



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

## External Quality Review Technical Report **FINAL**

MCO Contract Year(s) 2011–2012  
Report Date: August 2013

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

## TABLE OF CONTENTS

1. EXECUTIVE SUMMARY .....	1
Purpose of Report .....	1
Scope of EQR Activities Conducted.....	1
Overall Conclusions and Recommendations.....	3
2. BACKGROUND .....	11
Kentucky Medicaid Managed Care Program.....	11
3. EXTERNAL QUALITY REVIEW ACTIVITIES .....	14
4. FINDINGS, STRENGTHS AND RECOMMENDATIONS WITH CONCLUSIONS RELATED TO HEALTH CARE QUALITY, TIMELINESS AND ACCESS .....	15
Introduction.....	15
Compliance Monitoring .....	15
Validation of Performance Measures .....	55
NCOA HEDIS® 2013 Compliance Audit.....	60
CAHPS® 5.0 Adult Survey .....	73
CAHPS® 5.0 Child Survey.....	74
Validation of Performance Improvement Projects.....	76
5. ADDITIONAL EQR ACTIVITIES IN PROGRESS .....	94
6. MCO AND DMS RESPONSE TO PRIOR RECOMMENDATIONS.....	97
APPENDIX A – MEDICAID MANAGED CARE COMPLIANCE MONITORING.....	115
APPENDIX B – VALIDATION OF MEDICAID MANAGED CARE PERFORMANCE IMPROVEMENT PROJECTS .....	118
APPENDIX C – VALIDATION OF PERFORMANCE MEASURES.....	120

## TABLE OF FIGURES

Figure 1: Annual Compliance Reviews- Domains by Plan .....	16
Figure 2: Overall Compliance Determination by Review Area – 2013.....	19
Figure 3: Elements Requiring Corrective Action by Review Area – 2013 .....	20
Figure 4: Healthy Kentuckians Performance Measures 2010-2012 .....	58
Figure 5: HEDIS® Board Certification Rates.....	63
Figure 6: HEDIS® Effectiveness of Care Rates.....	64
Figure 7: HEDIS® Access and Availability .....	70
Figure 8: HEDIS® Use of Services.....	72
Figure 9: CAHPS® Adults .....	73
Figure 10: CAHPS® Children .....	74
Figure 11: PIP Performance Measures.....	89
Figure 12: Passport Health Plan Response to Recommendations Issued in 2011 Technical Report.....	97
Figure 13: DMS Response to Recommendations Issued in 2011 Technical Report .....	113

# 1. EXECUTIVE SUMMARY

## Purpose of Report

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

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

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

## Scope of EQR Activities Conducted

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

### Compliance review

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

### Validation of Performance Measures (PMs)

Each MCO is required to report annual performance measures based upon the *Healthy Kentuckians 2010* goals. *Healthy Kentuckians 2010* is Kentucky’s commitment to the national prevention initiative *Healthy People 2010*. *Healthy Kentuckians 2010* includes goals and objectives in the priority areas of Clinical Preventive Services and Health Services and focuses on areas of disparity where attention to prevention and quality can demonstrate improved health care delivery and outcomes. Individual clinical preventive services, such as timely, age appropriate immunizations, screening tests, and counseling, have been shown to have a substantial impact on morbidity and mortality (*Healthy Kentuckians 2010*).

Annually, the non-HEDIS<sup>®1</sup> measures are validated by the EQRO. As required by the health plan contract, and by Federal Medicaid managed care regulations and requirements, under contract with DMS as the EQRO, IPRO addresses the reliability and validity of the reported performance measure rates.

#### Validation of Performance Improvement Projects (PIPs)

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

The results of these three EQR activities performed by IPRO are detailed in Section 4 of the report.

---

<sup>1</sup> HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)  
Kentucky Technical Report FINAL  
Page 2

## Overall Conclusions and Recommendations

The following is a high-level summary of the conclusions drawn from the findings of the EQR activities regarding the Kentucky Medicaid Managed Care health plans' strengths and IPRO's recommendations with respect to quality of care and access to/timeliness of care. Specific findings, strengths and recommendations are described in detail in Section 4 of this report.

### CoventryCares of Kentucky

#### Quality of Care

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

- § The plan reported above national average rates for the following HEDIS® measures: Immunizations for Adolescents, Pharmacotherapy Management of COPD Exacerbation and Persistence of Beta-Blocker Treatment After a Heart Attack.
- § The plan performed well in the domain of Medication Management as demonstrated by above national average rates for most measures.
- § The plan achieved full compliance for all requirements under the Enrollee Rights and Protection: Member Education and Outreach domain.

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

- § CoventryCares of Kentucky demonstrates an opportunity for improvement in regard to the quality and adequacy of its provider network. The plan reported below national average rates for the HEDIS® Board Certification measure for all provider types. Further, the Credentialing File Review found that 7 of 20 provider files reviewed were not documented appropriately.
- § The plan reported below national average rates for the following HEDIS® Effectiveness of Care measures: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Childhood Immunization Status: Combo 3, Appropriate Testing for Children with Pharyngitis, Appropriate Treatment for Children with URI and Controlling High Blood Pressure.
- § The plan reported rates below the national average for all measures under the Diabetes and Musculoskeletal domains.
- § The plan submitted a proposal for the PIP, "Major Depression: Antidepressant Medication Management and Compliance"; however, the numerator and denominator for the indicator are not described. Further, the plan does not make use of any interventions to address the cultural and linguistic barriers.
- § The Grievance File Review, performed as part of the plan's annual compliance review, found that only 7 of the 30 member files reviewed supplied accurate and appropriate communication with the member.

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

- § Should work to improve the quality of its provider network by increasing the number of board-certified primary care physicians and specialists that make up its network, as well as develop a procedure to ensure proper documentation for all providers is collected and reviewed.
- § Should work to improve HEDIS® Effectiveness of Care rates, especially those related to the quality of child care and diabetes care.

- § Should implement a procedure for accurately documenting all communications with members as it pertains to member grievances, in accordance with the contract requirements.

### Access to Care/Timeliness of Care

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

- § The plan reported above national average rates for the following HEDIS® measures: Adults' Access to Preventive/Ambulatory Health Services for all age groups, Children and Adolescents' Access to PCPs: 12-24 Months and 25 Months-6 Years, Annual Dental Visit and Well-Child Visits in the First 15 Months of Life: 6+ Visits.
- § The plan performed well in regard to prenatal care as demonstrated by rates which exceed the National Benchmark 75<sup>th</sup> percentile for the Timeliness of Prenatal Care and Frequency of Ongoing Prenatal Care: 81+ Percent measures.
- § The plan reported above national average rates for the CAHPS® Adult and Child surveys for the Getting Care Quickly question.
- § The plan achieved at least substantial compliance for all requirements under the Quality Assessment and Performance Improvement: Access – Utilization Management domain, with most achieving full compliance.

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

- § The plan demonstrates an opportunity for improvement in regard to access to/timeliness of women's preventive care as represented by below national average rates for the following HEDIS® Effectiveness of Care measures: Cervical Cancer Screening and Chlamydia Screening in Women.
- § The plan demonstrates an opportunity for improvement in regard to access to/timeliness of child and adolescent care as represented by below national average rates for Lead Screening in Children; Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life and Adolescent Well-Care Visits measures.
- § The plan submitted a proposal for the PIP, "Decreasing Non-Emergent/Inappropriate Emergency Room Utilization"; however, the performance indicators selected lack clarity. In addition, the PIP does not include process measures.

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

- § Should work to improve access to and timeliness of women's preventive health, especially as it relates to the HEDIS® Cervical Cancer Screening and Chlamydia Screening in Women measures.
- § Should work to improve HEDIS® measures related to child and adolescent care that perform below the national averages.
- § Should continue to monitor and modify the ongoing PIPs, including proposed performance indicators, process measures and interventions.

## Kentucky Spirit Health Plan

### Quality of Care

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

- § The plan reported rates above the national average for the following measures: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, Annual Monitoring for Patients on Persistent Medications: Total.
- § During the annual compliance audit, 12 of 12 credentialing files were found to be compliant with the requirements issued in the state contract.
- § The plan reported above average rates for the adult CAHPS® survey questions: Rating of Personal Doctor and Rating of Specialist Seen Most Often.

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

- § The plan was unable to report rates for the Board Certification measure for the HEDIS® 2013 Audit.
- § The plan reported rates below the national average for most measures in the following HEDIS® Effectiveness of Care domains: Prevention and Screening, Respiratory, Cardiovascular, Diabetes, Musculoskeletal and Behavioral Health.
- § The plan received an overall Minimal Compliance rating for the review area of Program Integrity. In addition, incomplete documentation was provided for the Grievance and Member Appeal file reviews.

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

- § To ensure full compliance with HEDIS® reporting, the plan should address the issues that prevented it from reporting board certification rates during the 2013 HEDIS® reporting period.
- § Should implement interventions to improve HEDIS® rates performing below the national averages, especially those related to diabetes care.
- § Should develop a system to ensure that grievances and appeals are appropriately documented according to the requirements of the state contract.

#### Access to Care/Timeliness of Care

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

- § The plan performed above the national averages for the following HEDIS® Access and Availability measures: Adults' Access to Preventive/Ambulatory Health Services for all age groups, Children and Adolescents' Access to Primary Care – 12-24 Months and 25 Months-6 Years, Annual Dental Visit, Initiation and Engagement of AOD Dependence Treatment – Initiation: Total, Prenatal and Postpartum Care: Timeliness of Prenatal Care and Call Answer Timeliness.
- § The plan reported rates above the national average for the Frequency of Ongoing Prenatal Care: 81+ Percent measure.
- § The plan reported above national average rates for the adult and child CAHPS® survey question for Getting Care Quickly.
- § The plan submitted a proposal for a PIP entitled, "Improving Cervical Cancer Screening Rates". The PIP includes identification of high incidence and mortality rates of cervical cancer, as well as quantifiable goals for the project.

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

- § The plan performed below the national averages for the following HEDIS® measures: Initiation and Engagement of AOD Dependence Treatment – Engagement: Total, Prenatal and Postpartum

Care: Postpartum Care, Cervical Cancer Screening, Chlamydia Screening in Women and Follow-Up After Hospitalization for Mental Illness.

- § The plan demonstrates an opportunity for improvement in the domain of child and adolescent access to care as demonstrated by below average rates for the following measures: Well-Child Visits in the First 15 Months of Life: 6+ Visits; Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life and Adolescent Well-Care Visits.
- § The plan submitted a PIP proposal, "Prenatal and Postpartum Depression Screening and Management", which lacked clarity with respect to calculation of a performance indicator. In addition, the plan failed to include in the proposal, a copy of the survey to be distributed as part of the PIP.
- § The plan was found to be non-compliant for several elements under the Quality Assessment and Performance Improvement (QAPI): Access and QAPI: Access – Utilization Management domains during the annual compliance review.

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

- § Should implement initiatives to improve those HEDIS® measures that fall below the national averages, especially those related to women's health.
- § Should work to improve the access to and the timeliness of child and adolescent care. The plan could benefit from a PIP aimed at increasing the frequency of well-visits for children and adolescents.
- § Should continue to monitor and modify ongoing PIPs, including proposed performance indicators, process measures and interventions.

## Passport Health Plan

### Quality of Care

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

- § Passport Health Plan demonstrated improvement in regard to the Healthy Kentuckians (HK) Performance Measures as the plan's rates have trended upward for two consecutive periods for the following measures: HEDIS® Adult BMI Assessment; HEDIS® Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile; HK Weight Assessment/Counseling for Nutrition and Physical Activity: Healthy Weight for Height, age groups 3-11 years and 3-17 years; HK Adolescent Screening/Counseling for Mental Health Assessment/Screening; and HK Prenatal Education/Counseling: Drug Abuse, Domestic Violence, Members Screened and Identified as Smokers Who Received Counseling for Smoking Cessation and Screening and/or Counseling for Tobacco.
- § The plan also performed strongly with respect to the following HEDIS® domains: Prevention and Screening, and Diabetes. The plan exceeded the national average for the majority of the measures reported in these two domains.
- § The plan demonstrated two consecutive years of improved rates for the HK Adolescent Screening/Counseling for Mental Health and HK Prenatal Education/Counseling for Drug Abuse, Domestic Violence and Smoking Cessation: Combined measures.

- § In 2012, the plan completed the Performance Improvement Project (PIP) titled, "Smoking Cessation, Yes You Can!" Although there was no quantifiable improvement, reported quit rates of members who remained in the program and were able to be reached were very high.

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

- § Although the plan has reported increased performance for some HK Performance Measures, the plan continues to demonstrate an opportunity for improvement in this area. The plan continues to report declining rates for HK Healthy Height and Weight, age group 12-17 years; HK Prenatal Education/Counseling Members Screened and Identified as Non-smokers and HEDIS® Controlling High Blood Pressure.
- § The plan demonstrates an opportunity for improvement in regard to the quality and adequacy of its provider network. The plan reported below national average rates for the HEDIS® Board Certification measure for Internal Medicine, OB/GYN, Pediatricians and Other Physician Specialists.
- § Although the plan's proposal for the PIP, "Reduction of Inappropriately Prescribed Antibiotics in Children with Pharyngitis and Upper Respiratory Infection", targets an important public health issue, the interventions planned are passive in nature and fail to target members.

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

- § Should work to improve the quality of its provider network by increasing the number of board-certified primary care physicians and specialists that make up its network.
- § Should continue to work to improve Healthy Kentuckian and HEDIS® measures that perform below the national average.
- § In regard to the "Reduction of Inappropriately Prescribed Antibiotics in Children with Pharyngitis and Upper Respiratory Infection" PIP, the plan should develop interventions that directly impact members and providers.

#### Access to Care/Timeliness of Care

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

- § The plan reported rates above the National Benchmark's 75<sup>th</sup> percentile for the HEDIS® Chlamydia Screening in Women, HEDIS® Adults' Access to Preventative/Ambulatory Health Services: Total and HEDIS® Annual Dental Visit measures.
- § Passport Health Plan produced an interim report for their PIP, "Reduction of Emergency Room Care Rates". This PIP includes proposed interventions aimed at reducing ED utilization rates, including a 24-hour nurse line accessible to members, as well as placement of Care Management staff on-site at providers' offices.
- § Passport Health Plan produced an interim report for the PIP, "Dental Care in Children with Special Health Care Needs" in which the plan identified barriers to dental access, including incomplete data regarding race, ethnicity and language of members. Interventions were implemented to address the language barrier through written and telephonic outreach.
- § In RY 2012, Passport Health Plan achieved full compliance for all elements of QAPI - Access: Utilization Management. As the plan previously achieved full compliance, QAPI - Access was not reviewed for Passport Health Plan during the most recent compliance review.

- § The plan exceeded the national averages CAHPS® Getting Care Quickly adult and child measures.
- § The plan exceeded the national average on the HEDIS® Timeliness of Prenatal Care measure.

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

- § The plan continues to struggle with children’s access to care. Rates for the HEDIS® Well-Child Visit – 15 Months of Life (6+ Visits) and HEDIS® Well-Child Visit – Third, Fourth, Fifth and Sixth Years of Life have fallen drastically since RY 2010. In addition, HEDIS® Children’s Access to PCPs showed declining rates for all age groups in RY 2012.
- § The plan reported below average rates for the Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening Performed and Comprehensive Diabetes Care: Eye Exam (Retinal) Performed measures.
- § The plan’s PIP, “Dental Care in Children with Special Health Care Needs”, demonstrated a slight decline in the performance indicator at the interim phase. The plan failed to adequately explain or identify possible causes for this decline.
- § The plan’s Case Management/Care Coordination compliance review and DCBS file review showed that several members were lacking a well-child visit, and no outreach was made to coordinate care.
- § The plan demonstrates an opportunity for improvement in regard to child behavioral health as indicated by below national average performance on the HEDIS® Follow-Up Care for Children Prescribed ADHD Medication Initiation Phase and Continuation and Maintenance Phase.

