meaningful comparisons between MCOs as well as between states. Once state policy makers understand how their MCOs compare and how their state ranks nationally, they are better able to identify program strengths and weaknesses and target areas most in need of improvement. Improvement in the Kentucky strategy is measured by a comparison of the state’s rate to the 50<sup>th</sup> or 75<sup>th</sup> percentile of the national benchmark or as ten percent difference between the state’s baseline rate and the re-measurement rate. Using national performance is a reasonable approach to setting benchmarks and the Commonwealth modestly sets the bar at the 50<sup>th</sup> percentile for the majority of the measures (colorectal cancer screening, breast cancer screening, cervical cancer screening, comprehensive diabetes care, cholesterol management, antidepressant medication management and outpatient visits). Also, by allowing the improvement target to be met by a 10% rate of improvement from the baseline year to the current re-measurement year means that even if a measure falls below the national benchmark, if it has improved significantly from one time period to the next (defined as the rate difference of 10%) then improvement has been achieved.

MCOs in Kentucky are aware of the Quality Strategy program goals and are setting their own performance goals and objectives to align with the state’s program goals. Passport noted that a number of the measures selected for their Pay for Performance for providers align with the state goals as do some of their member incentive programs. MCOs also refer to the state performance

measures when selecting topics for their Performance Improvement Projects (PIP). For example, CoventryCares of Kentucky selected Improving Antidepressant Medication Management as a PIP.

Going forward, DMS may want to expand the number and/or focus of their strategy goals and measures to include prenatal and child health measures. The Kentucky Department of Public Health has major ongoing initiatives to improve infant mortality and nutrition that are not represented in the current goals and performance measures. On March 3, 2013, the Governor's Summit on Infant Mortality called attention to this critical problem and brought together many state and national stakeholders to discuss current issues and next steps. Data published by the Kentucky Department of Public Health, Division of Maternal and Child Health in March, 2013 showed Kentucky's infant mortality rate for 2007–2009 at 6.8 infant deaths for every 1,000 live births, compared to a national rate of 6.6. Preterm births, a significant contributor to infant mortality, were 13.7% of total births compared to 12% nationally. Another statistic presented, showed that 22.9% of Kentucky resident women reported smoking in any trimester of pregnancy in 2011, compared to 10.4% nationally. Further, according to the Kentucky Maternal and Child Health Five-Year Needs Assessment developed in 2010 for the Maternal and Child Health Bureau, Health Resources and Services Administration, the top five priority issues were: 1) smoking and substance abuse; 2) teen pregnancy; 3) obesity; 4) oral health and 5) school health.<sup>10</sup>

The state currently collects all HEDIS® measures and many state-specific indicators relating to Healthy Kentuckians prenatal and child health goals such as adult and child body mass index screening, counseling for nutrition and physical activity, adolescent risk screening and prenatal screening and counseling. In addition to Kentucky's state-specific indicators, there are also several HEDIS® and CAHPS<sup>11</sup> consumer satisfaction performance measures that could be considered: Adolescent Preventive Care Measures; Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents; Prenatal and Postpartum Care; and Medical Assistance with Smoking Cessation (from CAHPS). DMS may also want to consider the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) initial core set of children's health care quality measures.<sup>12</sup> The initial core set includes twenty-four measures covering a wide range of health issues.<sup>13</sup>

## Methodology

The methodology for this evaluation includes a systems review, a document review and stakeholder interviews. A summary review of other state strategies was also conducted to provide a sharing of state practices.

A review of systems included an overview of data reporting systems, communications and the functions of the External Quality Review Organization (EQRO). Information was obtained from EQRO and state reports, state and plan websites and news releases in the public media. Other state Quality Strategies were obtained from state websites and key areas were compared including Medicaid enrollment, number of MCOs, accreditation status, Performance Improvement Projects (PIPs) performed, Pay for Performance, state-MCO collaboration, public reporting and EQR activities.

Documents such as the Commonwealth of Kentucky Strategy for Assessing and Improving the Quality of Managed Care Services and the Urban Institute's Evaluation of Statewide Risk-Based Managed Care in Kentucky, A First Year Implementation Report were key documents referenced. Federal regulations (42 C.F.R. §438.200 et seq.) describing the intent and process of developing a State Quality Strategy were also reviewed along with the most recent compliance reports conducted by the EQRO.

The most critical component of this evaluation approach was the interviews conducted with key stakeholders. These allowed the reviewer to gain information not readily available in written reports or websites, but more importantly offered an opportunity to better understand the interconnectedness and perspectives of all those involved with providing, monitoring and assessing access, timeliness and quality of care. Conference call interviews were held with IPRO, the Kentucky DMS and three Medicaid MCOs – CoventryCares of Kentucky, Passport Health Plan and WellCare of Kentucky. Results and findings are presented for discussion and potential implementation by the state, the MCOs and/or the external quality review organization (EQRO).

## Summary of Findings – Medicaid Managed Care Quality Strategy Assessment

### Processes for Program Monitoring and Measuring

#### Responsibility for Program Monitoring

Program monitoring, as described in the Quality Strategy, begins with an understanding of how specific contract provisions in the state's Medicaid MCO Model Contract meet the standards for access to care, structure and operations, and quality measurement and improvement.

At the program level, the DMS is tasked with the responsibility to purchase quality healthcare and related services that produce positive outcomes for persons eligible for programs administered by the department. As purchaser, DMS oversees the Medicaid Managed Care Program, which includes contracting with Medicaid MCOs, monitoring their provision of services according to state and federal regulations and overseeing their quality programs. DMS also contracts with an EQRO to assist in review and evaluation of state and MCO quality performance and improvement.

DMS is currently in the process of re-organizing its structure to better address its responsibilities for monitoring and oversight of an expanding Medicaid managed care program. As many states have discovered in the process of implementing and growing a Medicaid managed care program, coordination and communication are key. The state's Medicaid program must now change its paradigm to better align with a risk-based managed care environment as noted in the Urban Institute's evaluation of Kentucky's first year of implementation, "...the state's oversight of Medicaid managed care plans is still developing. State managed care expertise is expanding and efforts to monitor health plan quality and beneficiary access are underway, though the state is still determining how best to use and disseminate the information they are collecting from plans."<sup>14</sup>

From the time Governor Beshear signed legislation authorizing the transition to statewide, risk-based managed care on March 25, 2011, DMS staff released an RFP soliciting bids from MCOs and finalized contracts with four managed care plans by early July, 2011 – a little over three months' time. The first notifications went out to enrollees in September 2011 and open enrollment ended January 31, 2012.

With this rapid transition behind them, the department re-assessed functions, staff availabilities and skills and designated two Divisions to handle aspects of the managed care program – the Division of Program Quality and Outcomes and the Division of Policy and Operations.

- New Division of Program Quality and Outcomes includes a Disease and Case Management Branch and a Managed Care Oversight – Quality Branch
  - The Managed Care Oversight – Quality Branch focuses on managed care quality including implementation of the state's Quality Strategy; contracting and managing

- the EQRO contract; overseeing MCO quality improvement initiatives and data resources related to quality.
- Division of Policy and Operations now includes a Managed Care Oversight – Contract Management Branch
    - The Managed Care Oversight – Contract Management Branch facilitates implementation of new plans; participates in on-site audits and operational reviews and reviews MCO quarterly and annual reports to monitor compliance with the contract. The branch has designated staff liaisons for each of the state's Medicaid MCOs. As the program matures, their role will become less of a funnel of information back and forth and more contract compliance.

Several staff developments are notable. A new Chief Medical Officer, Dr. John Langefeld joined DMS effective June 1, 2013. His background includes extensive health care experience in clinical care, provider management, managed care and data analysis. Several key staff positions are currently vacant and being recruited including Director and Assistant Director of the Division of Program Quality and Outcomes; Branch Managers of Disease and Case Management and Managed Care Oversight-Quality and Branch Manager of Managed Care Oversight-Contract Management in the Division of Policy & Operations. It is also anticipated that there will be additional staff hired in the Managed Care Oversight-Quality Branch.