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

- § Implement initiatives to improve the below average HEDIS® Use of Service rates. As demonstrated by low utilization rates and a file review that was not fully compliant, the plan must work to improve children’s access to care. The plan could benefit from a PIP aimed at improving the HEDIS® Well-Child Visit rates.
- § Continue to monitor the success of the ongoing performance improvement projects and modify interventions, as necessary.
- § To ensure measurable improvement for the “Dental Care in Children with Special Health Care Needs” PIP, the plan should investigate the decline in performance, monitor the effectiveness of implemented interventions and modify ineffective interventions accordingly.

## WellCare of Kentucky

### Quality of Care

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

- § The plan reported above national average rates for the following HEDIS® measures: Immunizations for Adolescents, Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis, Controlling High Blood Pressure and Antidepressant Medication Management.
- § The plan met or exceeded the national average for all rates reported in the Medication Management domain.
- § The plan performed well in regard to consumer satisfaction with providers as demonstrated by above average rates for the adult and child CAHPS® survey question, Rating of Personal Doctor.

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

- § The plan reported below national average HEDIS® Board Certification rates for all provider types.
- § The plan demonstrated an opportunity for improvement in the domain of Prevention and Screening, Respiratory Care and Musculoskeletal Care, as demonstrated by the majority of rates being below the national average.
- § The plan submitted a proposal for the PIP, "Utilization of Behavioral Health Medication in Children". The proposal does not include timeframes necessary to meet the objectives of the PIP or indicators that address PCP depression-identification and management.
- § Of the 20 provider credentialing files reviewed during the on-site compliance review, several files were lacking elements required by the contract.
- § WellCare of Kentucky received minimal compliance determinations for the Health Risk Assessment and Enrollee Rights and Protection: Member Education and Outreach review areas during the annual compliance audit.

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

- § Should work to improve the quality of its provider network by increasing the number of board-certified primary care physicians and specialists that make up its network.
- § Should work to improve HEDIS® measures which fall below the national averages.
- § Should continue to monitor and modify the ongoing PIPs, including proposed performance indicators, process measures and interventions.

#### Access to Care/Timeliness of Care

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

- § The plan exceeded the national average for the following HEDIS® measures: Adults' Access to Preventive/Ambulatory Health Services for all age groups, Children and Adolescents' Access to Primary Care Practitioners for age groups 12-24 Months and 25 Months-6 years and Annual Dental Visit.
- § The plan demonstrated strong performance in regard to prenatal care as demonstrated by above national average rates for the Prenatal and Postpartum Care: Timeliness of Prenatal Care and Frequency of Ongoing Prenatal Care: 81+ Percent measures.
- § The plan exceeded the national averages for both the child and adult CAHPS® survey question, Getting Care Quickly.
- § The plan was fully compliant with all requirements listed under the Quality Assessment and Performance Improvement: Access – Utilization Management domain.

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

- § The plan reported below national average rates for the following HEDIS® measures: Follow-Up Care for Children Prescribed ADHD Medication, Initiation and Engagement of AOD Dependence Treatment: Initiation Treatment and Engagement Treatment, Call Answer Timeliness and Postpartum Care.
- § Plan performance regarding child and adolescent care indicate opportunities for improvement. The plan reported below national average rates for the Well-Child Visits in the First 15 Months of Life; Well-Child Visits in the Third, Fourth, Fifth or Sixth Years of Life and Adolescent Well-Care Visits measures.

- § Although the plan-submitted PIP proposal, “Inappropriate Emergency Department Utilization”, gave a well-developed rationale, the project could benefit from modifications to the structure of the study, including further stratification of the performance indicator and development of additional interventions.

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

- § Should implement initiatives to improve HEDIS® rates reported below the national averages.
- § Should work to improve child and adolescent access to and timeliness of care. The plan could benefit from a PIP aimed at increasing the frequency of well-visits for children and adolescents.
- § Should continue to monitor and modify the ongoing PIPs, including proposed performance indicators, process measures and interventions.

## 2. BACKGROUND

### Kentucky Medicaid Managed Care Program

#### HISTORY OF KENTUCKY MEDICAID MANAGED CARE PROGRAM

In December 1995, the Commonwealth of Kentucky was granted approval for an amendment to the Medicaid Access and Cost Containment Demonstration Project. The approved amendment permitted the establishment of eight regional managed care networks consisting of public and private providers to deliver health care services to Medicaid beneficiaries. Each region would have one managed care entity or Partnership, subject to state-specified guidelines. Medicaid beneficiaries would be enrolled into the Partnership designated for their area.

The Partnership demonstration was implemented on November 1, 1997. Initially, two (2) partnerships were developed and implemented in Region 3 (Louisville and 15 surrounding counties) and Region 5 (Lexington and its surrounding counties). Combined, the regions served approximately 34% of the Kentucky Medicaid population. In 1999, the Region 5 Partnership notified the Commonwealth of Kentucky, Department for Medicaid Services (DMS) that it could no longer maintain its provider community, primarily due to widespread dissatisfaction with federally mandated reporting requirements, and what they felt were unacceptable profit margins. The Commonwealth then sought authority from CMS to move from a statewide to a sub-state model and continue to operate its one remaining partnership plan. In 1999 and 2000, CMS approved amendments of the Commonwealth's waiver program that allowed for the continuation of the only remaining partnership.

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

However in 2011, as a result of an increased demand for cost-effective health care, the Kentucky Cabinet for Health and Family Services, and the Department for Medicaid Services (DMS) initiated an expansion of the Medicaid Managed Care program in order to offer quality health care statewide. In November 2011, three MCOs, CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky, joined Passport Health Plan in offering Medicaid services including those related to behavioral health. These plans are responsible for policy areas such as quality assurance, utilization management, compliance analysis and the annual evaluations. With this expansion, Medicaid services in Kentucky were made available statewide, allowing all eligible Kentuckians to enroll in a managed care plan. For the reporting year 2012, Kentucky MCOs operate regionally, as follows: CoventryCares of Kentucky operates in all regions; Kentucky Spirit Health Plan operates in all regions, except Region 3; Passport Health Plan operates in Region 3; and WellCare of Kentucky operates in all regions.

#### KENTUCKY MANAGED CARE QUALITY STRATEGY

In September 2012, DMS issued the Kentucky Managed Care Quality Strategy (MCQS) to outline the goals, objectives and expectations of the expanded Managed Care program.

In keeping with federal regulation and in an effort to show its dedication to the national initiative, *Healthy People 2010*, DMS issued a measure set which Medicaid plans would be required to report. This

initiative, *Healthy Kentuckians*, includes ten leading health indicators along with related goals and objectives. Other performance measures, including ones derived from HEDIS®, are included in the requirement for plan reporting to allow for comparison to national benchmarks. Together, these measures address timeliness of, quality of and access to care provided to individuals enrolled in managed care.

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

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

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

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

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

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

percentile or by 10 percent and decrease HEDIS® Ambulatory Care-ED Utilization rate by 10 percent.

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

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

#### ANNUAL EQR TECHNICAL REPORT

Kentucky DMS contracted IPRO to conduct the EQR of the health plans participating in the Medicaid Program for Policy Year 2011-2012 as set forth in 42 CFR §438.356(a)(1). After completing the EQR process, IPRO prepared this *2011-2012 External Quality Review Technical Report for Kentucky Medicaid Managed Care*, in accordance with 42 CFR §438.364, that describes the manner in which data from activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and how conclusions were drawn as to the *quality, timeliness* and *access* to the care furnished to Kentucky's Medicaid recipients by their MCOs.

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

- § Monitoring of the compliance with standards
- § Validation of PMs
- § Validation of PIPs

This report presents the findings for all health plans participating in Kentucky's Medicaid Managed Care Program during Policy Year 2011–2012: CoventryCares of Kentucky, Kentucky Spirit Health Plan, Passport Health Plan, and WellCare of Kentucky.

### 3. EXTERNAL QUALITY REVIEW ACTIVITIES

During the past year, IPRO conducted a compliance monitoring site visit, validation of performance measures and validation of performance improvement projects for Kentucky Medicaid managed care plans. Each activity was conducted in accordance with CMS protocols for determining compliance with Medicaid managed care regulations. Details of how these activities were conducted are described in Appendices A-C, and address:

- § Objectives for conducting the activity,
- § Technical methods of data collection,
- § Descriptions of data obtained, and
- § Data aggregation and analysis.

Conclusions drawn from the data and recommendations related to access, timeliness and quality are presented in Section 1, Executive Summary, of this report.

## 4. FINDINGS, STRENGTHS AND RECOMMENDATIONS WITH CONCLUSIONS RELATED TO HEALTH CARE QUALITY, TIMELINESS AND ACCESS

### Introduction

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

This report includes baseline results for three plans, CoventryCares of Kentucky, Kentucky Spirit Health Plan, and WellCare of Kentucky, that became operational in November 2011. Passport Health Plan has been in operation in Region 3 since 1997, and as such, trending and responses to previous technical reports are included in this report.

### Compliance Monitoring

#### Review of Medicaid Managed Care Organization Compliance with Regulatory Requirements

This section of the report presents the preliminary results of the reviews by IPRO of Kentucky MCOs' compliance with regulatory standards and contract requirements for contract year 2011–2012<sup>2</sup>. The information is derived from IPRO's conduct of the annual compliance reviews in March 2013.

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

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

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

1. A "full review" consists of an evaluation under all available domains and file review types.
2. A "re-review" evaluates only those domains for which the plan previously lacked full compliance.

For reporting year 2012, CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky received a full compliance review. Passport Health Plan was re-reviewed, based on the findings of its previous Compliance Reviews.

The figure below displays the domains that were reviewed for each plan for the 2013 Annual Compliance Review.

---

<sup>2</sup> The 2013 Compliance Review assessed MCO performance for the time period of November 1, 2011 – December 31, 2012.

**Figure 1: Annual Compliance Reviews- Domains by Plan**

Topic/Tool	Passport Health Plan	CoventryCares of Kentucky	Kentucky Spirit Health Plan	WellCare of Kentucky
Behavioral Health Services	**	r	r	r
Case Management/Care Coordination	r	r	r	r
Continuity & Coordination of Care	r			
Enrollee Rights: Enrollee Rights and Protection	r	r	r	r
Enrollee Rights: Member Education and Outreach		r	r	r
EPSDT		r	r	r
Grievance System	r	r	r	r
Health Risk Assessment		r	r	r
Medical Records		r	r	r
Pharmacy Benefit		r	r	r
Program Integrity		r	r	r
QAPI: Access		r	r	r
QAPI: Access – Utilization Management	r	r	r	r
QAPI: Measurement and Improvement	r	r	r	r
QAPI: Measurement and Improvement – Health Information Systems (HIS) <sup>1</sup>		r	r	r
QAPI: Structure and Operations- Credentialing		r	r	r
QAPI: Structure and Operations – Delegated Services	r	r	r	r

<sup>1</sup>At the time of publication of this report, QAPI: Measurement and Improvement - HIS compliance reviews had not yet been completed for 2013.

\*\*Not a covered benefit

A description of the content evaluated under each domain follows:

§ Behavioral Health Services – The evaluation in this area included, but was not limited to, review of policies and procedures related to behavioral health services and coordination of physical and behavioral health services.

§ Case Management/Care Coordination – The evaluation in this area included, but was not limited to, review of policies, procedures, and processes for case management and care coordination of the Department of Community Based Services’ (DCBS) and the Department for Aging and Independent Living (DAIL) clients, dissemination of information to members and providers; and monitoring, analysis, reporting and interventions. In addition, documentation review for care coordination and case management were conducted.

- § Continuity & Coordination of Care: Behavioral and Physical Health Care – The evaluation in this area included, but was not limited to, review of policies and procedures related to coordination of physical and behavioral health services.
- § Enrollee Rights: Enrollee Rights and Protection – The evaluation in this area included, but was not limited to, review of policies and procedures for member rights and responsibilities, PCP changes and Member Services functions.
- § Enrollee Rights: Member Education and Outreach – The evaluation in this area included, but was not limited to, a review of the Member and Community Outreach plan, member informational materials, and outreach activities.
- § EPSDT – The evaluation in this area included, but was not limited to, a review of policies and procedures for: EPSDT services, identification of members requiring EPSDT special services, education/information program for health professionals, EPSDT provider requirements and coordination of services. The review also included a file review of UM decisions and appeals related to EPSDT services, and review of the annual EPSDT reports.
- § Grievance System – The evaluation of the Grievance System included, but was not limited to, review of policies and procedures for grievances and appeals, file review of member and provider grievances and appeals, review of MCO program reports on appeals and grievances and QI committee minutes.
- § Health Risk Assessment – The evaluation in this area included, but was not limited to, a review of initial health screenings and plan-initiated contact.
- § Health Information Systems – The evaluation in this area included, but was not limited to, a review of policies and procedures for claims processing, claims payment and encounter data reporting, timeliness and accuracy of encounter data, timeliness of claims payments and methods for meeting KHIE requirements.
- § Medical Records – The evaluation in this area included, but was not limited to, a review of policies and procedures related to confidentiality, access to medical records, advance medical directives, and medical records and documentation standards.
- § Pharmacy Benefit – The evaluation in this area included, but was not limited to, a review of policies and procedures for pharmacy benefit requirements, structure of pharmacy program, pharmacy claims and rebate administrations, drug utilization review, and pharmacy restriction program. In addition, this review included evaluation of the Preferred Drug List and authorization requirements.
- § Program Integrity – The evaluation in this area included, but was not limited to, review of MCOs' policies and procedures, training programs, reporting and analysis, compliance with Annual Disclosure of Ownership (ADO) and financial interest provisions, and file review of program integrity cases.
- § Quality Assessment and Performance Improvement (QAPI): Access – The evaluation of this area included, but was not limited to review of policies and procedures for direct access services, provider access requirements, program capacity reporting, evidence of monitoring program capacity and provider compliance with hours of operation and availability.

- § Quality Assessment and Performance Improvement (QAPI): Measurement and Improvement – The evaluation in this area included, but was not limited to, review of: Quality Improvement (QI) Program Description, Annual QI Evaluation, QI Work Plan, QI Committee structure and function including meeting minutes, Performance Improvement Projects (PIPs), performance measure reporting and clinical practice guidelines.
- § Quality Assessment and Performance Improvement (QAPI): Structure and Operations: Credentialing– The evaluation in this area included, but was not limited to, review of the policies and procedures related to the credentialing and recredentialing of network providers and enrollment of out-of-network providers.
- § Quality Assessment and Performance Improvement (QAPI): Structure and Operations – Delegated Services – The evaluation in this area included, but was not limited to, review of subcontractor contracts and subcontractor oversight.
- § Quality Assessment and Performance Improvement: Access – Utilization Management (UM) – The evaluation in this area included, but was not limited to, review of UM policies and procedures, UM committee minutes, and UM files.

Typically, the MCOs' response to prior year recommendations would be evaluated during the compliance review. IPRO did not evaluate the MCOs' progress related to the 2012 review recommendations, as three of the plans began operation in 2011, making the 2013 compliance review the first annual review for those plans. In the future, these plans will be given the opportunity to respond to the findings of the compliance reviews.