Overall, DMS staff interviewed expressed positive energy regarding the reorganization and are working together to more clearly define functions, responsibilities and communications between the branches as well as with other agencies in the Cabinet of Health and Family Services.

## Data Sources

In order to comply with state and federal regulations regarding Medicaid managed care, each MCO must maintain a Management Information System (MIS) that will support all aspects of a managed care operation and demonstrate sufficient analysis and interface capabilities. The following subsystems are required:

- Member Enrollment – enrollment and member demographics,
- Encounter Data System – utilization data including encounters in all settings, emergency room use, outpatient drug therapy, EPSDT and out of network services,
- Provider Network – provider demographics, provider type, specialty code, licensing, credentialing,
- Claims – payment processing, adjustment processing, accounts receivable and all other financial transaction processing, and
- Surveillance Utilization Review System (SURS) – capability to identify fraud and/or abuse of providers or members.

An additional data system for managed care plans is their HEDIS® quality performance database. HEDIS® data, as specified by NCQA, is required to be submitted contractually each August to DMS. This past June, the MCOs submitted this data in order for it to be incorporated into the Annual Report Cards that are provided to members during open enrollment.

The MCO is responsible for verifying, through edits and audits, that the information contained in their databases is accurate and timely. They are expected to screen for data completeness, logic and consistency. The data must be consistent with procedure codes, diagnoses codes and other codes as defined by DMS and in the case of HEDIS® quality data, as defined by NCQA. This evaluation of data sources focuses on the three database systems from which data are submitted to DMS – encounter data, provider network data and HEDIS® quality performance data.

### Encounter Data

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

and validity of encounter data improves over time, the state and EQRO will be able to calculate many of the utilization metrics that are currently being submitted quarterly by the MCOs, thus reducing the MCOs' reporting requirements.

May 2013 was the first month for submitting encounter data for the expansion MCOs. Passport Health Plan had previously submitted encounters for seven years, stopping in June, 2012 and starting again in May, 2013 using the new file format. The EQRO received a final extracted file from DMS for further processing. A monthly data validation report is created by the EQRO to summarize MCO submissions. The format of this report is similar to the monthly reports previously prepared for encounter submissions through June 2012, which included the following information:

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

A review of the June 2012 Monthly Encounter Data Validation Report (PHP), prepared by the EQRO, revealed notable missing data for the following data elements:

#### Encounter Detail File (779,721 record count)

- Diagnosis Codes were missing, particularly Diagnosis code 3 (57% missing) and Diagnosis code 4 (100% missing),
- Place of Service and Procedure Codes were missing in 11% of records, respectively,
- Procedure Modifier was missing 80% of the time,
- Revenue Code was missing in 68% of records, and
- 100% of the records lacked Submitting Provider ID and Submitting Provider National Provider Identification (NPI).

#### Pharmacy Detail File (1,580,344 record count)

- 100% of the records were missing Submitter Provider NPI Number.

The Kentucky MCOs have not seen the EQRO monthly encounter data reports. These reports are used primarily as an internal tool by DMS to monitor encounter data submissions. The state has, however, convened a weekly encounter data workgroup to discuss and resolve current encounter submission problems MCOs are facing. Interviews with the EQRO and the MCOs indicated that coding continues to be a problem:

- All MCOs mentioned a common issue of confusion over codes related to provider matching between state and MCO provider data – provider name, taxonomy code, NPI numbers and effective dates.

- It has not been easy to implement the changes with all their providers in the short period prior to submission, thus there is a blend of provider ID codes submitted leading to rejected records.
- MCOs are struggling to void and resubmit corrected encounters in the 10 days allowed, and feel this turn-around time is too short to adequately correct and resubmit records.
- Another issue that relates to the time for correcting and resubmitting is that the error report sent to plans is a first level error report and for some of the rejected records more specific information from the second and third level error reports is needed. The MCO has to request the additional reports.
- A number of the threshold edits, for example for pharmacy encounters, were the same edits that are used for fee-for-service claims applicable to rebates that are not applicable to managed care.

Kentucky MCOs report that prior to submission they edit and validate data completeness and accuracy. CoventryCares of Kentucky and WellCare of Kentucky are able to take advantage of corporate-level staff expertise to evaluate file completeness and accuracy and make corrections prior to submission. The EQRO work plan with the Commonwealth of Kentucky includes an activity to validate encounter data, but due to the recent nature of the encounter data submissions, a validation has not yet occurred. In terms of validating their own data, two of the three plans interviewed reported that as part of program integrity, they conduct verification of services using claims data, not encounter data.

### Provider Network Data

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

Each of the Kentucky MCOs maintains a Provider Network database that is continually updated and submitted to DMS on a monthly basis. The MCOs use their Provider Network data to populate their annually printed Provider Directory and their on-line provider query tool for members and potential members. The state also uses the submitted Provider Network data to populate an on-line provider query tool. Each MCO runs geo-access reports against their Provider Network database and submits these reports to the state on a quarterly basis.

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

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

In terms of plan monitoring for completeness and accuracy of the network data, all of the MCOs report conducting desk audits of the data prior to submission and using the geo-access reports to identify problem areas in availability using metrics for open and closed panels and distribution of specialties. One of the MCOs reported they are looking into the possibility of sending the provider a summary of data submitted for their verification.

The EQRO reviews documents during their compliance review to verify that MCOs are satisfying the contract requirements for access and availability monitoring. Conducting Access and Availability surveys is included in the Kentucky EQRO contract work plan, but this activity has not, as of yet, been implemented. The EQRO conducted a survey of Kentucky MCOs and found that, some, but not all, of the MCOs use their Provider Network database to conduct secret shopper calls to assess access and availability of provider offices. CoventryCares of Kentucky did some secret shopper calls using in-house plan staff but has now contracted with a vendor for the calls. WellCare of Kentucky uses a vendor to assess access and availability but their callers identify themselves as representing the plan. Passport Health Plan monitors appointment availability through metrics using calls to member services and also noted that during on-site practice level reviews, the MCO staff review appointment bookings. The state needs to determine if a survey (secret shopper or otherwise) is appropriate for assessing provider access and availability and who should be responsible for conducting it – the MCO, the EQRO or the state.

#### Quality Performance Data – HEDIS®

The objectives established for the Commonwealth of Kentucky's Quality Strategy are all measured using NCQA's Healthcare Effectiveness Data and Information Set, referred to simply as HEDIS®. National benchmarks used are derived from the NCQA's Quality Compass which is an aggregate report of Medicaid managed care plans' HEDIS® submissions. While MCOs that are NCQA accredited must submit audited HEDIS® data to NCQA annually, submission is optional for non-accredited MCOs.<sup>15</sup> Quality Performance data includes effectiveness of care measures, access to services, use of services and member satisfaction measures in the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

A HEDIS® submission for all managed care plans occurred this June, 2013 for services provided in calendar year 2012. Passport Health Plan had been submitting quality performance data prior to the expansion.

All Kentucky MCOs contract with vendors to assist in conducting HEDIS® measurement, medical record reviews and conducting NCQA audits of the data prior to submission. The process a plan uses to conduct their HEDIS® data collection depends on their preferences for use of in-house staff, temporary staff and/or vendors. The amount of in-plan record reviews and over-reads of the record varies by plan and their staff resources. WellCare of Kentucky corporate office contracts with a vendor to handle all WellCare of Kentucky submissions but the local MCO hires temporary staff to oversee the medical record reviews and conduct the record checks. NCQA certified vendors are required for conducting CAHPS satisfaction surveys and auditing HEDIS® findings. In some states, such as New York, CAHPS satisfaction surveys and HEDIS® audits of Medicaid-only plans are conducted through the EQRO contract.

WellCare of Kentucky reported that they intend to report some of their performance results in member and provider newsletters, but are not planning to create a summary report of all measures. The plan does create provider –level reports comparing each provider to overall plan averages and shares these as part of provider relations visits. CoventryCares of Kentucky plans to provide a summary of rates to members and providers via their website. Passport Health Plan intends to share recent rate results with their external quality committee, but is not anticipating any publication of rates to enrollees. Summary data results from this most recent HEDIS® submission were prepared by the EQRO in a one-page document entitled “A Member’s Guide to Choosing a Medicaid Health Plan”. Copies of the guide were included in open enrollment mailings by DMS to WellCare of Kentucky and CoventryCares of Kentucky enrollees for their recent open enrollment period.