**Figure 2: Overall Compliance Determination by Review Area – 2013**

Tool #/Review Area	CoventryCares of Kentucky		WellCare of Kentucky		Kentucky Spirit Health Plan		Passport Health Plan	
	Point Average	Determination <sup>1</sup>	Point Average	Determination <sup>1</sup>	Point Average	Determination <sup>1</sup>	Point Average	Determination <sup>1</sup>
1. QI/MI	2.80	Substantial	2.89	Substantial	2.64	Substantial	2.95	Substantial
2. Grievances	2.49	Substantial	2.80	Substantial	2.06	Substantial	2.75	Substantial
3. HRA	2.14	Substantial	1.86	Minimal	2.14	Substantial	NA	NA
4. Credentialing/Recredentialing	2.99	Substantial	2.69	Substantial	2.84	Substantial	NA	NA
5. Access	2.85	Substantial	2.40	Substantial	2.50	Substantial	NA	NA
5a. UM	2.92	Substantial	3.00	Full	2.00	Substantial	NA	NA
6. Program Integrity	2.61	Substantial	2.49	Substantial	1.92	Minimal	NA	NA
7. EPSDT	2.40	Substantial	2.60	Substantial	2.65	Substantial	NA	NA
8. Delegation	2.68	Substantial	2.76	Substantial	2.62	Substantial	2.36	Substantial
10. Care Management	2.33	Substantial	2.40	Substantial	2.20	Substantial	2.33	Substantial
11. PH/BH Coordination	NA	NA	NA	NA	NA	NA	2.90	Substantial
12a. Enrollee Rights	2.22	Substantial	2.58	Substantial	2.16	Substantial	2.88	Substantial
12b. Member Outreach	3.00	Full	1.11	Minimal	2.5	Substantial	NA	NA
13. Medical Records	2.85	Substantial	2.58	Substantial	2.44	Substantial	NA	NA
15. Behavioral Health Services	2.79	Substantial	2.11	Substantial	2.83	Substantial	NA	NA
16. Pharmacy Services	3.00	Full	2.46	Substantial	2.23	Substantial	NA	NA

<sup>1</sup>The Overall Determination is calculated as follows:

Full Compliance – point average of 3.0

Substantial Compliance – point average of 2.0-2.99

Minimal Compliance – point average of 1.0-1.99

Non-Compliance – point average of 0-0.99

NA: Not Applicable

**Figure 3: Elements Requiring Corrective Action by Review Area – 2013**

Tool#/Review Area	CoventryCares of Kentucky		WellCare of Kentucky		Kentucky Spirit Health Plan		Passport Health Plan	
	# of Elements Requiring Corrective Action	Total # of Elements Reviewed	# of Elements Requiring Corrective Action	Total # of Elements Reviewed	# of Elements Requiring Corrective Action	Total # of Elements Reviewed	# of Elements Requiring Corrective Action	Total # of Elements Reviewed
1. QI/MI	3	76	3	70	7	75	0	86
2. Grievances	11	82	3	82	28	82	3	53
3. HRA	2	7	3	7	2	7	NA	NA
4. Credentialing/Recredentialing	0	80	7	78	3	80	NA	NA
5. Access	3	77	14	78	10	78	NA	NA
5a. UM	0	49	0	48	17	49	NA	NA
6. Program Integrity	16	117	20	118	32	117	NA	NA
7. EPSDT	5	20	2	20	2	20	NA	NA
8. Delegation	4	34	3	34	3	34	NA	NA
10. Care Management	7	30	8	30	8	30	0	11
11. PH/BH Coordination	NA	NA	NA	NA	NA	NA	2	6
12a. Enrollee Rights	22	86	11	86	12	86	0	29
12b. Member Outreach	0	18	11	18	2	18	0	26
13. Medical Records	1	40	6	40	3	39	NA	NA
15. Behavioral Health Services	4	53	15	53	3	53	NA	NA
16. Pharmacy Services	0	13	1	13	3	13	NA	NA
Total #/% of Elements Requiring Corrective Action	78/782	10%	107/775	14%	135/781	17%	5/211	2%

Note: Total number (#) of elements reviewed will not be the same for each MCO since the # of not applicable elements varied by MCO, and PHP underwent a partial review this year.

NA: Not Applicable

*CoventryCares of Kentucky 2012 Medicaid Compliance Review Findings for Contract Year 2011–2012*

This technical report was issued prior to the completion of the first compliance review since the expansion of the Kentucky Medicaid Managed Care Program and therefore only the preliminary results of the compliance reviews have been included. For the 2012 Technical Report, a description of the current year findings for all standards/elements not found fully compliant including a summary of the file review results are provided. Elements/standards for which compliance standing was pending at the time of publication have not been included in the summary. In future editions of this report, these results will be accompanied by current year overall category compliance designations and CoventryCares of Kentucky’s response and action plan as applicable.

CoventryCares of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2011/2012)	
Standard	Description of Review Findings Not Fully Compliant
Behavioral Health Services	<p>§ <u>Substantial</u>: Compliance: in “Community Mental Health Centers (CMHCs) located within the Contractor service region shall be offered participation in the Contractor provider network”. Regions 5 and 6 not fully compliant</p> <p>§ <u>Minimal</u>: Compliance with regard to BH Provider Network: Provider Program Capacity Demonstration as results for individual Kentucky market were not made available, only MHNNet national provider network</p> <p>§ <u>Minimal</u>: BH Services Hotline: cannot impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Member – Member services manual does not address duration of calls.</p> <p>§ <u>Substantial</u>: Coordination between the Behavioral Health Provider and PCP: The Provider Orientation Education policy and procedure and Provider Orientation Presentation provided do not explicitly address screening and identification of behavioral health disorders.</p> <p>§ <u>Minimal</u>: Follow-up after Hospitalization for behavioral health services – no timeframe given for when case managers will contact members regarding missed appointments</p> <p>§ <u>Substantial</u>: Court-ordered services: Provider Quick Reference Guide does not address modification or termination of services.</p> <p>§ <u>Minimal</u>: Provider Manual and physician contract do not specifically address sharing of medication usage information among providers regarding psychopharmacological medications.</p>
Case Management/ Care Coordination	<p>§ <u>Non-Compliant</u>: Linkage of care coordination with other contractor systems not addressed in the policies provided</p> <p>§ <u>Non-Compliant</u>: Documentation provided does not address measurement of utilization, access, complaints and grievances and satisfaction for foster care population.</p> <p>§ <u>Minimal</u>: Service plans and care coordination for DCBS and DAIL members are inconsistent.</p> <p>§ <u>Non-Compliant</u>: Individuals in adult guardianships have separate policies; however, they were not submitted for review.</p> <p>§ <u>Substantial</u>: Plan not explicit about coverage during interruptions for children receiving school-based services in regard to duplication of services and plan coverage/responsibilities.</p> <p>§ <u>Substantial</u>: For children receiving school-based services, plan does not explicitly address parental permission.</p> <p><u>Care Coordination File Review (Total Files Reviewed: 20)</u></p> <p>§ All files reviewed contained requirements.</p>

CoventryCares of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p><u>DCBS Service Plan File Review (Total Files Reviewed: 20)</u>            § 11 files contained service plans.</p> <p><u>DCBS Claims File Review (Total Files Reviewed: 20)</u>            § 13 files had evidence of at least one well-visit during review period.            § Of 7 files without a well-visit, 5 had no evidence of outreach efforts.            § All files requiring care coordination showed evidence of care coordination.</p>
<p>Enrollee Rights and Protections: Enrollee Rights</p>	<p>§ <u>Substantial</u>: The plan has no method of providing the policies and procedures to out-of-network providers.            § <u>Non-Compliant</u>: The plan did not provide a policy and procedure for Member Services Functions, including all 22 required elements under this domain.</p>
<p>Enrollee Rights and Protection: Member Education and Outreach</p>	<p>§ All requirements fully compliant</p>
<p>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</p>	<p>§ <u>Minimal</u>: Although the Provider Manual states that the Contractor is obligated to employ trained EPSDT providers and adequately equipped offices, there is no evidence that the EPSDT Provider Reference Manual was approved or made available to providers.            § <u>Substantial</u>: Member Handbook includes the member's right to appeal decisions related to Medicaid services, but does not specify EPSDT services.            § <u>Minimal</u>: Although provided in the policies and procedures, evidence of tracking system for monitoring acceptance and refusal of EPSDT services by members was not provided.            § <u>Minimal</u>: No evidence of provider training in regard to EPSDT compliance was provided.            § <u>Minimal</u>: The document provided for the EPSDT Coordination staff requirement was not dated. Also, the EPSDT liaison position is vacant on the organizational chart provided.            § <u>Non-Compliant</u>: The document provided regarding the required functions of the EPSDT Coordination staff was not dated. No formal position description includes arranging for and assisting with scheduling EPSDT Services.</p> <p><u>EPSDT Appeal File Review: (Total Files Reviewed: 5)</u>            § 1 file had no documentation provided.            § 1 file lacked an acknowledgement letter.            § 3 files reviewed were fully compliant.</p> <p><u>EPSDT UM File Review: (Total Files Reviewed: 5)</u>            § All files reviewed were fully compliant.</p>
<p>Grievance System</p>	<p>§ <u>Substantial</u>: Provider Manual does not address filing a grievance on a member's behalf.</p>

CoventryCares of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>§ <u>Substantial</u>: Overlap of responsibility and unclear organization and documentation of resolution of grievances</p> <p>§ <u>Substantial</u>: For some provider grievances that appeared to be clinical, non-clinical staff performed the review. Documentation of investigation and resolution not present in all cases</p> <p>§ <u>Minimal</u>: Submitted documents do not appear to include language that punitive action will not be taken against a Member or service provider who files a grievance or appeal.</p> <p>§ <u>Minimal</u>: The Provider Manual includes the written consent requirement for filing appeals on behalf of members, but grievances are not addressed.</p> <p>§ <u>Minimal</u>: Although the plan properly addressed the receipt and notification of receipt of a grievance within the appropriate timeframe in the Member Handbook, review of files indicated that the plan did not consistently follow these specifications.</p> <p>§ <u>Minimal</u>: No mention of extensions in the grievance policy given.</p> <p>§ <u>Minimal</u>: Review of files indicated that the plan did not consistently inform members of resolution of grievance.</p> <p>§ <u>Substantial</u>: In review of EPSDT appeals, one file did not contain documentation.</p> <p>§ <u>Substantial</u>: The timeframe of 14 days for newly requested services does not appear evident in policies or in the Member Handbook.</p> <p>§ <u>Substantial</u>: Notice of resolution did not refer to the member's right to a state hearing in several of the files reviewed.</p> <p>§ <u>Non-Compliant</u>: The Member Handbook indicates that if a member wants their benefits to continue during a state hearing, they must file within 10 days of notice of the action or appeal decision, rather than 30 days. The Member Handbook does not state that the Contractor can cease to provide benefits if the member withdraws the appeal or if 14 days have passed since the date of the resolution letter and no action has been taken on behalf of the member.</p> <p>§ <u>Minimal</u>: The Member Handbook does not explicitly state that the Contractor may cease to provide benefits if the Cabinet issues a state fair hearing decision adverse to the member.</p> <p>§ <u>Substantial</u>: Language regarding payment for services if adverse decision is reversed and prompt and expeditious authorization is not evident in policies.</p> <p>§ <u>Substantial</u>: For one appeal reviewed, there was no documentation that expedited appeal was discussed with the member, when this could have been a viable option for this member.</p> <p>§ <u>Substantial</u>: Punitive action against a member as a result of request for expedited resolution is not referenced in the Member Handbook.</p> <p>§ <u>Substantial</u>: According to the file reviews, there is an apparent confusion about what constitutes a provider inquiry and a provider grievance. Of those provider grievances reviewed, not all received required documentation within the given timeframe, if at all.</p> <p><u>Grievance File Review (Total Files Reviewed: 30 Member, 15 Provider)</u></p> <p>§ 3 of 9 potential Clinical cases were not reviewed by clinical staff.</p> <p>§ 7 member files had acknowledgment letter sent to member with expected resolution date, within 5 day of receipt.</p>

CoventryCares of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>§ 9 member files included an acknowledgment letter that did not reference a resolution date.</p> <p>§ 10 member files had no record of acknowledgement letter sent.</p> <p>§ 14 member and 6 provider files had clear resolutions within 30 days with a written resolution letter.</p> <p>§ 8 member files had no record of resolution letter or resolution date.</p> <p><u>Appeal File Review (Total Files Reviewed: 15 Member, 10 Provider)</u></p> <p>§ 14 member files included appropriate appeal documentation.</p> <p>§ 12 member files received acknowledgement letters within 5 days.</p> <p>§ 13 member and 8 provider files were resolved within 30 days and received a resolution letter.</p> <p>§ 3 files lacked an acknowledgement letter sent within 5 days.</p> <p>§ 1 EPSDT appeal file had no appeal documentation.</p>
Health Risk Assessment	<p>§ <u>Minimal</u>: The plan did not provide adequate files for review of Health Risk Assessment.</p> <p>§ <u>Substantial</u>: Assisting the member with an initial PCP appointment is not specifically referenced in the provided documentation.</p> <p><u>Health Risk Assessment File Review (Total Files Reviewed: 3)</u></p> <p>§ The plan provided 3 of the 50 requested files.</p> <p>§ 1 file did not contain information on demographics, as required.</p> <p>§ 1 file did not provide clear date of completion.</p>
Medical Records	<p>§ <u>Substantial</u>: Not all contracts included a provision for when a member changes PCPs, e.g., the medical records or copies of medical records shall be forwarded to the new PCP within 10 days from receipt of request and the Contractor's PCPs shall have members sign a release of medical records before a medical record transfer occurs.</p> <p>§ <u>Non-Compliant</u>: Evidence of a process for detecting instances of over-utilization, under-utilization and miss-utilization was not provided.</p> <p>§ <u>Substantial</u>: Physical examinations are not included in the medical record documentation audit tool.</p> <p>§ <u>Substantial</u>: The medical record documentation audit tool includes medication history but does not address medications prescribed, including the strength, amount, directions for use and refills; or therapies and other prescribed regimen.</p>
Pharmacy Benefits	<p>§ All requirements fully compliant</p>
Program Integrity	<p>§ <u>Minimal</u>: Although 2012 Annual Disclosure of Ownership addressing CoventryCares of Kentucky was provided, disclosure information for subcontractors was not provided, only contract provisions.</p> <p>§ <u>Non-Compliant</u>: Prioritization of cases not specifically addressed in the documents provided</p> <p>§ <u>Minimal</u>: It is not evident that CoventryCares of Kentucky reports internal monitoring and auditing activities for the Contractor itself.</p> <p>§ <u>Minimal</u>: CoventryCares of Kentucky noted CP-012 Provider Terminations and Member Moves as evidence for</p>

CoventryCares of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>Contractor's obligation to report providers denied enrollment; however, this document was not provided.</p> <p>§ <u>Non-Compliant</u>: In terms of patient abuse, PIP does not specifically address requirement for notifying DCBS, DMS and OIG.</p> <p>§ <u>Substantial</u>: In terms of Fraud, Waste and Abuse complaint files reviewed, one file did not state the source of the referral and one did not include the name of the investigator.</p> <p>§ <u>Substantial</u>: In terms of Fraud, Waste and Abuse complaint files reviewed, supporting documentation was not always included in the files provided.</p> <p>§ <u>Substantial</u>: In terms of Fraud, Waste and Abuse complaint files reviewed, one file indicates that the case is closed; however, status/outcome of recovery is not documented.</p> <p>§ <u>Non-Compliant</u>: CoventryCares of Kentucky did not provide the Record Retention Policy document which contained the plans policy on collection and retention of documents for a period of 5 years from the end of the contract.</p> <p>§ <u>Non-Compliant</u>: Contractor does not address the process that will follow in the event no action toward collection of overpayments is taken by the Contractor after 180 days.</p> <p>§ <u>Non-Compliant</u>: Plan does not have policy in place to provide identify and cover documents for undercover investigators.</p> <p><u>Program Integrity File Review (Total Files Reviewed: 10)</u></p> <p>§ 1 file was not completed in a timely manner.</p> <p>§ 1 file lacked name of the investigator</p> <p>§ 1 file states that a referral was received but source is unknown</p> <p>§ For all files, supporting documents were not provided.</p> <p>§ Summary of attachments was not provided.</p>
<p>Quality Assessment and Performance Improvement (QAPI) – Access</p>	<p>§ <u>Minimal</u>: No evidence of monitoring of provider compliance with hours of operation, including after-hours access, was available.</p> <p>§ <u>Non-Compliant</u>: Documents provided did not address the documentation required when no agreement can be reached concerning terms and conditions with providers located in community mental health centers.</p> <p>§ <u>Non-Compliant</u>: The plan does not explicitly address the inclusion of charitable providers serving members in the contractor region as eligible for a participation agreement.</p> <p>§ <u>Substantial</u>: The Contractor's policies/procedures do not specifically address the Contractor's requirement for participating providers by number, type and specialties or the procedure for when the Contractor is unable to contract with these providers.</p> <p>§ <u>Substantial</u>: Provided documents do not address the updating of program mapping to reflect changes in Contractor's network.</p> <p>§ <u>Substantial</u>: P/P UM-O20 does not address primary care dental and oral surgery services and evaluations by</p>

CoventryCares of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
<p>Quality Assessment and Performance Improvement (QAPI) – Structure and Operations- Credentialing</p>	<p>orthodontists and prosthodontists.</p> <p>§ <u>Substantial</u>: During the onsite review of credentialing files, 7 of 20 providers were not documented correctly/ according to the contract requirements. Information was inconsistently organized. Reviewer found that MCO would benefit from a provider profile in the physician’s chart.</p> <p><u>Credentialing File Review (Total Files Reviewed: 10 PCPs, 10 Specialists)</u></p> <p>§ 1 PCP file and 1 specialist file had out of state licenses.</p> <p>§ 1 PCP file was unable to determine hospital privileges.</p> <p>§ 2 PCP files had no evidence of hospital affiliations.</p> <p>§ 1 specialist file had no evident board certification.</p>
<p>Quality Assessment and Performance Improvement (QAPI) – Structure and Operations- Delegated Services</p>	<p>§ <u>Substantial</u>: For one subcontractor, the MCO did not perform a pre-delegation audit prior to the date delegation was provided.</p> <p>§ <u>Minimal</u>: Evidence of ongoing monitoring and/or an annual audit was lacking for several of the MCO’s subcontracts.</p> <p>§ <u>Minimal</u>: Results of ongoing monitoring for several subcontractors was not provided; it is not clear whether corrective actions are in place in response to regular reporting for these entities or whether the Contractor assures that the Subcontractor is in compliance with requirements in 42 CFR 438.</p> <p>§ <u>Substantial</u>: One contract was not compliant in keeping an up-to-date certificate of accreditation with the Contractor.</p> <p>§ <u>Non-Compliant</u>: No documentation addressed the obligation of the Contractor to inform the Department of any Subcontractor which engages another Subcontractor in any transactions, in any term of the contract which exceeds \$250,000 or 5% of the Subcontractor’s operating expenses.</p>
<p>Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement</p>	<p>§ <u>Substantial</u>: In regard to processes that provide for the evaluation of access to care, continuity of care, health care outcomes and services provided, the plan did not have appropriate identification and categorization of all member quality of care concerns. The plan needed to further investigate trends of specific categories of quality of care concerns and adverse events.</p> <p>§ <u>Minimal</u>: Although the plan did document working on behavioral health and physical health coordination initiatives, the plan did not provide reports of indicators relevant to behavioral health/physical health integration.</p> <p>§ <u>Substantial</u>: The plan did not provide all of the requested information for annual compliance review by the EQRO, such as HRA member files.</p> <p>§ <u>Substantial</u>: In terms of timeliness for the QAPI program plan, it was unclear if listed dates were target completion dates or actual completion dates of activities.</p> <p>§ <u>Substantial</u>: The plan did not provide a specific policy relevant to the development or adoption of clinical practice guidelines.</p> <p>§ <u>Minimal</u>: In regard to the plan’s innovative programs, reports on the plan’s program to improve and reform the pharmacy program management were not provided for review.</p>

CoventryCares of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>§ <u>Minimal</u>: Evidence of QMAC review and comment on grievance and appeals policy and process was not available for review.</p> <p>§ <u>Substantial</u>: The plan did not yet conduct special member surveys, although surveys of members regarding Health Services are referenced in the UM Program Description</p>
Quality Assessment and Performance Improvement (QAPI): Access – Utilization Management	<p>§ <u>Substantial</u>: The Contractor did not address triage decision policy and procedures in the UM Program.</p> <p>§ <u>Substantial</u>: The Contractor did not provide P/P UM – 017, Monitoring of Over/Under Utilization, for review.</p> <p>§ <u>Substantial</u>: P/P APP – 002, Appeals Members did not include in it the Member's right to request a State hearing.</p> <p>§ <u>Substantial</u>: P/P UM-008, Notice of Action, did not include policy and procedure for continuation of benefits.</p>

*Kentucky Spirit Health Plan 2012 Medicaid Compliance Review Findings for Contract Year 2011–2012*

This technical report was issued prior to the completion of the first compliance review since the expansion of the Kentucky Medicaid Managed Care Program and therefore only the preliminary results of the compliance reviews have been included. For the 2012 Technical Report, a description of the current year findings for all standards/elements not found fully compliant including a summary of the file review results are provided. In future editions of this report, these results will be accompanied by current year overall category compliance designations and Kentucky Spirit Health Plan’s response and action plan as applicable.

Kentucky Spirit Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2011/2012)	
Standard	Description of Review Findings Not Fully Compliant
Behavioral Health Services	<ul style="list-style-type: none"> <li>§ <u>Non-Compliant</u>: PCP training on how to screen for and identify behavioral health disorders was not conducted in 2012.</li> <li>§ <u>Substantial</u>: The plan’s P/P CCL.204 states that BH providers are “encouraged” to send initial and quarterly reports to the member’s PCP, rather than “required” to send initial and quarterly reports.</li> <li>§ <u>Minimal</u>: Although the plan indicates that data is collected and analyzed regarding coordination of care annually, no reports for 2012 were found and this activity was not seen in the QI Work Plan.</li> <li>§ <u>Non-Compliant</u>: Evidence of monitoring and evaluation of member confidentiality was not found in the QI Work Plan and no reports were found.</li> </ul>
Case Management/Care Coordination	<ul style="list-style-type: none"> <li>§ <u>Minimal</u>: The policy states that 3 measures, quantitative results, benchmarks and plans for intervention will measure program effectiveness, while feedback and complaints will measure satisfaction. Reports meeting this description were not submitted. Monthly DCBS Report #65 did not contain indicators or analysis or seem to address member satisfaction.</li> <li>§ <u>Substantial</u>: No evidence that the Contractor employed reasonable efforts to identify ISHCN’s based on the homeless or 65+ years populations was found.</li> <li>§ <u>Minimal</u>: Aside from EPSDT and the APA Periodicity Schedule, no specific clinical guidelines are named, submitted or found and none specifically address ISHCN.</li> <li>§ <u>Substantial</u>: Language regarding the DAIL level of responsibility for making medical decisions with respect to adults in Guardianship was not found in the provided documents.</li> <li>§ <u>Substantial</u>: Although all DCBS files reviewed contained a DCBS staff signature, language regarding co-signature of service plans, disagreement and resolution were not evident in documentation provided.</li> <li>§ <u>Non-Compliant</u>: Documentation does not address the requirement for the Contractor to have providers in-network with the capacity to perform forensic pediatric sexual abuse examinations. Patients directed to the ER.</li> <li>§ <u>Non-Compliant</u>: Documentation provided does not address the Contractor’s obligation to establish procedures to coordinate care for children receiving school-based/early intervention services in a manner that prevents duplication of services.</li> <li>§ <u>Non-Compliant</u>: Documentation provided does not address the Contractor’s obligation to provide all Medically Necessary Covered Services to children receiving school-based services when an interruption in treatment exists such as school breaks.</li> <li>§ <u>Non-Compliant</u>: Documentation provided does not address the coordination of services between the First Steps</li> </ul>

Kentucky Spirit Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>program and Contractor coverage.</p> <p>§ <u>Non-Compliant</u>: Documentation provided does not address the Contractor’s and providers’ responsibility to coordinate care provided to children receiving early intervention/school-based services by sharing information, with appropriate permission from parents.</p> <p><u>Care Coordination File Review (Total Files Reviewed: 20)</u></p> <p>§ All member files had comprehensive assessment, as well as a care plan with established goals.</p> <p><u>DCBS Service Plan File Review (Total Files Reviewed: 20)</u></p> <p>§ 16 files contained detailed service plans.</p> <p>§ All service plans contained a staff signature.</p> <p><u>DCBS Claims File Review (Total Files Reviewed: 20)</u></p> <p>§ For all 20 files, claims data was not submitted.</p> <p>§ For all 20 files, provision of well-visits and EPSDT services was not able to be determined.</p>
<p>Enrollee Rights and Protections: Enrollee Rights</p>	<p>§ <u>Substantial</u>: Although the Member Handbook and Provider Manual address the following rights and responsibilities, P/P KY.MBRS.25 does not address the following rights and responsibilities of the members: consent for, or refusal of, treatment and active participation in decisions; have questions answered with complete information related to the member’s medical condition/treatment options; voice grievances and file appeals; timely access to care without access barriers; prepare Advance Medical Directives pursuant to KRS; assistance with Medical Records in accordance with applicable laws; timely referral and access to medically indicated specialty care; freedom from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; abide by the Contractor’s and Department’s policies and procedures; become informed about service and treatment options; actively participate in personal health and care decisions; practice healthy life styles; report suspected Fraud and Abuse and keep appointments or call to cancel.</p> <p>§ <u>Substantial</u>: P/P KY.MBRS.25 does not specify that the Member Handbook must be made available online.</p> <p>§ <u>Non-Compliant</u>: P/P KY.MBRS.25 does not specify whether the Handbook is reviewed by the plan annually or how changes to the Handbook are addressed.</p> <p>§ <u>Substantial</u>: P/P KY.MBRS.25 does not address the requirements of the Contractor’s listing of Primary Care Providers.</p> <p>§ <u>Substantial</u>: Contractor’s policy does not indicate that the Contractor’s contact information, including hours of business, be made available in the Member Handbook.</p> <p>§ <u>Substantial</u>: P/P KY.MBRS.25 does not address the list of covered services along with explanations of any limitations; the procedure for obtaining emergency care and non-emergency after hours care; procedures for obtaining transportation for both emergency and non-emergency situations; information on the availability of maternity; family planning and</p>

Kentucky Spirit Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>sexually transmitted disease services; procedures for arranging EPSDT for persons under the age of 21 years; procedures for obtaining access to Long Term Care Services; procedures for notifying the Department for Community-Based Services (DCBS) of family size changes, births, address changes and death notifications; list of direct access services that may be accessed without the authorization of a PCP; information about procedures for selecting a PCP or requesting a change of PCP and specialists; information about how to access care before a PCP is assigned or chosen; member's right to obtain a second opinion; procedures for obtaining covered services from non-network providers; procedures for filing a Grievance or Appeal; information about the CHFS's independent ombudsman program for members; information on the availability of, and procedures for, obtaining behavioral health/substance abuse health services; information on the availability of health education services; information deemed mandatory by the Department and the availability of care coordination, case management and disease management provided by the Contractor.</p> <p>§ <u>Substantial</u>: P/P KY.UM.01.01, Covered Benefits and Services, does not include in its policy that members must be notified, in writing, of their right to request a second opinion.</p> <p>§ <u>Substantial</u>: P/P KY.MSPS.21 indicates that the Member and Provider Services Department will monitor call volume and ensure service levels are met for the average speed of answer but does not give documentation of policy regarding separate phone lines.</p> <p>§ <u>Substantial</u>: None of the policies provided had specific documentation of ongoing training for providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.</p> <p>§ <u>Non-Compliant</u>: The Member Handbook and Provider Manual did not contain information regarding the requirements for service locations or those regarding patient access to medical records.</p> <p>§ <u>Substantial</u>: In regard to Member Services responsibilities, the plan does not specifically address the requirements for grievances; describe the requirements for assisting members with filing appeals; identify the Member Identification Card as a responsibility of Member Services; address specific services for which Member Services can help facilitate access to outside the Contractor's network, including transportation; or facilitating access to various types of provider sites.</p> <p>§ <u>Substantial</u>: Provider Manual does not address the consequences related to unlawfully billing members (other than applicable co-pays or other cost-sharing requirements) for Medicaid-covered services.</p> <p>§ <u>Substantial</u>: Documentation provided does not include policy that a member may agree, in writing, to pay for a non-Medicaid covered service.</p> <p>§ <u>Substantial</u>: P/P KY.ELIG.04 and P/P KY.ELIG.03 do not address disabled children or foster children in policies related to the member's choice of providers.</p> <p>§ <u>Minimal</u>: Documentation provided does not specify that there is a limited timeframe, 10 days, in which a member has to select a new PCP before the Contractor may assign a new PCP to a member.</p> <p>§ <u>Minimal</u>: Documentation provided indicates that a member may change PCPs, and gives information as to how to go about doing so, but does not include all the circumstances or causes included in these requirements.</p> <p>§ <u>Non-Compliant</u>: Documentation provided did not address the right of the PCP to request a member's disenrollment from his/her practice or the circumstances necessary to make such a request.</p>

Kentucky Spirit Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>§ <u>Minimal</u>: Policies provided did not address provider right to request member disenrollment or the member's right to appeal such a request.</p> <p>§ <u>Non-Compliant</u>: Policies provided do not address the Contractor's obligation to notify a member, within 15 days, if their PCP has been involuntarily or voluntarily disenrolled or been terminated from Contractor's network.</p>
<p>Enrollee Rights and Protection: Member Education and Outreach</p>	<p>§ <u>Substantial</u>: While the Contractor did submit reports that described an outreach program for the Homeless population, it did not include a separate outreach plan policy.</p> <p>§ <u>Non-Compliant</u>: There is no specific policy or plan submitted that addressed transportation services for the homeless or victims of domestic violence.</p> <p>§ <u>Substantial</u>: While the Contractor's policy does state that members will be notified through the newsletter, Member Handbook or Kentucky Spirit Health Plan website of any changes with regard to the list of participating providers, P/P KY.MBRS.02 does not include how members may obtain an updated list of participating providers.</p> <p>§ <u>Non-Compliant</u>: P/P KY.Members.25 addresses non-discrimination; however, it does not establish the requirement of addressing the special health care needs of its members needing culturally sensitive services.</p>
<p>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</p>	<p>§ <u>Minimal</u>: EPSDT policy/procedure does not include right to appeal decisions related to EPSDT services.</p> <p>§ <u>Non-Compliant</u>: Documents provided do not address tracking of acceptance and refusal of EPSDT services.</p> <p>§ <u>Substantial</u>: Although the plan did submit quarterly reports, including EPSDT screening and participation rates for the Categorically Needy, Kentucky Spirit Health Plan did not provide EPSDT screening and participation rates for the Medically Needy.</p> <p><u>EPSDT Appeals File Review (Total Files Reviewed: 2)</u></p> <p>§ Files lacked dated appeal requests.</p> <p>§ Notices lacked required language informing members of the opportunity to examine the case file and the opportunity to present evidence.</p> <p>§ Resolution notices were not properly worded.</p> <p><u>EPSDT UM File Review (Total Files Reviewed: 5)</u></p> <p>§ All files reviewed were fully compliant.</p>
<p>Grievance System</p>	<p>§ <u>Substantial</u>: The Work Process is not clear as it appears to address both grievances and appeals, but these are not sufficiently distinct in the procedure.</p> <p>§ <u>Minimal</u>: At the onsite review, the MCO indicated that a member inquiry is only considered a grievance if it cannot be resolved within 24 hours. This is not stated in the Grievance and Appeal System P/P or in the Work Process. In addition, the DMS Contract does not contain a provision for this, and it does not appear that the MCO obtained approval from DMS for this policy prior to implementation.</p> <p>§ <u>Substantial</u>: Neither P/P KY QI.11 nor the Member Handbook provides information on available assistance for members</p>