## Quality Monitoring and Assessment

### External Quality Review and State Review Activities Overview

From the state perspective, data collection is just the first step in assuring a quality of care program. Using and analyzing the data is a critical next step. States are using a number of tools to help them maximize the program's ability to provide quality of care. This section looks at the policies Kentucky is implementing as part of their quality strategy and discusses several innovative policies from other states for monitoring MCO performance.

Historically, as more states began to look at managed care as a way of providing quality care while maximizing efficiency and managing the use of services, concerns were being raised. In 1993, the Government Accountability Office noted in testimony before the House of Representatives, Subcommittee on Oversight and Investigations that the capitated nature of managed care could cause fiscal incentives to underserved beneficiaries and it recommended that states carefully monitor access to and quality of care delivered to Medicaid beneficiaries.<sup>16</sup>

To address these concerns, the Social Security Act (Part 1932(a))<sup>17</sup> required states that contracted 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. It wasn't until early 2003 when CMS issued a final rule that the requirements for external quality review and state quality monitoring were clearly defined.<sup>18</sup> Regulations required three mandatory review activities and up to five optional activities. The three mandatory activities must be conducted, but the regulations allow states to conduct the activities themselves or to contract with an EQRO. States can further conduct any or all of the optional activities or can contract with an EQRO.

Mandatory and optional review activities are as follows:

#### Mandatory:

- Validation of performance improvement projects (PIPs);
- Validation of plan performance measures reported by the MCO for the preceding 12 months;
- A review conducted at least once every 3 years, to determine MCO compliance with state and federal standards for access to care, structure and operations, and quality measurement and improvement.<sup>19</sup>

#### Optional:

- Validation of encounter data submitted by an MCO;
- Administration and validation of consumer and provider surveys;
- Calculation of additional performance measures;
- Conduct of additional PIPs;
- Conduct of studies on quality focused on a clinical or nonclinical topic.<sup>20</sup>

The monitoring activities described in Kentucky's Quality Strategy include all the mandatory activities plus numerous optional and additional activities. The Kentucky EQRO work plan includes the following activities:

- Validate performance improvement projects (PIPs);
- Validate plan performance measures;
- Conduct review of MCO compliance with state and federal standards;
- Validate encounter data;
- Validate Provider Network submissions;
- Develop MCO Quality Dashboard;
- Develop annual health plan report cards;
- Conduct focused studies;
- Prepare EQRO Technical Report;
- Provide technical assistance and presentations as needed
- Conduct Access and Availability surveys as needed.

In Kentucky, the EQRO conducts several state-specific quality monitoring and quality improvement activities such as the Dashboard, Annual Health Plan Report Card, and an EPSDT Report prepared as part of the Compliance Review and technical assistance and presentations.

In addition to EQRO monitoring activities, DMS staff in the Managed Care Oversight – Quality Branch and the Managed Care Oversight – Contract Management Branch are responsible for overseeing all EQRO activities, managing data submissions (encounters, HEDIS® performance and provider network), reviewing all quarterly and annual MCO required reports, participating in all compliance reviews, focused studies and PIPs. Developing an effective working relationship between the state and the EQRO is important. Through interviews with both DMS and the EQRO, it was apparent to the reviewer that their working relationship was positive and supportive. DMS expanded oversight of the MCOs by directing the EQRO to review additional optional activities. The EQRO, understanding the needs of the program, has been able to provide technical assistance and quality monitoring and improvement activities that effectively support DMS' quality strategy.

### **Compliance Reviews**

The EQRO conducts an annual compliance review for MCOs in Kentucky. State staff also participates on-site or by phone for quality, encounter data and case management. Sixteen areas of review are covered to assess state and federal standards for structure and operations, access to care and quality measurement and improvement. The survey includes a review of documents, interviews with key MCO staff and medical record reviews. The on-site portion of the survey takes two days on average to complete. MCOs involve about 25 – 30 staff members in preparing and participating in the compliance review and they spend anywhere between two full weeks to a month prior to and including the on-site review. Although the federal regulations require that a compliance review be conducted at least once every three years, Kentucky requires an annual review.

Compliance review findings are rated by the EQRO as fully compliant, substantially compliant, minimally compliant and non-compliant. Areas that are fully compliant require no further action; substantially compliant items require an MCO response; and minimal or non-compliant areas require a corrective action plan (CAP). The CAP is reviewed by both the EQRO and state. The EQRO often makes recommendations as part of their findings that may change the way they will review future compliance, for example, the EQRO recently recommended that a sample of medical records for behavioral health be undertaken in the next compliance review. Another concern that was raised in the last compliance review was the lack of coordination and sharing of data between state offices and MCOs regarding children in foster care and the aging. The Department of Community Based Services (DCBS) assesses each child enrolled in foster care and should be forwarding this information to the MCO upon the child’s enrollment. In the same way, information on individuals assessed for care by the Department of Aging and Independent Living (DAIL) also needs to be shared with MCOs upon the individual’s enrollment in managed care. The MCO is responsible for monitoring the continuity and coordination of care for these children and adults. All MCOs expressed the desire to have better communication with these state agencies and each has set up regular conference calls with the agencies to improve coordination.

MCOs observed that there is some duplication of elements reviewed in the Compliance Review and also reviewed by the state in their annual desk audit. Prior to the Compliance Review, MCOs have been asked to provide the EQRO reports they have already submitted to DMS. In terms of the reports requested, one MCO commented that they feel they could have presented other, more informative documents than those that were requested.

Passport Health Plan, which is an NCQA accredited MCO, had some accreditation standards deemed as equivalent to state requirements and those items are not covered every year in the EQRO’s compliance review. According to 42 CFR 438.360, states can use information obtained from a national accrediting organization review for the mandatory external quality review activities conducted by either the state or its EQRO. With this authority, states can deem NCQA standards as equivalent to state requirements or use the information obtained through accreditation surveys to streamline their oversight process. NCQA annually publishes a crosswalk to assist states in determining which of their state requirements would qualify for deeming and thus reduce duplicative reviews. The degree of comparability is described as follows:

Table 3. Equivalency of Federal Requirements to 2012 NCQA Accreditation Standards<sup>21</sup>

Regulation Category	Equivalency
Quality Measurement and Improvement	75% of federal requirements are comparable to NCQA standards
Structure and Operations	78% of federal requirements are comparable to NCQA standards
Access to Care	82% of federal requirements are comparable to NCQA standards

The EQRO and DMS have reviewed the NCQA Toolkit for States and the URAC Guide to Medicaid Managed Care External Quality Review, 2009<sup>22</sup> to determine which standards can be deemed as

met with accreditation. Their report entitled, "Proposal for Implementation of Deeming Option" presents a crosswalk comparison of NCQA and URAC equivalency for each federal regulation standard. Of the 173 standards listed, 38 were deemed "Not Met" and 49 deemed N/A or Not Addressed by NCQA, leaving 86 standards, or about 50% that can be met or partially met by NCQA accreditation.

As of 2012, as many as 34 states, including Kentucky, recognized NCQA Accreditation for Medicaid.<sup>23</sup> The state of Virginia's Managed Care Quality Strategy, 2011 – 2015 includes a thorough description of the role that NCQA accreditation plays in monitoring quality, access to care and structure and operations, including a matrix they developed for declaring an element deemed or not (Appendix E of their strategy).<sup>24</sup> Kentucky requires that MCOs in the Medicaid managed care program be NCQA accredited within two years of contracting with the state. Currently, only Passport Health Plan is NCQA accredited and will be re-certifying in August, 2014. CoventryCares of Kentucky is applying for NCQA certification by June, 2014, and WellCare of Kentucky had a mock review with NCQA in May, 2013 and is scheduled for final review in the second quarter of 2014. Kentucky's Quality Strategy should be updated to better reflect the role of NCQA accreditation in their program oversight.