Kentucky Spirit Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>(interpreter, TTY/TTD, toll-free numbers).</p> <p>§ <u>Minimal</u>: Due to incomplete information in the file review, there was no evidence that the policy required a health care professional with appropriate clinical experience to issue a decision on an appeal for the following: appeal of a Contractor denial that is based on lack of medical necessity, Contractor denial that is upheld in an expedited resolution or a grievance or appeal that involves clinical issues.</p> <p>§ <u>Substantial</u>: The plan's Work Process does not address the obligation of the plan to ensure that no retaliatory action is taken against a member or service provider that files a grievance or appeal.</p> <p>§ <u>Minimal</u>: Kentucky Spirit Health Plan had a limited number of member grievances due to the fact that the MCO had been classifying complaints as grievances only when not resolved within 24 hours. File review was conducted for 10 files. Results showed lack of clarity as little documentation was supplied.</p> <p>§ <u>Minimal</u>: File review found that one grievance was discontinued due to member not submitting a request in writing. The Contract states that grievances may be filed either orally or in writing.</p> <p>§ <u>Minimal</u>: No evidence that the plan contacted the grievant with written notice of receipt of the grievance and expected date of resolution or resolved grievance within 30 days of receipt was present in the file review.</p> <p>§ <u>Minimal</u>: Grievance files included resolution notices; however, contents of notices did not consistently address sub-requirements A, B or C.</p> <p>§ <u>Non-Compliant</u>: Documentation provided does not address the member's right to file an appeal due to the failure of the Contractor to complete authorization request in a timely manner or due to Contractor's denial of member's request to obtain service outside the network when member is located in a rural area.</p> <p>§ <u>Substantial</u>: Work Process does not address the circumstances under which expedited resolution of an appeal is available and how to request it or the member's right to have benefits continue pending resolution of an appeal or state fair hearing</p> <p>§ <u>Non-Compliant</u>: Documentation provided does not address obligation of the plan to send a notice of action to member or provider filing the appeal within 10 days of the action for previously authorized services</p> <p>§ <u>Minimal</u>: No evidence that the plan contacted the member with written notice of receipt of the appeal within 5 days of receipt was present in the file review.</p> <p>§ <u>Non-Compliant</u>: No evidence in either policies/procedures or file review that the Contractor provides the member or the member's representative a reasonable opportunity to present evidence of the facts or law, or that the member/representative is given an opportunity to examine the member's case file.</p> <p>§ <u>Non-Compliant</u>: P/P KY.QI.11 does not address the contents of the appeal resolution letter. Files included resolution notices; however, issues with template language and clarity were noted as described above.</p> <p>§ <u>Substantial</u>: The Provider Manual and Member Handbook state that continuation of benefits/services shall occur only if an appeal is submitted in writing within 10 days of the denial letter. This is not compliant with the 30 day timeframe in contract requirements and neglects other contract provisions.</p> <p>§ <u>Non-Compliant</u>: Documents provided do not address the obligation of the Contractor to inform the Member of the</p>

Kentucky Spirit Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>limited time available to present evidence and allegations in fact or law.</p> <p>§ <u>Substantial</u>: P/P KY.QI.11 provided, however the P/P does not include the 5 day timeframe for the Contractor to submit supporting documentation when a State Fair Hearing is requested by a member.</p> <p>§ <u>Non-Compliant</u>: Documentation provided does not address failure of the Contractor to comply with the State Fair Hearing requirements of the state and federal Medicaid will result in automatic ruling in favor of member.</p> <p>§ <u>Minimal</u>: Provider grievances and appeal files were reviewed for compliance. These files lacked documentation and clarity.</p> <p>§ <u>Substantial</u>: The Work Process does not address provider grievances and appeals, except with regard to member appeals filed by the provider.</p> <p>§ <u>Minimal</u>: Documentation provided does not address the need for the plan to make grievance and appeals files available/accessible to DMS or its designee for review for 10 years following the final decision.</p> <p>§ <u>Non-Compliant</u>: Based on the results of the file review for grievances and appeals, the requirements for file organization and content were not met.</p> <p>§ <u>Non-Compliant</u>: Documents provided do not address the obligation of the plan to make documentation regarding the grievance available to the member, if requested.</p> <p><u>Grievance File Review (Total Files Reviewed: 10)</u></p> <p>§ Incomplete documentation. Timeliness of resolution, appropriateness of resolution, communication between the MCO and the member and nature of the grievance could not be determined.</p> <p>§ One file discontinued because grievance was not filed in writing.</p> <p><u>Appeal File Review (Total Files Reviewed: 5 Member, 10 Provider)</u></p> <p>§ Member: Incomplete documentation. Timeliness of case processing, acknowledgment letters and evidence of a decision making reviewer not involved in previous stages of review could not be determined.</p> <p>§ Member: Notices of Action were compliant.</p> <p>§ Member: Resolution Notices contained unclear language, above the required reading level.</p>
Health Risk Assessment	<p>§ <u>Minimal</u>: In regard to the Contractors obligation to conduct an initial health screening assessment for pregnant members, no timeframe is given in documentation provided.</p> <p>§ <u>Minimal</u>: By contract, the plan is required to “make all reasonable efforts” to contact new members. While the plan included this in its documentation, the file review showed that only 7 of 50 files had documentation of a completed telephone call.</p> <p>§ <u>Substantial</u>: P/P KY.CM.01.01 does not specifically indicate what health care professionals are involved in the assessment process.</p> <p>§ <u>Substantial</u>: The HRA script directed members to Member Services for help in scheduling an initial appointment with</p>

Kentucky Spirit Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>their PCP.</p> <p><u>Health Risk Assessment File Review (Total Files Reviewed: 50)</u></p> <ul style="list-style-type: none"> <li>§ 7 files had documented health risk assessments.</li> <li>§ 21 members received no follow-up calls.</li> <li>§ Automatic scoring system found that only 1 of the 7 cases needed to be evaluated for case management. File review found that all 7 should have been evaluated.</li> <li>§ 3 of the 7 files with HRAs showed no evidence that the interviewer offered any assistance in arranging an initial visit with their PCP.</li> </ul>
Medical Records	<ul style="list-style-type: none"> <li>§ <u>Non-Compliant:</u> Kentucky Spirit Health Plan did not provide documentation of HIPAA privacy and security audits of its providers.</li> <li>§ <u>Substantial:</u> The provisions for transfer of member medical records to the PCP or MCO were not addressed in the documents provided. No timeframes were included.</li> <li>§ <u>Substantial:</u> Kentucky Spirit Health Plan has not yet conducted its first medical record audit (CY 2012). No documentation was found related to monitoring of medical record keeping for ancillary providers.</li> <li>§ <u>Non-Compliant:</u> The policy does not address cost for additional copies of a member's medical record, or that the member is entitled to free copy. In addition, retention of immunization and tuberculosis records is not addressed in the P/Ps provided.</li> <li>§ <u>Substantial:</u> Race/Ethnicity was not addressed in documents provided in terms of the information requirements of a member's medical record.</li> <li>§ <u>Substantial:</u> The plan's documents indicate that patient medical history, including serious accidents, operations, and illnesses, history of nicotine, alcohol or substance abuse, is a required element only for patients seen 3 or more times. The contract does not allow for this restriction.</li> <li>§ <u>Substantial:</u> Documentation of reportable diseases/conditions and follow-up visits appears in the medical record review tool, but not in the Provider Manual.</li> <li>§ <u>Substantial:</u> Documentation provided showed that written denials of service were addressed in the medical record review tool but not in the Provider Manual.</li> <li>§ <u>Substantial:</u> Reference to relevant psychological and social conditions was not found in provided documentation regarding the requirements of a member's medical record for clinical encounters.</li> <li>§ <u>Substantial:</u> Both the Provider Manual and the medical record review tool state that only abnormal results from prior visits be addressed in the member's clinical encounter medical record.</li> <li>§ <u>Substantial:</u> Provider Manual does not list medication history and states only "instructions for medications" are required for plan of treatment history in a member's clinical encounter medical history.</li> <li>§ <u>Substantial:</u> No evidence/documentation of training for Member Services staff provided.</li> </ul>

Kentucky Spirit Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>§ <u>Substantial</u>: The following provisions were not addressed in the documents reviewed: Assuring confidentiality of services for minors for diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth and how to contact the minor Member for follow-up and limitations on telephone or mail contact to the home.</p> <p>§ <u>Non-Compliant</u>: Documentation provided did not address the confidentiality agreement that the Contractor is required to sign on behalf of its employees, agents and assigns.</p>
Pharmacy Benefits	<p>§ <u>Minimal</u>: MCO Report # 45B Reviewed. Of this report, the PDL indicates that restrictions on commonly utilized antibiotics are excessive. The impact of these restrictions on members does not appear to be measured.</p> <p>§ <u>Minimal</u>: Information is made available to pharmacy providers and members regarding PDL and co-pays, etc; however, the process for ensuring this availability is found in a free-standing, undated document.</p> <p>§ <u>Substantial</u>: Although the dates of the P&amp;T Committee meetings are announced on the website, no specific invitation for public participation is apparent.</p> <p>§ <u>Substantial</u>: Paper or manual claims are only partially addressed within the Coordination of Benefits policy.</p> <p>§ <u>Non-Compliant</u>: P/P Rebates USS.FIN.07 does not address requirement that the state collect CMS level rebates on all Medicaid MCO utilization.</p>
Program Integrity	<p>§ <u>Minimal</u>: The Business Ethics and Code of Conduct were not provided. KY.COMP.27 is referenced, however, the P/P was not provided.</p> <p>§ <u>Minimal</u>: Policy regarding training about fraud, waste and abuse only addresses training for PIU staff and Kentucky Spirit Health Plan staff. Does not include providers and members.</p> <p>§ <u>Non-Compliance</u>: Policies and procedures provided do not address the enforcement of standards through disciplinary guidelines.</p> <p>§ <u>Substantial</u>: P/P KY.COMP.16 indicates that the following circumstance would not warrant a full investigation; an educational letter is sent: reports of other individuals using the member's ID card.</p> <p>§ <u>Minimal</u>: Although in P/P KY.COMP.16 addresses provisions for internal monitoring and auditing, no documentation of internal monitoring or audits conducted was provided.</p> <p>§ <u>Non-Compliant</u>: P/P KY.COMP.16.01, EOB Service Verification is referenced. However, this P/P was not provided nor was documentation that this activity was conducted.</p> <p>§ <u>Non-Compliant</u>: Policies and procedures provided do not address process for card sharing cases.</p> <p>§ <u>Minimal</u>: MCO provided reports of algorithms for detecting potential FWA cases. Algorithm reports (SUR 75) were provided for each month of 2012 with all fields blank.</p> <p>§ <u>Non-Compliant</u>: Case file showed Contractor did not follow cases from the time they opened until they closed.</p> <p>§ <u>Non-Compliant</u>: No documentation of Contractor attendance at DMS-sponsored FWA trainings was provided.</p> <p>§ <u>Substantial</u>: Although 2012 Annual Disclosure of Ownership addressing and subcontractors was provided, the accuracy is</p>

Kentucky Spirit Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	questionable.
	§ <u>Non-Compliant</u> : No documentation of the number of staff or roles/professional qualifications of the PIU staff for Kentucky Spirit Health Plan was provided.
	§ <u>Non-Compliant</u> : P/P provided do not address the prioritization of work to ensure that cases with the greatest potential program impact are given the highest priority, or any of the provisions that follow.
	§ <u>Non-Compliant</u> : No documentation of training sessions or staff attendance provided in regard to Fraud, Waste and Abuse trends inkling CMS initiatives.
	§ <u>Non-Compliant</u> : No documentation of Contractor attendance at DMS-sponsored FWA programs was provided.
	§ <u>Non-Compliant</u> : P/P does not address the Contractor’s obligation to initiate and maintain network and outreach activities that ensure effective interaction with all internal components of the Contractor.
	§ <u>Non-Compliant</u> : P/P does not address the Contractor’s obligation to make and receive recommendations to enhance the Contractor’s ability to prevent, detect and deter Fraud, Waste or Abuse.
	§ <u>Minimal</u> : Although P/P does address internal monitoring and auditing, no documentation of quarterly reports for internal monitoring and/or subcontractor FWA activities was provided.
	§ <u>Substantial</u> : Although continuous and on-going reviews of all MIS data are present in policies and procedure provided, there is no mention of involvement of grievances and appeals in this process.
	§ <u>Non-Compliant</u> : P/P provided does not address Contractor’s responsibility to conduct onsite and desk audits of providers and report back to DMS.
	§ <u>Non-Compliant</u> : P/P provided does not address Contractor’s responsibility to maintain locally, cases under investigation for possible FWA activities and report to DMS and OIG.
	§ <u>Non-Compliant</u> : Documents provided do not address PIU’s responsibility to ensure the integrity of PIU referrals to DMS.
	§ <u>Non-Compliant</u> : Documents provided do not address PIU’s responsibility to comply with expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by provider were received.
	§ <u>Non-Compliant</u> : P/P CC.CRED.03 Initial Credentialing Verification referenced, however, the P/P was not provided, nor was documentation of reporting providers who were denied enrollment to DMS.
	§ <u>Non-Compliant</u> : Patient Protection and Affordable Care Act is not referenced in any policies or procedures provided.
	§ <u>Non-Compliant</u> : Documents provided do not address the PIU’s responsibility to immediately inform OIG of any suspected violations of criminal Medicaid fraud statutes or the Federal False Claims Act.
	§ <u>Non-Compliant</u> : No documentation found regarding the PIU’s obligation to suspension of provider payments in the event of a pending investigation of credible allegation of fraud.
	§ <u>Minimal</u> : P/P KY.COMP.16 references the SIU database – Trail Tracker, but does not specify its capabilities in reference to FWA investigations. Grievance tracking is not mentioned.
	§ <u>Non-Compliant</u> : Quarterly reports provided by the PIU in reference to activities and processes for each investigative

Kentucky Spirit Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>case, did not include an OIG case number.</p> <p>§ <u>Non-Compliant</u>: Quarterly reports provided by the PIU in reference to activities and processes for each investigative case, did not include whether or not the complaint was substantiated.</p> <p>§ <u>Non-Compliant</u>: Documentation provided does not address the Contractor’s obligation to provide all contracted rates for providers upon request.</p> <p>§ <u>Non-Compliant</u>: Documentation provided does not address the Contractor’s obligation to make available and grant the PIU access to any records or data for the purpose of carrying out PIU functions or responsibilities.</p> <p>§ <u>Non-Compliant</u>: Documentation provided does not address the Contractor’s obligation to provide identity and cover documents and information for law enforcement investigators under cover.</p> <p><u>Program Integrity File Review (Total Files Reviewed: 3 member, 8 provider)</u></p> <p>§ Case investigation reports untimely</p> <p>§ 10 files showed evidence of communication between the PIU and Kentucky Spirit Health Plan Compliance regarding cases undergoing MCO approval.</p> <p>§ 1 file contained date the case was assigned to the investigator as well as the name of the investigator.</p> <p>§ Date of completion was not identifiable in any of the files reviewed.</p> <p>§ 7 files contained the methodology used for the investigation.</p> <p>§ 2 files included adequate investigative documentation and case reports.</p> <p>§ 0 files reviewed included exhibits, supporting documentation or a summary of attachments.</p> <p>§ 2 of the 6 files which required recommendations for administrative action or policy revision were compliant.</p> <p>§ 0 files made any mention of identification of overpayment or recommendations related to collection.</p>
<p>Quality Assessment and Performance Improvement (QAPI) – Access</p>	<p>§ <u>Substantial</u>: Documentation provided does not indicate that there must be an agreement between the member (or family of member) and the specialist for the specialist to serve as the member’s PCP.</p> <p>§ <u>Substantial</u>: Policy regarding the Contractor’s obligation to assure that all Covered Services are accessible to members, as the same services are available to commercial insurance members, did not include all elements such as the prohibition of incentives.</p> <p>§ <u>Substantial</u>: P/P KY.PRVR.10, Measuring Provider Accessibility, addresses member-to-PCP ratio but does not specify the accepted ratio of 1500:1.</p> <p>§ <u>Substantial</u>: Documentation provided does not address services not to exceed 60 days for other referrals or requirement that specialists shall be commensurate with the subpopulations designated by the Department, including sufficient pediatric specialists to meet the needs of members younger than 21 years of age.</p> <p>§ <u>Substantial</u>: Documentation provided does not address the requirement that transport time to hospital care for Behavioral Health and Physical Rehabilitative services is not to exceed 60 minutes.</p>

Kentucky Spirit Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>§ <u>Non-Compliant</u>: Documentation provided did not include any policy regarding the Contractor’s obligation to attempt to enroll the following providers in its network: Kentucky Commission for Children with Special Health Care Needs.</p> <p>§ <u>Non-Compliant</u>: P/P KY CONT.01 does not include the requirement that the Contractor must provide documentation to DMS showing that adequate services and service sites are available in the event that the Contractor is not able to reach agreement with any Community Mental Health Centers.</p> <p>§ <u>Non-Compliant</u>: Documentation does not address the requirement that Contractor may include charitable providers in its network.</p> <p>§ <u>Substantial</u>: P/P CC.OI.04, Evaluation of Practitioner Availability, does not include provision to submit documentation to the Department if the MCO is unable to contract with sufficient types, numbers and specialties of providers.</p> <p>§ <u>Non-Compliant</u>: The following categories were not addressed on the maps provided and had no documented accessibility analysis: Primary Care Centers, non-FQHC and RHC, After Hours Urgent Care Centers, Local Health Departments, Family Planning Clinics and Significant Traditional Providers.</p> <p>§ <u>Substantial</u>: Although a summary of dentists was reviewed, showing dentist accessibility in 4 regions, no map was given.</p> <p>§ <u>Substantial</u>: Midwives and Nurse Practitioners are located on their own maps. Physician Assistants were not identified on any maps.</p> <p>§ <u>Non-Compliant</u>: No documentation provided addressed the ability of the Contractor to provide additional medically necessary services to members or the provisions that must be followed.</p> <p>§ <u>Substantial</u>: Provider Manual does not explicitly address the Contractor’s inability to prohibit providers from advising a member about medical care or treatments that are not covered by the Contractor.</p> <p>§ <u>Minimal</u>: The Contractor’s policy does not explicitly state that any forms completed for a Medicaid-covered service must be completed in accordance with Kentucky Administrative Regulation.</p> <p>§ <u>Substantial</u>: The requirement that the Contractor must provide any medically necessary services out-of-network, if the network is not sufficient to cover the needed service, is only partially addressed in P/PKY.UM.24 and P/PKY.CONT.01.</p>
<p>Quality Assessment and Performance Improvement (QAPI) – Structure and Operations- Credentialing</p>	<p>§ <u>Substantial</u>: Language regarding training to serve children with special health care needs in lieu of board certification was not seen.</p> <p>§ <u>Substantial</u>: P/P did not include language stating that coversheets will be submitted electronically to the Department’s Fiscal Agent.</p> <p>§ <u>Substantial</u>: The Contractor’s policy does not include required provision regarding enrollment forms for providers/ service sites.</p> <p>§ <u>Non-Compliant</u>: Documents provided do not address the Contractor’s obligation to offer participation agreements to providers currently enrolled in Medicaid who receive EHR incentive funds and are willing to agree to terms.</p> <p>§ <u>Non-Compliant</u>: Departmental enrollment processes to assign provider numbers to out-of-network providers are not found in documentation nor are processes for reporting out-of-network utilization to the Department.</p>

Kentucky Spirit Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>§ <u>Non-Compliant</u>: Documents provided do not address the provision that the Contractor may enroll non-Medicaid participating providers in its network.</p> <p>§ <u>Substantial</u>: Timeframe for notifying DMS regarding suspension, termination, and exclusion of a provider from Contractor's network is not included in documentation.</p> <p><u>Credentialing File Review (Total Files Reviewed: 12)</u></p> <p>§ 12 files were compliant in regard to board certification.</p> <p>§ 12 files had Credentialing Process Coversheets.</p> <p>§ 12 files showed evidence of structured review against internal and contractual standards.</p>
<p>Quality Assessment and Performance Improvement (QAPI) – Structure and Operations- Delegated Services</p>	<p>§ <u>Substantial</u>: Policies and procedures for subcontractor oversight were not submitted for review. Subcontractor Oversight Committee description was not submitted for review.</p> <p>§ <u>Substantial</u>: Only 6 of 7 contracts reviewed contained language regarding oversight obligations of the MCO; the issuance of a corrective action plan and the Contractor's right to approve, suspend or terminate any provider selected by that subcontractor were not addressed in 1 file.</p> <p>§ <u>Non-Compliant</u>: Documents provided do not address the Contractor's and DMS's role in the approval of a subcontract.</p> <p>§ <u>Substantial</u>: Only 6 of 7 subcontracts reviewed showed evidence that the subcontract specified procedures and criteria for extension, renegotiation, and termination.</p> <p>§ <u>Substantial</u>: Only 4 of 7 contracts/amendments contained language specifically prohibiting incentives for withholding necessary covered services.</p> <p>§ <u>Minimal</u>: Although all 7 subcontracts reviewed were NCOA or URAC certified, no NCOA or URAC survey reports were submitted for review.</p> <p>§ <u>Non-Compliant</u>: Policies and Procedures for subcontractor Oversight were not submitted for review. No evidence found of policy regarding Contractor obligation to inform the Department of any subcontractor providing covered services that engages another subcontractor in any transaction.</p>
<p>Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement</p>	<p>§ <u>Substantial</u>: In regard to the plan's QAPI strategy, some activities, such as meetings of the Quality Improvement Committee, did not appear to be consistent throughout 2012 as reflected in submitted documents.</p> <p>§ <u>Substantial</u>: Although members provided feedback regarding their experiences with the plan, no review of QI activities or documents was noted. Input from members is required to influence the QAPI program.</p> <p>§ <u>Substantial</u>: The plan did not achieve full compliance with the EQR provision of information or administrative review requirements as some of requested information for the annual compliance review, such as Health Risk Assessment files, was not provided for onsite review.</p> <p>§ <u>Substantial</u>: The QIC did not include providers which were representative of all specialties.</p> <p>§ <u>Substantial</u>: Although the QI Work Plan indicates that the committee would meet quarterly, there was only evidence of 3 meetings in 2012.</p>

Kentucky Spirit Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>§ <u>Substantial</u>: Regarding the PIP requirements, the plan did not submit adequate baseline rates with either of the PIP proposals.</p> <p>§ <u>Substantial</u>: The plan did not adequately address the following in the PIP proposals: Topic and Importance to Enrolled Members, Methodology for topic selection, Goals and Intervention(s).</p> <p>§ <u>Minimal</u>: QMAC minutes did not provide evidence of review of quality and access standards, grievance and appeals processes, the Member Handbook, Member education materials, community outreach activities or polices that impact Members, as is required.</p> <p>§ <u>Non-Compliant</u>: The plan did not indicate that assessment for the need for special surveys was conducted, although behavioral health survey, MHSIP, was in process.</p>
<p>Quality Assessment and Performance Improvement: Access – Utilization Management</p>	<p>§ <u>Substantial</u>: Policy and procedures regarding the Utilization Management program does not address specific requirements.</p> <p>§ <u>Minimal</u>: Language regarding mechanisms to ensure consistent application of review criteria in regard to the Medical Necessity review process not found in individual, executed agreements with subcontractors.</p> <p>§ <u>Non-Compliant</u>: Written confirmation of approvals regarding Medical Necessity reviews is not addressed. P/P UM.05, Timeliness of UM Decisions and Notifications, was not submitted for review.</p> <p>§ <u>Substantial</u>: Availability, process and timeframes for appeal of the decision might include expedited resolution, although not specifically stated. File review found all 5 files to have evidence that member was notified of the circumstances under which expedited resolution was available and how to request it.</p> <p>§ <u>Non-Compliant</u>: Because P/P UM.05, Timeliness of UM Decisions and Notifications, was not submitted, the plan was found not compliant with all (9) such events listed in the contract under which the Contractor must give notice by the date of the Action.</p> <p>§ <u>Non-Compliant</u>: No language found in policy stating notice must be made on the date of the Action when the Action is a denial of payment.</p> <p>§ <u>Minimal</u>: Plan policy does not address extensions in detail, or the procedure in the event that an extension is granted, in regard to the Contractor’s obligation to give notice of decision of service authorization.</p> <p>§ <u>Minimal</u>: Plan language varies from the requirement which requires the Contractor to make an expedited authorization decision in the event that the standard timeframe could seriously jeopardize the Member’s health and does not reference Member’s health condition specifically (but does address hospitalization).</p> <p>§ <u>Non-Compliant</u>: P/P UM.05 was not submitted. No evidence of compliance in regard to the Contractor’s obligation to give notice to the member that a decision has not been reached on an authorization by the deadline.</p> <p><u>UM File Review (Total Files Reviewed: 20)</u></p> <p>§ 15 records contained administrative denials.</p> <p>§ 5 records were denials based on medical necessity.</p>

Kentucky Spirit Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
 (Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>§ All 5 records contained evidence member notification included the action the Contractor intended to take, member's right to appeal, member's right to request a state hearing, procedure for filing an appeal, procedure for requesting an expedited resolution.</p>

*Passport Health Plan 2012 Medicaid Compliance Review Findings for Contract Year 2011–2012*

This technical report was issued prior to the completion of the compliance review since the expansion of the Kentucky Medicaid Managed Care Program and therefore only the preliminary results of the compliance reviews have been included. For the 2012 Technical Report, a description of the current year findings for all standards/elements not found fully compliant including a summary of the file review results are provided. In future editions of this report, these results will be accompanied by current year overall category compliance designations and Passport Health Plan’s response and action plan as applicable.

Passport Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2011/2012)	
Standard	Description of Review Findings Not Fully Compliant
Continuity & Coordination of Care: Behavioral and Physical Health Care	<p>§ <u>Substantial</u>: Although policies and procedures do include information regarding the member’s ability to obtain behavioral health services through the fee-for-service program, they do not include language related to behavioral health claim denials.</p> <p>§ <u>Substantial</u>: Complex Case Management Program Descriptions do not include behavioral health indicators among indicators for referral. Also, compliance reviewer was unable to locate referral form on Passport Health Plan website.</p> <p>§ <u>Substantial</u>: Primary Care Provider Responsibilities: monitoring interval as described in QM 5.0 (per prior IPRO comments) does not allow follow-up of prior review determinations and recommendations.</p>
Case Management/Care Coordination	<p>§ <u>Minimal</u>: Service plans were not made available during the file review. In addition, outreach could not be assessed for DCBS clients due to the directive that prohibits the plan from communicating directly with DCBS members/caregivers.</p> <p>§ <u>Minimal</u>: The plan did not adequately track, analyze and report metrics related to DCBS members. Utilization measures provided ranged in date from 2006 to 2012, disregarding the timeframe specified by the report title. Reports regarding Access measures were not provided for review, and corrective actions the plan intended to take have not been completed.</p> <p><u>DCBS Claims File Review</u></p> <p>§ 15 of 20 files included evidence of at least one well care visit during the review period.</p> <p>§ 14 of 15 were coded using a 993xx CPT code for EPSDT.</p> <p>§ Outreach efforts were not evident in the 5 files lacking a well-visit.</p> <p>§ 1 file contained documentation of coordination between physical and behavioral health.</p>
Enrollee Rights and Protections: Enrollee Rights	<p>§ <u>Substantial</u>: Provided policies and procedures did not include requirement that the Member Handbook must include revision dates so that it is evident which Handbook is the most current version.</p> <p>§ <u>Substantial</u>: Although review of the Member Handbook found that Covered services, limitations or exclusions are addressed, a provision stating that the Contractor will be liable only for those services authorized by the Contractor was not found.</p> <p>§ <u>Substantial</u>: Direct information on how to access care before a PCP is assigned or chosen was not found in the Member Handbook. The Handbook does indicate that a PCP will be assigned to a member upon enrollment, and that this PCP will</p>

Passport Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
Grievance System	<p>be listed on the member ID card.</p> <p>§ <u>Minimal</u>: The requirement that any quality of care concern be referred to the Quality Department, including PCP change requests that are based on care concerns, is not clearly addressed in the provided policies and procedures. Although Passport Health Plan responded with a corrective action plan, corrections were not made. The same policies were approved without updates.</p> <p>§ <u>Substantial</u>: Although the plan does have policy and procedure for documenting Grievances in the Contractor’s Management Information System, the plan is still in the process of drafting a QOC plan.</p> <p>§ <u>Substantial</u>: One file reviewed did not have the member’s name on the file, as is required.</p> <p>§ <u>Substantial</u>: Although a resolution was present in all files reviewed, some resolutions were of questionable appropriateness.</p> <p>§ <u>Minimal</u>: Although all files reviewed demonstrated that a corrective action had been taken, the appropriateness of such actions was not consistent.</p> <p>§ <u>Substantial</u>: In regard to the requirement for oversight of Member Services’ representatives dealing with grievances, P/P MS 16.0 does not clearly describe a mechanism for oversight and audit by quality management staff.</p> <p>§ <u>Minimal</u>: File review indicated that there are instances where quality of care concerns are addressed at the member level but not followed up by the Quality Department to ensure that any needed system changes are made.</p> <p>§ <u>Substantial</u>: Although P/P QR 1.01 states the Clinical Quality Review Nurse will notify Member Services of each concern so that a letter can be processed to inform the member that the QOC are investigated and corrective action taken as appropriate, file review found that this procedure is not always carried out in practice.</p> <p>§ <u>Substantial</u>: Although policies and procedures provided state that the member has the right to have someone else present an appeal for them, it does not specify that this must be an authorized representative or legal representative acting on behalf of a deceased member’s estate.</p> <p>§ <u>Substantial</u>: In the quarterly DMS Statutory Report for Appeals, Passport Health Plan did not include expedited appeals, or mention if there were no expedited appeals.</p> <p><u>Grievance File Review</u></p> <p>§ 1 out of 35 files was missing member’s name.</p> <p>§ Resolutions and corrective actions were not always appropriate, given the situation.</p> <p>§ 4 out of 20 files did not have clear evidence that the member was notified of the resolution.</p>
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations – Delegated Services	<p>§ <u>Substantial</u>: Of the reviewed contracts, it was not always evident that the contract with a subcontractor addressed all provisions required by the DMS contract.</p> <p>§ <u>Substantial</u>: Only 9 of 12 reviewed subcontracts specified that there could be no provisions that provide incentives, monetary or otherwise, for the withholding of medically necessary services from members.</p> <p>§ <u>Substantial</u>: Only 8 of 12 reviewed subcontracts contain a prohibition on assignment, or on any further subcontracting,</p>

Passport Health Plan: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>without the prior written consent of DMS.</p> <p>§ <u>Substantial</u>: Only 10 of 12 contracts reviewed contained an explicit provision stating that the Department is the intended third-party beneficiary of the subcontract and, as such, the Department is entitled to all remedies entitled to third-party beneficiaries under law.</p> <p>§ <u>Substantial</u>: Only 10 of 12 contracts reviewed included the subcontractor’s obligation to comply with all rights of DMS, the Office of the Inspector General and other authorized Federal and Commonwealth agents to investigate, inspect, monitor and audit operations.</p> <p>§ <u>Substantial</u>: Only 6 of 12 contracts reviewed showed evidence that subcontractors with NCOA accreditation provide the Contractor with a copy of their current certificates of accreditation and survey reports.</p> <p>§ <u>Substantial</u>: Only 9 of 12 contracts reviewed provided a process for the subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.</p>
<p>Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement</p>	<p>§ <u>Substantial</u>: Although the plan updated the QI Work Plan to include results of EQR activities, it did not include descriptions of any changes brought about through PIPs.</p> <p>§ <u>Substantial</u>: QI Work Plan does not include timeframes for implementing current and future activities.</p> <p>§ <u>Substantial</u>: Although the QI Work Plan includes goals set by the work group, these goals are not quantified.</p> <p>§ <u>Substantial</u>: In regard to PIPs, the policies and procedures provided do not directly address the procedure for continuing interventions that have proven to be successful after the course of the study.</p>
<p>Quality Assessment and Performance Improvement (QAPI): Access – Utilization Management</p>	<p>§ Full compliance achieved for all required elements</p>

*WellCare of Kentucky 2012 Medicaid Compliance Review Findings for Contract Year 2011-2012*

This technical report was issued prior to the completion of the first compliance review since the expansion of the Kentucky Medicaid Managed Care Program and therefore only the preliminary results of the compliance reviews have been included. For the 2012 Technical Report, a description of the current year findings for all standards/elements not found fully compliant including a summary of the file review results are provided. In future editions of this report, these results will be accompanied by current year overall category compliance designations and WellCare of Kentucky's response and action plan as applicable.