### EPSDT Report

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally required Medicaid program for children that has two major components – EPSDT Screenings and EPSDT Special Services. The Screening Program provides well-child check-ups and screening tests for Medicaid eligible children in specified age groups. Included are the following: preventive check-ups, growth and development assessments, vision testing, hearing testing, teeth examinations, immunizations and laboratory tests. The recommended frequency of check-ups is ages: 1 month; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 24 months; 3 years; 4 years; 5 years; 6 years; 8 years and once a year for ages 10-20. While any Medicaid eligible child can receive EPSDT screenings, 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. MCOs are required to submit EPSDT rates quarterly, and during an MCO's annual Compliance Review, the EQRO conducts a review of adherence to EPSDT protocol using MCO EPSDT data reports and a review of a sample of files related to complaints, grievances, denials and care management. A separate EPSDT Report is prepared by the EQRO.

In addition to the Compliance Review of EPSDT, the EQRO is also preparing to conduct an EPSDT screening encounter data validation study. A study sample will be drawn from an eligible population of Medicaid managed care enrolled children age 1 year through 20 years over a four month measurement period. Encounter record data will be validated against medical record documentation, and rates based on validation will be derived for screening-well visit, developmental screening, and vision and hearing screening. A record review tool is currently being developed by the EQRO.

### Technical Report

Based on guidelines in the Balanced Budget Act and final regulations, the EQRO prepares a technical report on each MCO annually. The Technical Report is a detailed summary of each MCO's regulatory compliance and results of their PIPs and Performance Measures. The report provides a quantitative analysis of a plan's program to provide access, timeliness and quality of care. The EQRO, as per regulation, is required to include a discussion of the MCO's strengths and weaknesses and identify opportunities for improvement. With each annual Technical Report, the MCO is requested to provide the EQRO with a description of actions they have taken to address their weaknesses and opportunities for improvement.

Preparing this report requires data input from many data sources, but once aggregated, tells a story about the plan that can be very useful for public policy makers. In New York State, on-site compliance reviews of quality, conducted by state staff, use the plan's Technical Report as a base for questions regarding quality activities and improvement results. Technical Reports for each MCO and for the state overall are posted on several state websites including New York State and California, giving the public, other state governments and other MCOs, the opportunity to learn from each other the process of quality measurement and improvement.<sup>25</sup>

### Quality Performance Dashboard

The EQRO, under its contract with the Commonwealth of Kentucky, is currently developing a Quality Performance Dashboard. This tool, similar in design to the gauges on a vehicle's dashboard, is intended to pictorially describe statewide and MCO-specific performance on selected quality measures. The EQRO is collaborating with DMS on the content and format of the Dashboard. A preliminary version of the Dashboard is currently available through a secure EQRO portal for DMS to view and use as an internal tool in their review of program and MCO performance. The audience for the Dashboard is intended for now, to be DMS, but as DMS plan liaisons begin to follow-up with MCOs regarding the results and identified "red flags", distribution of the Dashboard results to the MCOs should be considered. Nebraska is developing a similar tool intended to be displayed on the Department of Health and Human Services website.

### Annual Plan Report Card

Another tool in the EQRO contract for monitoring MCO quality performance is the development of Annual Plan Report Card. Unlike the Dashboard, this tool is intended for MCO member distribution. This report compares MCO performance on selected preventive, access and consumer satisfaction measures using a visual representation of rates, namely a star rating system. The areas of focus in this report include:

- Preventive Care: childhood immunizations, adolescent immunizations, cervical cancer screening and prenatal care;
- Access to Care: access to dental visits, adult primary care visits, child primary care visits, adult doctor availability and child doctor availability; and

- Getting Care When Needed: getting adult care quickly, getting child care quickly, adult customer service, child customer service, adult overall satisfaction and parent overall satisfaction with child's care.

The presentation is consumer friendly and the guide is being included with MCO enrollment information to help enrollees select a plan during open enrollment. In late July, 2013, enrollees in WellCare of Kentucky and CoventryCares of Kentucky were sent open enrollment letters which included the guide.

Two of the three Kentucky MCOs were aware of the state's intention to create an annual plan report card. However, none of the plans interviewed knew what the report card content or format would be like at the time of the interviews. They all expressed a desire to be given an opportunity to provide feedback prior to publication. Similar consumer-type guides are used by many states including New York State, California, Kansas and Louisiana among the states reviewed in this summary. New York State consumer guides provide regional comparisons of plans and are distributed in enrollment packets and on-line.<sup>26</sup>

### Monitoring Access to Care

Geographic Access reports are a tool used by MCOs and DMS to monitor state standards for access to care. MCOs process geographic access reports on their provider networks quarterly and submit reports to DMS. These reports allow DMS to assess whether MCO provider networks are sufficient in number, mix and geographic distribution. In addition to these reports, DMS also monitors program capacity through the member and provider satisfaction survey responses, reports of grievances and complaints related to provider access and encounter data/utilization metrics. Encounter data metrics are used to monitor the number of office visits, emergency room visits and urgent care visits per member per year including per member per month (PMPM) encounters by category of service and average encounters by site.

Other possible monitoring tools that can be considered include access and availability surveys and member services surveys. Access and Availability surveys, especially those that use the "secret shopper" methodology, are one way to assess if enrollees are getting appointments based on urgent and non-urgent situations within the time guidelines established in the contract. New York State contracts with the EQRO to conduct secret shopper calls for Access and Availability on a yearly basis to review provider availability/accessibility and to determine compliance with contractually defined performance standards. Using information from the most recently submitted Provider Network, a sample of providers is selected per region and calls are made according to a strict protocol of circumstances and call back requirements. MCOs with providers showing less than 85% compliance are required to prepare a corrective action plan and are resurveyed at a later date. New York State also uses the EQRO to conduct "secret shopper" surveys of MCO member services departments. Based on a scenario of 10-15 questions, member services staff are asked questions, some of which relate to provider access. Incorrect, inaccurate or inappropriate responses are reported in findings to the state.

## Care Coordination

Care coordination is a cornerstone of managed care and is based on the assurance that all enrollees have an ongoing source of primary care 24 hours a day, 7 days a week. The MCO also plays a unique role in being able to identify persons with special health care needs (including chronic physical, developmental, behavioral, neurological or emotional conditions) and offer care coordination through case management. Identifying new enrollees with care coordination needs starts with the completion of a Health Risk Assessment (HRA). MCOs are required to request that all members complete an initial HRA. Through the HRA, MCOs collect patient information regarding demographics, socioeconomic status, current health status, patient prescription drug use and behavioral risks. When enrollees' needs are known, disease management, case management and other member education programs can be targeted to appropriate persons. Unfortunately, the response rate of completed HRAs is often low. The MCO can also identify enrollees in need of care coordination who don't have an HRA, by using encounter data algorithms to track diagnosis codes, high utilization, repeated use of emergency rooms, frequent in-patient stays and hospital readmissions as markers. As Medicaid managed care programs expand enrollment to include populations historically exempted, the need for care coordination and case management will become even more important.

Coordination between MCOs and the Kentucky Departments of Community Based Services (DCBS) and Department for Aging and Independent Living (DAIL) is a case in point. The MCOs are responsible for ongoing care coordination for these members and thus it is critical that the MCOs have access to baseline information about these individuals to enable timely and appropriate referrals and interventions to assure access to needed services. DCBS/DAIL service plans are the key source of this baseline information and ongoing communication with DCBS/DAIL staff is essential to coordinate the most appropriate services needed by individual members. DCBS/DAIL staff members are key members of the care coordination team, working with the MCOs to identify changing needs, assess the effectiveness of interventions taken, and modify care plans accordingly. In a recent Compliance Review it was strongly recommended that all relevant entities (DCBS, DAIL, DMS, and MCOs) establish mutually-agreeable communication and information-sharing protocols to remedy this situation in order to comply with federal and state requirements, and most importantly, permit active, effective care coordination for these members.