WellCare of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2011/2012)	
Standard	Description of Review Findings Not Fully Compliant
Behavioral Health Services	<p>§ <u>Non-Compliant</u>: Documents provided do not specifically address the requirement for network providers to have experience serving specific groups of people.</p> <p>§ <u>Substantial</u>: The quarterly compliance rates for the Provider Program Capacity Demonstration left considerable room for improvement. Also, folders submitted in the pre-onsite documents were empty.</p> <p>§ <u>Substantial</u>: P/P CBCS.062, Customer Service Crisis Policy, was provided; however, file could not be opened.</p> <p>§ <u>Minimal</u>: Average time on hold for the Behavioral Health Services Hotline was only compliant 3 out of 4 quarters in 2012.</p> <p>§ <u>Non-Compliant</u>: Since P/P CBCS.062, Customer Service Crisis Policy, file could not be opened, no evidence was found that the plan was compliant in regard to the requirement that an intake line cannot be answered by an answering machine, the Hotline's ability to connect members to other Crisis Response Systems, Contractor's option to operate one hotline for multiple services or the Contractor's inability to limit call durations on the Hotline.</p> <p>§ <u>Substantial</u>: Policy/procedure addressing hotline access to linguistic services not provided.</p> <p>§ <u>Non-Compliant</u>: Documents provided do not address the option that the Behavioral Health Services Hotline may serve multiple Contractor Programs and multiple regions if the Hotline staff is knowledgeable about each.</p> <p>§ <u>Substantial</u>: The provider training materials provided do not explicitly address screening and identification of behavioral health disorders.</p> <p>§ <u>Non-Compliant</u>: Provider Manual does not address referral for known or suspected and untreated physical health problems or disorders.</p> <p>§ <u>Non-Compliant</u>: Court-ordered services, including the Contractor's responsibilities and limitations, are not addressed in the documents provided; it is not evident how this information is shared with providers.</p> <p>§ <u>Minimal</u>: Although the agreement with Central State Hospital is provided, responsibility to assure continuity of care for successful transition into community-based supports is not addressed.</p> <p>§ <u>Non-Compliant</u>: Documentation provided does not address the requirement that Contractor Behavioral Health Service Providers must participate in quarterly continuity of care meetings.</p> <p>§ <u>Non-Compliant</u>: Documentation provided does not address the requirement that Case Managers and other identified behavioral health service providers must participate in discharge planning meetings.</p> <p>§ <u>Non-Compliant</u>: Documentation provided does not address the requirement that there must be appropriate follow-up</p>

WellCare of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>by the Behavioral Health Service to ensure the community supports are meeting the needs of the Member.</p> <p>§ <u>Non-Compliant</u>: Documents provided do not address evaluation of member-approved communications between behavioral health providers and PCPs.</p>
Case Management/Care Coordination	<p>§ <u>Non-Compliant</u>: Policies provided do not address the linkage of care coordination with other Contractor systems.</p> <p>§ <u>Minimal</u>: Although the plan has policies and procedures to ensure access to care coordination for all DCBS clients, documentation provided does not address measurement of access and satisfaction for this population.</p> <p>§ <u>Minimal</u>: Although the plan provided reports regarding Children in Foster Care, which demonstrated contact with DCBS, the file review found that only one file had a service plan prepared by DCBS.</p> <p>§ <u>Minimal</u>: Although policy regarding the obligation of the Contractor and DCBS to agree on a service plan for each individual member was submitted, as was policy regarding children receiving adoption assistance, the Service file review showed that only one file had a Service Plan prepared.</p> <p>§ <u>Non-Compliant</u>: Availability of providers to perform forensic pediatric sexual abuse examinations was not addressed in the documents provided.</p> <p><u>Care Coordination File Review (Total Files Reviewed: 20)</u></p> <p>§ 4 files had gaps in documentation and/or follow-up on needs.</p> <p><u>DCBS Service Plan File Review (Total Files Reviewed: 20)</u></p> <p>§ Service Plan provided for 1 file</p> <p>§ 6 cases actively coordinated with DCBS</p> <p>§ All files demonstrated ongoing care coordination, where appropriate.</p> <p><u>DCBS Claims File Review (Total Files Reviewed: 20)</u></p> <p>§ 11 files had evidence of at least one well-visit.</p> <p>§ 5 files lacked evidence of a well-visit when members were due for a well-visit.</p> <p>§ 8 files had evidence of EPSDT services.</p> <p>§ Outreach efforts were not evident in the 8 files lacking a well-visit and/or EPSDT service claim.</p> <p>§ Care coordination was evident in the 2 files requiring such services.</p>
Enrollee Rights and Protections: Enrollee Rights	<p>§ <u>Substantial</u>: The plan's policies indicate that out-of-network providers can access the Member Rights and Responsibilities documents via the plan's website, rather than requesting a hard copy from the plan, as required by the contract.</p> <p>§ <u>Substantial</u>: Although P/P C6CS-006, Twenty-Four Hour Coverage, addresses the need for a toll-free call-in system, it does not require that it be staffed by appropriately trained medical personnel.</p>

WellCare of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>§ <b>Substantial:</b> No evidence that the plan provides ongoing training to its staff and providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.</p> <p>§ <b>Non-Compliant:</b> Documentation provided does not address the following responsibilities of Member Services:</p> <ul style="list-style-type: none"> <li>§ Explaining the Contractor’s rights and responsibility to assure minimal waiting periods for office visits and telephone requests,</li> <li>§ Facilitating direct access to specialty physicians under specific circumstances,</li> <li>§ Arranging for, and assisting with scheduling, EPSDT Services,</li> <li>§ Providing members with information or referring to support services offered outside the Contractor’s network,</li> <li>§ Facilitating direct access to primary care vision services; primary dental and oral surgery services, and evaluations by orthodontists and prosthodontics; women’s health specialists; voluntary family planning; maternity care for members under age 18; childhood immunizations; sexually transmitted disease screening, evaluation and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases,</li> <li>§ Facilitating access to behavioral health services and pharmaceutical services,</li> <li>§ Facilitating access to the services of public health departments, Community Mental Health Centers, rural health clinics, Federally Qualified Health Centers, the Commission for CSHCN and charitable care providers,</li> <li>§ Assisting members in obtaining transportation,</li> <li>§ Facilitating access to Member Health Education Programs,</li> <li>§ Producing annual report about any changes needed in Member Services functions to improve quality of care.</li> </ul> <p>§ <b>Non-Compliant:</b> Policy does not address the Contractor’s right to bill the member if the member has agreed, in writing, to pay for a non-Medicaid covered service.</p>
<p>Enrollee Rights and Protection: Member Education and Outreach</p>	<p>§ <b>Substantial:</b> The plan did not provide evidence of assistance with transportation to access health care providers for homeless members.</p> <p>§ <b>Non-Compliant:</b> The plan did not provide evidence of a policy and procedure regarding Member Information Materials, and as such, did not meet any of the 10 requirements regarding Member Information Materials.</p> <p>§ <b>Minimal:</b> During the on-site visit, the plan did not provide a Cultural Competency Plan.</p> <p>§ <b>Substantial:</b> The plan did not supply a policy that explained how information regarding Cultural Consideration and Competency would be communicated to its subcontractors.</p>
<p>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</p>	<p>§ <b>Substantial:</b> Information regarding the right to appeal any decision relating to Medicaid services is included in the Member Handbook; however, EPSDT is not specifically mentioned.</p> <p>§ <b>Non-Compliant:</b> Documents provided do not address tracking of acceptance and refusal of EPSDT services, nor is there evidence of a tracking system.</p> <p>§ <b>Substantial:</b> Although the plan did submit Encounter Records, WellCare of Kentucky did not provide EPSDT screening and participation rates for the Medically Needy.</p>

WellCare of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>§ <u>Minimal</u>: Although P/P C7QI-034 Addendum E-Kentucky addresses the need for an EPSDT Coordinator, the position has not been filled.</p> <p>§ <u>Substantial</u>: Although WellCare of Kentucky submitted an EPSDT report, it did not contain EPSDT screening and participation rates for the Medically Needy.</p> <p><u>EPSDT Appeals File Review (Total Files Reviewed: 5)</u></p> <p>§ 3 Appeals were expedited appeals.</p> <p>§ Of the expedited appeals, 1 file did not inform the member of the limited time available to present evidence.</p> <p><u>EPSDT UM File Review (Total Files Reviewed: 5)</u></p> <p>§ All files reviewed were fully compliant.</p>
Grievance System	<p>§ <u>Substantial</u>: Although plan policies and procedures included language regarding health care professionals serving as reviewers for grievance or appeal cases involving clinical issues, file review found one case which did not appear to have clinical review in the file, when a clinical review should have been deemed necessary.</p> <p>§ <u>Minimal</u>: Although the plan provided appropriate policies regarding the Contractor’s obligation to supply the grievant with a resolution letter within 30 days of receipt of the grievance, the file review found that for 11/30 member grievances, a letter was sent within the specified timeframe; however, the resolution did not appear finalized.</p> <p>§ <u>Substantial</u>: The plan provided policy regarding the issuance of an extension in terms of grievance resolution; however, in the file review, there were 10 cases in which an extension was needed to continue investigation, yet the extension timeframe was never mentioned.</p> <p>§ <u>Substantial</u>: The plan provided policy regarding the contents of the grievance resolution letter, including all information considered in the investigation; however, in the file review, there were 11 cases where a resolution letter was sent, despite continuing investigation.</p> <p>§ <u>Minimal</u>: The plan provided policy regarding the contents of the grievance resolution letter including findings and conclusions as well as the disposition of the grievance; however, in the file review, there were 11 cases where a resolution letter was sent, despite continuing investigation.</p> <p>§ <u>Substantial</u>: P/P C7AP.035 indicates that an action that warrants an appeal includes denial of a rural resident member’s request to obtain services “outside of the Plan region” in rural areas with only one Contractor rather than outside of the network.</p> <p>§ <u>Substantial</u>: Procedures outlined in P/P C7UM MD 2.2 include the mailing of notice of action within 10 days of the date of action for previously authorized services and 14 days for newly requested services. Immediate notifications of denials of claims that may result in member financial liability do not appear to be reflected in policies.</p> <p>§ <u>Substantial</u>: P/P C7AP-035-PR001 notes that the plan will make available reasonable assistance to assist members with procedural steps, although not specifically in context of written appeals to follow oral appeals.</p>

WellCare of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>§ <b>Substantial:</b> Although the plan provided appropriate policy and procedures, file review found that 1 out of 3 member-expedited appeal files did not appear to include documentation that the member was informed of the limited time available to present evidence in an expedited review.</p> <p>§ <b>Substantial:</b> Description of a secure and designated area for grievance and appeal files and accessibility to the Department for review do not appear to be specified in policies and procedures</p> <p>§ <b>Substantial:</b> P/P C7 GR-003 record keeping requirements include requests for documentation or records related to the grievance, but do not appear to include correspondence or resolution notices sent to the member.</p> <p><u>Grievance File Review (Total Files Reviewed: 30 member, 15 provider)</u></p> <p>§ 1 member file did not include a clinical review, when a clinical review was necessary.</p> <p>§ 29 member files received acknowledgement letters within 5 days, with an expected resolution date.</p> <p>§ 29 member files received resolution letters within 30 days, however, 11 of these cases appeared to be ongoing at the time the resolution letter was sent.</p> <p>§ 1 member file did not give clear justification for the resolution.</p> <p>§ 15 provider files included resolution and written notices within 30 days.</p> <p><u>Appeal File Review (Total Files Reviewed: 15 member, 10 provider)</u></p> <p>§ All member appeals were reviewed by clinical staff, when necessary.</p> <p>§ All member files included written acknowledgement letters sent within 5 days.</p> <p>§ All member and provider files included resolutions letters sent within 30 days, with appropriate reasoning behind resolution, and a resolution date.</p> <p>§ All member files in which the resolution was not wholly in favor of the member contained the member's right to request a state hearing.</p>
Health Risk Assessment	<p>§ <b>Minimal:</b> P/P C6CS-037 and Addendum F describe the initial health screening assessment required for members, but not specific to any timeframes. The file review, for which only 5 of 50 cases had HRAs, indicated that the timeframes specified in the contract were not upheld.</p> <p>§ <b>Minimal:</b> Although P/P C6CS-037 and Addendum F describe the process of contacting the member by phone for the initial HRA, there is no documentation of making reasonable efforts.</p> <p>§ <b>Substantial:</b> Although the provided documents indicate that demographic information is collected in the HRA, file review found demographic data was not documented or asked.</p> <p>§ <b>Minimal:</b> Provided documents do not specify what health care professional is involved in the HRA process.</p> <p>§ <b>Substantial:</b> The policies provided do not specifically address the member assistance with arranging an initial visit with the member's PCP. However, the policy does state that a Customer Service Associate will contact the member with a script which directs the member to Customer Service for assistance in scheduling an appointment.</p>

WellCare of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p><u>Health Risk Assessment File Review (Total Files Reviewed: 5)</u></p> <ul style="list-style-type: none"> <li>§ Only 5 of the 50 requested files were submitted for review.</li> <li>§ 26 of the requested files could not be found.</li> <li>§ No evidence that timeframe standards were met.</li> <li>§ Efforts to contact members were not adequately documented.</li> <li>§ No evidence that demographic data was not documented or asked.</li> </ul>
Medical Records	<ul style="list-style-type: none"> <li>§ <u>Minimal</u>: Documents provided do not address the requirement for confidentiality policies and procedures and the requirement for HIPAA privacy and security audits. The MCO did not provide P/Ps C13HIP.01.002, HIPAA Records and Safeguards Policy or C13HIP.01.00, HIAA - Use and Disclosure of PHI Policy for review.</li> <li>§ <u>Minimal</u>: No evidence was submitted to verify that HIPAA privacy and security audits of providers were conducted.</li> <li>§ <u>Substantial</u>: Although Advanced Medical Directives is addressed in the Member Handbook and Provider Manual, no policy/procedure addressing AMD was provided for any of the related requirements.</li> <li>§ <u>Minimal</u>: The MCO provided the On Boarding Process for new hires that addresses the Confidentiality of Records requirements. However, a policy/procedure for confidentiality of records was not provided. Evidence of a signed confidentiality statement was not provided.</li> <li>§ <u>Non-Compliant</u>: Evidence of a Contractor signed confidentiality statement was not provided.</li> <li>§ <u>Non-Compliant</u>: A policy/procedure for confidentiality of records was not provided in order to satisfy the requirement that except as otherwise required by law, regulations or this contract, access to such information shall be limited by the Contractor and the Department to persons who or agencies which require the information in order to perform their duties.</li> </ul>
Pharmacy Benefits	<ul style="list-style-type: none"> <li>§ <u>Substantial</u>: Document provided in evidence of pharmacy provider relations and call center services was not supported by underlying policy for annual review/revision.</li> <li>§ <u>Minimal</u>: The formulary lists provided do not indicate any levels of utilization management requirements. In addition, the document, "Preferred Drug List PA Statement", lacks the context of any policies and is undated.</li> <li>§ <u>Substantial</u>: Evidence of public meeting agendas was found on WellCare of Kentucky website; however, meeting minutes indicating public inclusion that support KY state code were not provided.</li> <li>§ <u>Substantial</u>: Drugs listed in the PDL that require utilization management are not clear for pharmacies or the public.</li> <li>§ <u>Substantial</u>: KY Medicaid Quick Reference Guide includes instructions for submitting paper claims but policy addressing these requirements was not found.</li> <li>§ <u>Substantial</u>: Stand-alone document titled "Rebate Administration" provides guidance for dispute resolution but is not a stated policy of WellCare of Kentucky and is not dated.</li> </ul>