While it is still too soon to evaluate the effectiveness of case management in Kentucky's Medicaid managed care program, DMS has several ongoing monitoring activities for the program. MCOs are required to submit quarterly reports on MCO case management activity with aggregate counts of case management enrollment. Case management activities are also reviewed during the annual Compliance Review and a sample of case records are reviewed for appropriateness of referral services and frequency of contacts. The new branch of Disease and Case Management under the Division of Program Quality and Outcomes will be able to provide a greater focus on monitoring MCO case management programs.

MCOs responding to interview questions related to case management discussed several ways they review and monitor their case management programs including chart audits of open cases to assess if charts are complete and appropriate referrals are being made; satisfaction surveys of

enrollees in case management; and surveys of enrollees leaving case management. MCOs are also comparing utilization of preventive services for those in case management versus those not in case management or tracking HEDIS® scores and frequency of readmissions for case management enrollees. Passport Health Plan uses a rapid response team approach for members who report issues or problems with clinical care and follow-up with the enrollee to determine if a disease management or case management program may be able to help.

In an effort to better define and monitor effectiveness of MCO case management programs, the state of New York partnered with their EQRO, MCOs and national accrediting organizations to study case management in managed care. The project began with a survey of MCOs to describe and quantify their case management programs. Measures were developed and tested and a data collection tool was developed and implemented. All Medicaid MCOS in the state have now been submitting annual case management record files for three years. In addition to descriptive analysis of the programs statewide, the state is also able to match record information to encounter data utilization and expenditures to better understand the role of case management in improving health status and reducing cost.

#### **Member Rights/Program Integrity Monitoring Reviews**

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

DMS monitors Member Services activities through review of quarterly MCO reports and call center reports. Results of the CAHPS member satisfaction findings can also be monitored for questions related to customer service. As part of the EQRO Compliance Review, assessments of plan operational policies and procedures and interviews with MCO staff are conducted regarding member grievances, prior authorization, cultural and linguistic services, marketing and program integrity.

#### **Quarterly and/or Annual Reports**

As noted in the Urban Institute's 2012 Evaluation of Statewide Risk-Based Managed Care in Kentucky, MCOs are required to submit approximately 100 different monitoring reports regularly on a monthly, quarterly, or annual basis.<sup>27</sup> MCOs expressed concern over the number of reports, frequency of reporting and how the reports are being used. Also, in terms of duplication, one plan commented that the information submitted in several of the reports is surveyed again during the annual EQRO Compliance Review. The newly re-organized Department of Medicaid Services needs

to take another look at the reports currently being submitted and determine if the state can obtain that information in another way. One major way of achieving a reduced reporting load for the MCOs will be through using the deeming ability described in the federal regulations and the use of encounter data.

## State Strategies and Interventions to Promote Quality Improvement

In addition to monitoring, the state and EQRO can both play an important role in developing and promoting a quality performance improvement program. Beginning with federally required Performance Improvement Projects (PIPs), states have also initiated a number of other activities to improve performance such as focused clinical studies, satisfaction surveys, targeted HEDIS® measure improvement, state-MCO collaboration, pay for performance programs, public reporting and quality in auto-assignment. This section will discuss activities currently being undertaken by Kentucky and its EQRO to improve quality performance and includes several additional activities that other states are conducting that may be of interest to state policy makers in Kentucky.

### Other State Comparisons

A review of other state's Quality Strategies provides a broad range of different approaches to monitoring quality and conducting quality improvement. Information for this review was obtained from state websites and is summarized in Attachment Tables A and B. Included are states currently contracting with IPRO as their EQRO (Kentucky, Louisiana<sup>28</sup>, New York State<sup>29</sup>, Rhode Island<sup>30</sup> and Nebraska<sup>31</sup>) as well as five other state Medicaid programs (Kansas<sup>32</sup>, California<sup>33</sup>, Virginia<sup>34</sup>, Texas<sup>35</sup> and Delaware<sup>36</sup>) which represent a variety of small and large Medicaid programs, different geographic regions and a span of experience from program implementation in 1991 to 2013.

The majority of State Quality Strategies reviewed use their EQRO to conduct all three mandatory review activities. Kansas and Delaware contract with the EQRO for the three mandatory activities only, while Kentucky, Louisiana, NYS and Texas use their EQRO for many other quality monitoring and improvement activities such as focused studies, conducting CAHPS surveys, and other member and provider surveys. In New York State, state staff conducts the bulk of the periodic compliance reviews including on-site surveys but use the EQRO to evaluate MCO compliance with provider access and availability standards and member services/handbook compliance. Other unique features of the NYS monitoring program is the EQRO's responsibility to conduct an annual HEDIS® audit for each Medicaid-only MCO and to conduct (or subcontract with a certified vendor to conduct) annual CAHPS surveys.

### Performance Improvement Projects (PIPs)

Conducting PIPs is an opportunity for MCOs to follow a problem solving approach to achieve improvement, or what improvement experts have long called PDSA cycles (Plan-Do-Study-Act). A protocol for conducting PIPs was developed by CMS to assist MCOs in the design and implementation of a PIP. Federal regulations require that all PIPs be validated according to guidelines also specified in another CMS-designed protocol. The state's contracted EQRO is responsible for validating PIPs in all the state strategies reviewed, including Kentucky. But that is where the similarities end. The number of PIPs conducted each year, how the topics are selected, the duration of a PIP, how the results are used and whether they are collaborative projects varies by state.

In Kentucky, two new PIP topics are proposed each year and are generally completed in two to three years, meaning at some point in the next couple of years, MCOs will have a minimum of four PIPs in some stage of activity – initiation, baseline measurement, implementation, and up to two years of re-measurement. Initially, the MCO selected the PIP topics based on HEDIS® results. Currently, DMS has designated two topic categories - physical health and behavioral health, and each MCO is able to determine a specific PIP project within each category. PIPs currently ongoing include the following topics:

- Antidepressant Medication Management;
- Reducing ER Utilization;
- Dental Care Rates for Children with Special Health Care Needs;
- Reducing Inappropriate ER Utilization (2 MCOs);
- Reducing Inappropriate Antibiotic Use; and
- ADHD Medication for Children.

The EQRO has developed a process for validating the PIPs which begins with a template for submitting a PIP proposal including topic selected, goals, performance indicators and methodology. The state reviews the proposal and approves the topic and the EQRO reviews the proposal and discusses changes in the methodology with the MCO. Over the course of the PIP, there are regularly scheduled conference calls to discuss PIP activity and there is an interim report due from the MCO midway through the study and a final report when the PIP is completed. The EQRO validation team plays an invaluable role not only in validating the PIP results, but more importantly, in working with the MCO to refine the measurement indicators and study methodology prior to implementation. Because a team approach is used, they are able to get the shared perspective of more than one reviewer. The periodic calls to discuss ongoing activities can help identify problems early and suggest possible revisions.

PIP results may or may not indicate that an MCO achieved success in meeting their goals. Not meeting a goal, should not necessarily mean a failed project. The experience gained in every PIP is useful in that MCO staff is learning a valuable QI process that can be applied to many improvement issues.

MCOs interviewed about the PIPs commented on the amount of staff and financial resources that are often required to conduct a comprehensive PIP, and that having two new PIPs active each year means resources are stretched or the comprehensiveness of the project is minimized. For example, if provider education is one of the interventions for a PIP, an MCO may decide that they will send providers educational mailings and print articles in provider newsletters rather than conducting a more hands-on effort such as provider office detailing. And in this way, the effectiveness of the intervention is minimized. Of the ten states reviewed in this evaluation, six require two PIPs per year; Rhode Island requires four; Delaware requires three; and New York and Nebraska require only one PIP annually.

Two consistent trends in PIP processes among the states reviewed were evident: 1) states are more often selecting the topics for study and 2) collaborative PIPs are being promoted. Four of the states reviewed have ongoing collaborative PIPs. In New York State, MCOs were allowed to choose their own topics for many years and primarily chose topics related to HEDIS® measures. In an effort to promote collaboration between plans, the state began by offering MCOs the option of participating in a PIP collaborative topic, within which MCOs could identify their own goals. With positive feedback from participating MCOs that the collaborative approach offered the advantages of increased resources from the EQRO and state in terms of educational materials and input from clinical advisors and provided an opportunity to share ideas and coordinate activities between plans, another collaborative topic was initiated as a mandatory collaborative PIP for all MCOs. Again, feedback was positive and has encouraged the state to continue to promote the collaborative approach. From the state's perspective, another advantage of the collaborative PIP is knowledge that the same message is being shared with members and providers statewide at the same time and this provides an opportunity for a more powerful effect.

### Focused Studies

Conducting studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time is listed in federal regulation as an optional quality review activity that the Commonwealth of Kentucky has chosen to include in its quality strategy. The EQRO is currently conducting two related focused studies: 1) Neonatal readmissions and 2) Postpartum readmissions. The methodology for these studies includes hospital chart reviews and MCO case management record reviews. The EQRO initiates new topic selection by developing several proposals that are reviewed and discussed with DMS who makes the final choice of topics. While topics selected by the state have often been utilization-based, asthma and ADHD focused studies have also been conducted.

Focused studies allow state programs to measure actual provider practice as depicted in a sample of medical records. The MCO's role involves obtaining the records from the provider practices. When combined with a HEDIS® record review, this task becomes quite doable for plans. The challenge for state programs and MCOs is condensing the valuable information obtained from the study into actionable interventions to improve care. Publishing results of focused studies is a good first step in sharing the findings with MCOs and the Medicaid managed care community. A written report presented at a meeting of MCOs or a conference call/webinar can be a valuable means of sharing the findings. A focus study that is based on a clinical guideline may indicate numerous areas where providers are not performing according to standard. MCOs have used various interventions such as provider report cards, provider and member education and financial incentives such as pay for performance to change behavior. The most successful approaches have often involved multi-faceted approaches aimed at providers, members, and plan level changes.

### Surveys

Kentucky MCOs are required to conduct member and provider satisfaction surveys. Member satisfaction surveys are conducted annually by the MCOs using a CAHPS vendor and results were submitted to DMS in June, 2013 as part of their HEDIS® submission. MCOs are not contractually

obligated to submit this data to DMS until August. Member satisfaction results were included in the annual health plan report card. Member satisfaction is not included in Kentucky's Quality Strategy goals and to date, the state has not required the MCOs to take any corrective action regarding the findings.

Provider satisfaction surveys are conducted by MCOs, and are required to conduct them annually. DMS reviews and approves the content prior to the plan conducting the survey, which also gives the state the opportunity to request any state-specific questions they would like to see added. MCOs report survey findings in their quarterly reports to the state. Provider satisfaction survey response rates were reported to be quite low.

### State – MCO – EQRO Collaboration

Communications between state, MCO and EQRO staff serve as a means of oversight for DMS but can also provide valuable quality improvement feedback. Communications have taken several forms:

- The DMS Managed Care Oversight – Contract Management Branch staff serve as liaisons between the state and MCOs regarding contract management;
- DMS staff in information technology and encounter data systems have been holding a weekly conference call workgroup with MCOs to discuss issues surrounding data submissions;
- Conference calls between Department of Community Based Services, Department for Aging and MCOs to share information regarding foster children and adults in managed care are ongoing.
- As part of the EQRO's PIP validation process, the EQRO conducts periodic calls with each MCO to discuss PIP progress and provide technical assistance for any problems or challenges the MCO might be facing in their PIPs;
- The EQRO conducted PIP training for MCO and DMS staff in July, 2013; and
- QI Calls were scheduled monthly and included the EQRO, state staff and Passport Health Plan. The agenda for these calls spanned all quality activities, or any one call might focus on a specific area. There was a break in these calls over the past several months due to a transition to additional MCOs, but were resumed in September, 2013. They will continue again quarterly including all MCOs.

Other state Quality Strategies described various collaboration and communication avenues. Regularly scheduled meetings, monthly or quarterly between state and MCO staff are very common including specific meetings for state and MCO Medical Directors and for state and MCO CEOs. States with collaborative PIPs take advantage of regularly scheduled conference call meetings and webinars to share progress and information from invited speakers. Collaborative PIPs which follow a learning collaborative model<sup>37</sup> also have regularly scheduled face to face meetings of MCOs and invited speakers. Nebraska and Delaware both have a quality collaborative group with many partners. In Nebraska, the Quality Management Committee meets annually and includes staff from the state (Medicaid and Public Health), MCOs, providers and other

stakeholders. Delaware's Quality Initiatives Task Force (QII) includes staff from Medicaid funded community programs, MCOs, health benefits managers, pharmacy benefit managers, the EQRO and state agency representatives. The QII meets periodically through the year and is often called upon by the state to review and comment on Medicaid quality measurement and improvement topics.

Data sharing should also be a consideration when discussing state-MCO-EQRO collaboration. Intranet or FTP portals can be used to share utilization metrics from encounter data and dashboard metrics of HEDIS® and CAHPS results developed by the EQRO. PIP summaries or abstracts with baseline/remeasurement results can be made available to all plans.

### Public Reporting

We are now living in the age of technology where public media has made sharing information and learning just a click or an "app" away. Public reporting of quality measurement and improvement results supports program transparency and promotes better informed dialogue among stakeholders. The Kentucky Medicaid managed care program has used their website to inform Medicaid eligibles about the program and it was an invaluable tool in the recent program expansion. The website (<http://medicaidmc.ky.gov/Pages/about.aspx>) presents information for members, providers, frequently asked questions, news releases and contact information. Medicaid beneficiaries can read about the enrollment process, search to see what MCOs their providers participate with, use links to open MCO home pages and access the online application. At the time of writing of this report, quality performance information to assist beneficiaries in choosing an MCO is not yet available on the Medicaid managed care page.

The MCO webpages are very informative and offer potential enrollees information regarding Medicaid benefits, MCO wellness programs and services available, on-line provider search queries, corporate or sponsor information and contact information. Some of the MCO sites also cover enrollee rights and responsibilities and they all offer access to member education information.

While quality performance data was just recently submitted to DMS in June, 2013, it is not surprising that there is an absence of quality data on both the state and MCO websites. However, within a month of receiving HEDIS® data, a consumer-friendly annual plan report card was being distributed via open enrollment letters to enrollees in Medicaid managed care. Continuing to prepare and publish even the most basic quality performance summary should be a priority. Certainly a consumer-friendly annual report card with quality, access and satisfaction measures is valuable and should be available in both a printed version as well as electronically online.

In addition to offering information to potential enrollees, public reporting of quality performance data is a driver of quality improvement. Having quality performance rates in the public media may offer an opportunity for an MCO to market itself or the Medicaid managed care program in general. For those MCOs and measures that are below statewide or national benchmarks, the "shame factor" that comes with public reporting can be an improvement motivator. The

possibilities to consider for public reporting can include the following monitoring reports and quality performance indicators:

- HEDIS® compared to statewide/national averages and Healthy Kentuckians goals,
- Member satisfaction survey reports,
- PIP summaries and results,
- Focus study results, and
- EQRO Technical Reports.

The state comparison of public reporting practices shows a great variation in how states choose to share quality performance and improvement findings. New York State, California and Texas are examples of full disclosure in terms of reporting quality performance results. Printed and website publications include MCO enrollment, HEDIS® and CAHPS results, consumer friendly HEDIS® reports, EQRO reports including Technical Reports, focused studies and member experience of care surveys. Texas further publishes quality metrics by program level, service area and provider level.

### **Other Quality Improvement Innovations**

#### *Quality-Based Auto-Assignment*

One approach to promote quality improvement is the application of quality measures in the algorithm for auto-assignment of enrollees to a plan. State auto-assignment algorithms use a variety of criteria that are intended to match an enrollee who has not selected a plan to a plan that best matches the criteria. In a recent Kaiser Commission survey of all 50 states, only nine reported using health plan quality performance in auto-assignment.<sup>38</sup> New York State and California Medicaid managed care programs are among those nine. In New York State the proportion of the quality weight was increased over time up to 75%. In California, the quality criteria uses 6 selected HEDIS® indicators and two measures related to plans with continued commitment to include safety net providers in their networks. Both New York and California have 18 and 21 Medicaid managed care plans respectively, and quality-based auto-assignment may be an effective tool to reward high performance in a large market competing for enrollees. The criteria used in Kentucky's auto-assignment include participation of providers last used by the beneficiary, assigning related family members to the same plan and geographic proximity considerations. A state with a smaller Medicaid program and fewer plans, like Kentucky, may not see the value in implementing quality-based auto-assignment.

#### *Pay-For-Performance*

Another possible incentive to quality improvement is pay-for-performance (P4P). MCOs have used financial incentives for providers to improve data submission and to reward providers for adhering to standards of care. Often provider incentives are paired with member incentives, for example, pregnant women who receive the recommended number of prenatal and postpartum visits are given a baby stroller. P4P programs were included in the Quality Strategies of five of the ten states reviewed – Kansas, Texas, Louisiana, New York and Rhode Island. In some states, the reward is a return of a rate withhold, and others use savings resulting from reduced utilization to fund the

incentive. While the concept of reward for high performance has merit theoretically, many states choose not to implement a P4P program because it could lead to heightened competition in an already competitive market, it could incentivize MCOs to only focus improvement in the measures included in the P4P or it could also result in MCOs focusing only on ways to augment data collection. Kentucky does not have a state P4P program in place now, but research on the effectiveness of the programs is increasing as experience with the programs grows. A review of other state programs would be warranted before implementing one in Kentucky.

### *Quality Performance Matrix*

In order to monitor health plan performance on quality measures, New York State developed and implemented a quality performance matrix as part of its QI strategy in 1998. Still an active intervention, the matrix approach provides a framework for benchmarking performance and helps plans prioritize quality improvement planning. The matrix uses a 3x3 table of plan performance by comparing rates for selected measures in two ways: 1) to the statewide average and 2) trend over two years. Measures are displayed in cells corresponding to a letter grade ranging from A (best performance) to F (worst performance). MCOs are instructed to conduct a Root Cause Analysis and Action Plan for measures where there is poor performance based on the barriers identified. The action plans are reviewed and approved by state staff and are monitored throughout the year to assure that they are being conducted and evaluated for effectiveness in improving performance.<sup>39</sup>

## Strengths and Opportunities for Improvement

Strengths and opportunities for improvement regarding the Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services is presented in this section as a summary of findings from a comprehensive evaluation of the strategy, related documents and interviews with key stakeholders. The state's strengths in assessing and improving the quality of care for Medicaid managed care enrollees, opportunities for improvement and recommendations are summarized below.

### Strengths

#### *Regulation/Contract*

- The state's Quality Strategy is well written, follows the CMS outline, includes all required topics and adequately describes the Medicaid managed care program in Kentucky. The strategy is approved by CMS and all MCO contract provisions incorporate the standards of Part 438, subpart D.
- Core program goals were carefully selected to reflect Healthy Kentuckians goals and reflect the particular needs of the Medicaid population. Standardized benchmarks are used to measure improvement. MCOs are aware of the Quality Strategy goals and are setting their own performance goals to align with the state's goals.
- A contract with an external quality review organization is in place. The EQRO is conducting all of the mandatory and several of the optional quality monitoring and improvement activities as part of their contract. There is a good working relationship between the state and EQRO.
- Data collection systems are in place and include encounter data, provider network data and HEDIS® quality performance data.

#### *Monitoring Systems*

- The DMS is in the process of re-organizing its structure and operations to better align functions and staff dedicated to managed care. DMS staff interviewed expressed positive energy regarding the re-organization and are working together to more clearly define functions, responsibilities and communications.
- Contracts with four managed care organizations are in place with capacity to serve Medicaid enrollment statewide.
- An annual report card has been developed to assist Medicaid enrollees in selecting a managed care plan based on plan performance on selected preventive care, access and satisfaction measures.

#### *Coordination*

- Kentucky requires all Medicaid MCOs to become NCQA accredited.
- There are good lines of communications between DMS, the MCOs and the EQRO.
- Quarterly QI calls with DMS, MCOs and the EQRO were initiated in September, 2013.

## Opportunities for Improvement

### *Regulation/Contract*

- The frequency and content of Compliance Reviews should be studied in light of the impact of NCQA accreditation deeming of standards. Also, duplication of items reviewed quarterly or annually by DMS and are again reviewed as part of the Compliance Review needs to be addressed.
- The number of new PIPs required each year should be re-visited in light of other reporting and monitoring requirements. While many of the states reviewed in this evaluation required two active PIPs per year, adding two new PIPs each year, multiplies the number of PIPs ongoing for the plan. If it is desirable to have two PIPs active each year, DMS could consider not requiring new PIP topics to begin until the current two active PIPs are concluded.
- Based on CMS promotion of collaborative PIPs and reports of successful experiences in other states, DMS should consider requiring at least one of the two active PIPs to be an EQRO-led collaborative with other (or all) plans.

### *Monitoring Systems and Quality Improvement*

- The core program goals address preventive care for adults, chronic illness, behavioral health care for adults and children and access to a medical home. DMS may want to expand the number and/or focus of their goals to include prenatal and child health measures.
- Further study of the advantages and disadvantages of conducting a state-sponsored appointment Access and Availability Survey is needed. MCOs are handling their assessment of access and availability using different methodologies which could render results non-comparable and thus not provide an overall program assessment of access and availability.
- The state recently distributed summary HEDIS® performance data in the form of a report card via open enrollment letters. A Quality Performance Dashboard is also being developed by DMS and the EQRO. The Annual Plan Report Card is being shared with enrollees, but the Dashboard is intended to be an internal monitoring tool. DMS should consider getting feedback from MCOs regarding the Annual Plan Report Card format and content and should also consider providing results on their website.
- Validating the completeness and accuracy of encounter data will allow DMS to broaden its use of the encounter database to better monitor service utilization, access and continuity of service and to develop quality and performance indicators on a real-time basis.
- Kentucky has not taken advantage of the many avenues for public reporting that are available not only for HEDIS® performance data, but for enrollment reports, EQRO technical reports, focused study findings and PIP summaries. Kentucky should review their policies regarding public reporting and data transparency.
- DMS monitoring of MCO quality activities requires MCOs to submit many written reports – some quarterly and/or annually. This reporting burden was commented on by all MCOs interviewed and further supports the need for DMS to re-evaluate what is necessary to be

reported periodically and what can be obtained through EQRO work plan requirements, Compliance Reviews and/or NCQA accreditation reviews.

### *Coordination*

- New re-organization of DMS means recruiting several positions of leadership in the managed care program including Director and Assistant Director of the new Division of Program Quality and Outcomes; Branch Manager of Disease and Case Management and Branch Manager of Managed Care Oversight – Quality and Branch Manager of Managed Care Oversight – Contract Management. This is an opportunity to recruit staff experienced in both quality and managed care.
- DMS, MCOs, providers and enrollees are still adjusting to a quick transition to statewide managed care. MCOs are building enrollment statewide, enlisting participating providers and educating providers and enrollees in managed care processes. DMS and the MCOs need to provide continued information for both providers and enrollees through public media and MCO staff functions such as member services, provider relations and compliance.
- Continued communications between DMS and MCOs are needed to resolve issues occurring with coding and other encounter and provider network data submission problems.
- Communication between DMS and other Cabinet of Health and Family Services agencies needs to be continued and enhanced so that managed care enrollees can benefit from improved interagency connections.
- QI calls held regularly are an effective communication and sharing tool for key stakeholders and should be maintained and continued. Additional regularly scheduled meetings with MCO Medical Directors, Quality Directors and/or CEOs should also be considered.

### *Strategies from Other States*

- A review of selected state Quality Strategies highlighted several quality monitoring and improvement interventions that could be further investigated for application in Kentucky including: collaborative PIPs, MCO Medical Director and Quality Director meetings, public reporting, quality-based auto-assignment, pay for performance and a quality performance improvement process to target measures in need of improvement.

### *Recommendations*

- In the next update of the Strategy for Assessing and Improving the Quality of Managed Care Services, DMS should include a description of Kentucky's NCQA accreditation requirement and which standards can be deemed as met;
- Public reporting of quality reports should be expanded to include online versions of consumer-friendly HEDIS® performance data and member satisfaction results, enrollment reports and PIP summaries.
- Develop a plan of action to conduct periodic interagency meetings to discuss topics of mutual concern for the Medicaid managed care program and other Cabinet agencies.

- Study the feasibility of reducing the burden of reporting requirements to reduce duplication of MCO reporting to DMS and the EQRO.
- Study the feasibility of implementing one or more new quality improvement strategy interventions based on other states' experience.

## Attachment Table A. Selected States' Medicaid Managed Care Overview – IPRO Contracted Plans

State	Kentucky	Louisiana	New York	Rhode Island	Nebraska
Implemented	1997	2012 Bayou Health	1997 Partnership Plan	1994 and 2007 RlteCare	2011 Nebraska Health Connection
Administered by	Cabinet for Health and Family Services Department for Medicaid Services (DMS)	Dept. of Health and Hospitals (DHH)	NYS Dept. of Health, Office of Quality and Patient Safety	Office of Health and Human Services (HHS)	Dept. of Health and Human Services (DHHS)
Total Medicaid enrollment	816,000 (7/2013)	1.3 million (2010)	5.2 million (3/2013)	216,000 (2010)	287,000 (2010)
Number of plans	4	5	18	2	3 physical health MCOs
Date of Strategy	9/2012	9/2011	11/2012	10/2012	8/2010
MCO accreditation required	Yes within 2 years	Yes	No	Yes	Yes
Performance Improvement Projects (PIPs): number and how selected	2 new PIPs annually to be completed over 2-3 yrs. – area of study selected by state – plan determines specific topics	2/year – 1 clinical and 1 nonclinical. Want to build up to 4/yr. 1 state-mandated topic, the 2nd topic the plan can choose from a list provided by the State	1 annual – Topic selected by plan or collaborative PIP, may be designated by State	4 annual – State selects topics	At least 1 PIP annually. Plan selects one and state identifies a collaborative topic – current topic was obesity/new topic is ER utilization.
Pay for Performance (P4P)	No	5 HEDIS/CHIPRA measures selected by state – can result in \$ deducted from rate (PCCM plan can receive portion of cost savings from improvement)	Quality Incentive based on HEDIS results, compliance and Preventive Quality Indicators (PQI) – plan receives up to 2.5% PMPM rate	Performance Goal Program by measure category	No
State-MCO collaborate	DMS Oversight staff – MCO liaisons  QI call with IPRO, plans, and state – quarterly	Weekly meetings with plan to transition to bi-weekly or monthly	Medical Directors meeting every 2 months; Collaborative PIPs; PIP Conferences	Monthly contract compliance meeting	Quality Management Committee meets annually includes staff from DHHS, Medicaid, Public Health, MCOs,

State	Kentucky	Louisiana	New York	Rhode Island	Nebraska
					providers and other stakeholders. Collaborative PIP
Public reporting	Plan Report Card distributed via letters regarding open enrollment	Plan Quality report cards and Technical Reports are planned for website. Want to increase public reporting	Full disclosure; MCO enrollment HEDIS and CAHPS results; written reports and online Consumer Guides; plan quality comparisons EQR reports online	Measures in Performance Goal program on website, but not distributed directly to enrollees	Quality Performance Dashboard and Technical Reports to be on website
Quality in auto-assignment	No	No	Yes	No	No
EQR Activities	3 mandatory; Focus studies; Technical Reports; Compliance Review; MCO Performance Dashboard; Annual Health Plan Report Cards; TA and presentations; Validate Patient level claims; EPSDT Report Provider Network validation	3 mandatory; Validate encounter data; Validate consumer and provider surveys; Provide recommendations for Medical Loss Ratio calculation; Provide TA – Quality Companion Guide	Validate HEDIS results; Validate encounter data; Validate PIPs; Focus studies; Technical Reports; Access & Availability surveys; Member services surveys; Conducts annual CAHPS; TA and presentations; Provider Network validation	Validate PIPs; Validate encounter data; Focus studies	3 mandatory; On-Site Compliance Review; Technical Report

## Attachment Table B. Selected States' Medicaid Managed Care Overview – Quality Strategies Available On-line

State	Kansas	California	Virginia	Texas	Delaware
Implemented	2013 KanCare	1991 Medi-Cal	1996 Medallion II	1995 STAR/STAR+PLUS	1996 Diamond State Health Plan (DSHP)
Administered by	Dept. of Health and Environment (KDHE)	Dept. of Health Care Services (DHCS) Medi-Cal Managed Care Division	Dept. of Medical Assistance Services (DMAS)	Health and Human Services Commission (HHSC)	Division of Medicaid & Medical Assistance (DMMA) Dept. of Health and Social Services (DHSS)
Total Medicaid enrollment	471,554 (2013)	8.8 million (2010)	1.1 million (2012)	3.7 million (2013)	225,458 (2010)
Number of plans	3	21	6	19	2 MCOs 1 enhanced FFS program
Date of Strategy	11/2011	6/2013	6/2011	2012	4/2012
MCO accreditation required	Yes	NCOA is deemed for meeting state credentialing requirements	Yes	NCOA is deemed for meeting state credentialing requirements	Recognizes NCOA for meeting access to care, structure and operations and quality and improvement standards
Performance Improvement Projects (PIPs): number and how selected	2 annual	2 active annually – one is statewide collaborative and other can be internal or small group of plans. Most PIPs in place for 3 yrs.	2 annual - state selects 2 HEDIS measures.	2 annual – state determines topics from “overarching goals.”	3 PIPs annually – 2 are state required topics, 3 <sup>rd</sup> is chosen by MCO. Not addressed in strategy
Pay for Performance (P4P)	Yes – based on 6 performance measures selected by state (increasing to 15 measures) Withhold of capitation, % returned if plan meets benchmark	No	No	Provider incentives – gains sharing from savings incurred with reduced utilization, hospital admits and readmits	No
State-MCO	Not included in strategy	Quarterly meetings – all	Quality Collaborative	HHSC sponsors workshops to	QI Initiatives Task Force (QII) –

State	Kansas	California	Virginia	Texas	Delaware
collaborate		plan CEOs; all plan Medical Directors; All plans in all-cause readmission PIP collaborative; Plan Pharmacy Directors meet with DHCS quarterly; QI and Med Directors meet with DHCS quarterly	meetings with MCO quality staff	share info; TX Healthcare Learning Collaborative PIP; Listserv, webinars, and online sharing; Bi-annual conference; Quality Challenge Award – for superior performance	staff from Medicaid funded programs, MCOs, health benefits managers, pharmacy benefit managers, EQRO, state agencies – forum for info sharing – meets periodically
Public reporting	KanCare website: Info for consumers, links to plans, description of quality program	Full disclosure on website – HEDIS, CAHPS, Technical Reports, Consumer Guides, Quality Report for QI	HEDIS results – state averages and MCO rates for selected measures not distributed directly to enrollees	Quality metrics by program level, service area and compared to national benchmarks; also at provider level; Potentially Preventable Events report series	State sponsored Quality Courier newsletter
Quality in auto-assignment	Not addressed in strategy	Yes, uses HEDIS indicators and measures related to safety net providers in network	Not addressed in strategy	Not addressed in strategy	Not addressed in strategy
EQR Activities	3 mandatory	3 mandatory, plus CAHPS member survey every 2 yrs.	3 mandatory, plus Compliance Review every 3 years; Technical Report	3 mandatory, plus Focus studies; Encounter data validation; Validation of member satisfaction; Assistance w/ rate setting; MCO administrator interview surveys and on-site visits; Provider office satisfaction survey	3 mandatory

### **About the Author**

This evaluation was conducted by Beverly Pasley, an independent health systems analyst under contract with IPRO, the External Quality Review Organization for Kentucky. Ms. Pasley has over 20 years of experience in conducting and managing quality improvement programs in managed care, including over 15 years as Director of the Quality Improvement Unit in the Office of Quality and Patient Safety in the New York State Department of Health. She managed the New York State EQRO Medicaid managed care contract and was responsible for developing New York State's first Quality Strategy.

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The following paragraph on page 10 of the Comprehensive Evaluation Summary Report should be replaced with the following paragraph:

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

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