WellCare of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
Program Integrity	<ul style="list-style-type: none"> <li>§ <u>Substantial</u>: Policy and Procedure for verification of services billed by a provider were not submitted for review. However, Report #73, EOMB, was provided.</li> <li>§ <u>Minimal</u>: Card-sharing is not specifically addressed in the documents provided.</li> <li>§ <u>Substantial</u>: The plan did not meet all requirements listed under 37.15 Ownership and Financial Disclosure.</li> <li>§ <u>Minimal</u>: Although there is evidence that quarterly reports to the Department related to subcontractors were submitted, it is not evident that the Contractor reports internal monitoring or auditing of the Contractor itself.</li> <li>§ <u>Minimal</u>: Onsite reviews are not addressed in documents provided.</li> <li>§ <u>Minimal</u>: Review of member and provider grievance and appeal data not specifically addressed.</li> <li>§ <u>Non-Compliant</u>: Documents provided do not address conduct of onsite and desk audits required for the PIU.</li> <li>§ <u>Substantial</u>: Policy and procedure for verification of services billed by a provider were not submitted for review as required for PIU. However, Report #73, EOMB, was provided.</li> <li>§ <u>Non-Compliant</u>: Documentation provided made no mention of PIU’s policies to report any provider denied enrollment by Contractor for any reason to the Department within 5 days; correct any weaknesses, deficiencies; or noncompliance items that are identified as a result of a review or to work cooperatively and collaboratively with DMS to enhance Contractor’s PIU and address deficiencies.</li> <li>§ <u>Non-Compliant</u>: Documentation provided does not address policies regarding physical or mental abuse of members.</li> <li>§ <u>Non-Compliant</u>: In the quarterly reports the Contractor’s PIU is required to provide, OIG case numbers were missing.</li> <li>§ <u>Minimal</u>: Although quarterly Reports #76 and #77 were provided, they lacked documentation of a clear outcome of the complaint.</li> <li>§ <u>Non-Compliant</u>: Documentation provided did not show evidence that the Contractor regularly reported enrollment, provider or encounter data in a way usable by DMS and OIG.</li> <li>§ <u>Non-Compliant</u>: Documentation provided did not specifically address the Contractor’s obligation to report permit reviews, investigations or audits of all books, at the discretion of DMS or OIG.</li> <li>§ <u>Non-Compliant</u>: Documentation provided did not specifically address the Contractor’s obligation to produce records in electronic format for review/manipulation by DMS and OIG.</li> <li>§ <u>Non-Compliant</u>: Documentation provided did not specifically address the Contractor’s obligation to allow designated Department staff read access to ALL data in the Contractor’s MIS systems.</li> <li>§ <u>Non-Compliant</u>: Documentation provided did not specifically address the Contractor’s obligation to provide all contracted rates for providers upon request.</li> <li>§ <u>Non-Compliant</u>: Documentation provided did not specifically address the Commonwealth’s right to collect overpayments after 180 days if the Contractor has not done so.</li> <li>§ <u>Non-Compliant</u>: Documentation provided did not specifically address the Contractor’s obligation to provide identity, cover documents and information for law enforcement investigators under cover.</li> </ul>

WellCare of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p><u>Program Integrity File Review (Total Files Reviewed: 15)</u></p> <ul style="list-style-type: none"> <li>§ 3 files did not include any notes beyond October 2012</li> <li>§ 1 file indicates that the case contains information regarding claims, COB and eligibility, however none of these are present</li> <li>§ 1 file did not include details of the allegation.</li> <li>§ 2 files did not have a completion date, or evidence that the case was completed.</li> <li>§ Summary of documentation was included; however, documents listed in summary were not present.</li> </ul>
<p>Quality Assessment and Performance Improvement (QAPI) – Access</p>	<ul style="list-style-type: none"> <li>§ <u>Substantial</u>: Although documentation provided does state that a specialist may be a member’s PCP, it does not give the clause that there must be an agreement between the member and the specialist, or that the member has the right to an appeal.</li> <li>§ <u>Non-Compliant</u>: P/P C6NI-002 Addendum J has documentation regarding what is acceptable after hours but does not address what is unacceptable.</li> <li>§ <u>Substantial</u>: In regard to urgent care, the plan’s policies and procedures do not state that the Contractor is not responsible for providing transportation to a pharmacy.</li> <li>§ <u>Substantial</u>: Teaching hospitals and the Kentucky Commission for Children with Special Health Care Needs are not referenced in any policy documentation regarding the provider network.</li> <li>§ <u>Non-Compliant</u>: Documentation provided gives no evidence that the Contractor makes any attempts to enroll The Kentucky Commission for Children with Special Health Care Needs in its network.</li> <li>§ <u>Non-Compliant</u>: Documentation provided did not address the requirement that the if the Contractor cannot reach agreement with the providers required in the network, then the Contractor must agree to meet the needs of its members through specified providers with which no contract is held.</li> <li>§ <u>Non-Compliant</u>: Documentation provided does not address contracting with local health departments or the provisions which would accompany such a contract.</li> <li>§ <u>Non-Compliant</u>: Documentation provided does not address the inclusion of charitable providers in the network.</li> <li>§ <u>Substantial</u>: Policy provided does not include the plan’s obligation to recruit additional providers based on a member’s request.</li> <li>§ <u>Non-Compliant</u>: Documentation provided does not address the Contractor’s ability to provide additional services which are Medically Necessary or the procedure for doing so.</li> <li>§ <u>Non-Compliant</u>: Documentation provided does not address the obligation of the Contractor to ensure that required forms for any services are completed according to KAR and retained by the subcontractor/provider.</li> <li>§ <u>Non-Compliant</u>: Documentation provided does not address the member’s right to choose from all in-network specialists/hospitals, once Prior Authorization for referral is obtained from the Contractor.</li> <li>§ <u>Non-Compliant</u>: Documentation provided does not address payment for Emergency Services covered by a non-contracting provider</li> </ul>

WellCare of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
	<p>§ <b>Substantial:</b> There is no specific documentation that addresses enrollment of out-of-network providers into the Contractor’s network; however, out-of-network analysis found that several of the top-utilized out-of-network providers and labs have been enrolled in the Contractor’s network.</p> <p>§ <b>Non-Compliant:</b> Policies reviewed did not address the Contractor’s obligation to maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for members under the age of 18 pursuant to Title X, 42 CFR 59.11, and KRS 214.185.</p>
<p>Quality Assessment and Performance Improvement (QAPI) – Structure and Operations- Credentialing</p>	<p>§ <b>Substantial:</b> Policies/procedures reviewed were not consistent regarding the requirement for an initial site inspection at the time of credentialing. P/Ps provided indicate site visits are required; however, in practice they are conducted only as deemed necessary.</p> <p>§ <b>Non-Compliant:</b> Documentation provided does not address the Contractor’s obligation to report any serious quality deficiencies that could result in a practitioner’s suspension or termination to DMS.</p> <p>§ <b>Substantial:</b> In regard to the Contractor’s obligation to notify DMS of facts and outcomes regarding provider review by the Credentialing committee, there was not documented policy available for review. However, the MCO stated that no reports had been sent to DMS because there were no such cases during the review period.</p> <p>§ <b>Non-Compliant:</b> Documentation provided does not address the Contractor’s obligation to offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions.</p> <p>§ <b>Non-Compliant:</b> A report of out-of-network utilization was not provided for review as is required.</p> <p>§ <b>Non-Compliant:</b> Documents provided do not address the Contractor’s ability to enroll providers in their network who are not participating in the Kentucky Medicaid Program or the policies/procedures which accompany this right.</p> <p>§ <b>Substantial:</b> Although P/P address requirements regarding Enrolling Current Medicaid Providers, the Credentialing file review found that the files were inconsistent in documentation.</p> <p>§ <b>Non-Compliant:</b> Documentation provided does not address policies/procedures for enrolling new providers and providers not participating in Medicaid.</p> <p>§ <b>Non-Compliant:</b> Documents provided do not address the policies/procedures regarding termination of network providers or subcontractors.</p> <p><u>Credentialing File Review (Total Files Reviewed: 10 PCP, 10 specialist)</u></p> <p>§ 2 PCP and 2 Specialist files had out-of-state licenses.</p> <p>§ 1 PCP file did not clearly state if the provider had a current license.</p> <p>§ 2 PCP files did not give hospital privileges.</p> <p>§ 2 PCP files were missing KY Board of Medical Licensure.</p>
<p>Quality Assessment and Performance Improvement (QAPI) – Structure and</p>	<p>§ <b>Substantial:</b> Contractor failed to provide pre-delegation audit results for one of its subcontractors, as required by contract.</p>

WellCare of Kentucky: 2012 Medicaid Managed Care Compliance Review – Elements Not Fully Met  
(Review Year 2011/2012)

Standard	Description of Review Findings Not Fully Compliant
Operations- Delegated Services	<p>§ <u>Minimal</u>: The Contractor is required to monitor subcontractor performance continually and take corrective action when deficiencies are identified. The Contractor’s policy references preparation and review of a quarterly report although no evidence of these reports was found in the documents provided. Minutes of QIP meetings show discussions related to subcontractors refer only to audit findings, not monitoring. Further, review of Delegation Entity Scorecards was not evident. As continual monitoring is not evident, neither are any corrective actions taken in response to findings. It is, therefore, difficult to assess whether or not the Contractor is assuring that the subcontractor is in compliance with federal regulations.</p> <p>§ <u>Substantial</u>: Although the Contractor did provide certificates and survey reports for its subcontractors, it is not clear as to how the requirement for copies of such accreditations is communicated to subcontractors as contract language does not specify this requirement.</p>
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	<p>§ <u>Minimal</u>: In regard to the QAPI Work Plan, many activities have neither target nor reporting timeframes.</p> <p>§ <u>Substantial</u>: In regard to staffing requirements, policies and procedures of the QAPI program, the Contractor has not yet identified a new Medical Director, although there was evidence that the Contractor had been actively recruiting.</p> <p>§ <u>Minimal</u>: Although the plan submitted a response to the RFP describing a pharmacy management innovative program, this program was not found in the submitted documents.</p> <p>§ <u>Substantial</u>: In regard to the requirements for PIPs, the plan’s PIP proposal contained interventions that lacked detailed descriptions.</p> <p>§ <u>Minimal</u>: The plan’s obligation to utilize standard measures in PIPs to indicate performance was not fully met as some of the plan’s indicators in its current PIP required clarification and increased specificity for which revisions were never received.</p>
Quality Assessment and Performance Improvement: Access – Utilization Management	<p>§ The plan was in full compliance for all required categories.</p>

## Validation of Performance Measures

This section of the report summarizes the Medicaid MCOs' reporting of select performance measures followed by results of the HEDIS<sup>®</sup> 2013 audit.

### Kentucky DMS Requirements for Performance Measure Reporting

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

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

As required by DMS through the plans' contracts, all non-HEDIS<sup>®</sup> measures must be validated by an External Quality Review Organization (EQRO). For reporting year 2012, IPRO reviewed all data and documentation used to calculate the performance measures for Passport Health Plan to ensure the validity and reliability of the reported measures. Only Passport Health Plan reported performance measures for reporting year 2012, since the other MCOs began operation in November of 2011 and were not required to report *HK* performance measures for reporting year 2012.

### IPRO's Objectives for Validation of PMs

For this mandatory activity, IPRO validated and included in this report, the 2010-2012 *Healthy Kentuckians* rates for Passport Health Plan. In addition, IPRO integrated the HEDIS<sup>®</sup> 2013 rates for all four Medicaid managed care organizations for Kentucky into this Technical Report. The health plans' rates are compared to the *NCQA HEDIS<sup>®</sup> 2012 National Medicaid Benchmarks*.

## HEALTHY KENTUCKIANS (HK) CLINICAL OUTCOMES PERFORMANCE MEASURES REPORTING YEAR 2012

In addition to annual HEDIS<sup>®</sup> measures, health plans are required by DMS to calculate and report performance measures based on the *Healthy Kentuckians* goals on an annual basis. These measures are based on Kentucky's goals and objectives in the areas of clinical preventive services and health services. The EQRO validates these measures to evaluate the accuracy of the Medicaid performance measures reported by the plans and to determine the extent to which the Medicaid-specific performance measures, which are calculated by the plans, followed the specifications established by DMS. The information presented summarizes the validation activities and findings for the Healthy Kentuckians Outcomes Measure rates for measurement year 2011 (RY2012). For measurement year 2011, only Passport Health Plan was required to submit performance measures.

<p><i>Public Health Initiative: Normal Body Weight for Height for Adults and Children</i></p> <p>MEASURE(S):</p> <p>HEDIS<sup>®</sup> Adult BMI Assessment/ HK Assessment/Counseling for Nutrition and Physical Activity</p> <p>HEDIS<sup>®</sup> Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</p>
<p>HEDIS<sup>®</sup> <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i></p> <p>The percentage of members 2–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, assessment/counseling for nutrition and assessment/counseling for physical activity during the measurement year.</p>
<p>HK The percentage of child and adolescent members who had an outpatient visit and who had a height and weight documented. (REPORTING PURPOSES ONLY)<sup>1</sup></p>
<p>HK The percentage of child and adolescent members with documented height and weight that had appropriate weight for height. (REPORTING PURPOSES ONLY)<sup>1</sup></p>
<p>HEDIS<sup>®</sup> <i>Adult BMI Assessment</i></p> <p>The percentage of members 18–74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior the measurement year.</p>
<p>HK The percentage of adult members who had an outpatient visit and who had a height and weight documented. (REPORTING PURPOSES ONLY)<sup>1</sup></p>
<p>HK The percentage of adult members with documented height and weight that had appropriate weight for height. (REPORTING PURPOSES ONLY)<sup>1</sup></p>
<p>HK The percentage of adult members who had an outpatient visit and who had an assessment of, or counseling for physical activity documented.</p>
<p>HK The percentage of adult members who had an outpatient visit and who had a nutritional assessment or counseling and/or referral to qualified nutritionist or dietician documented.</p>
<p><i>Public Health Initiative: Reduced Morbidity from Hypertension</i></p> <p>MEASURE: HEDIS<sup>®</sup> Controlling High Blood Pressure</p>
<p>HEDIS<sup>®</sup> <i>Controlling High Blood Pressure</i></p> <p>The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (&lt;140/90) during the measurement year.</p>
<p><i>Public Health Initiative: Reduced Incidence of Dental Caries in Children</i></p> <p>MEASURE: HEDIS<sup>®</sup> Annual Dental Visit</p>
<p>HEDIS<sup>®</sup> <i>Annual Dental Visit</i></p> <p>The percentage of members 2–21 years of age who had at least one dental visit during the measurement year.</p>
<p><i>Public Health Initiative: Kentucky Cabinet for Health and Family Services (KCHFS) Childhood Lead Poisoning Prevention Program (CLPPP)</i></p> <p>MEASURE: HEDIS<sup>®</sup> Lead Screening in Children</p>
<p>HEDIS<sup>®</sup> <i>Lead Screening in Children</i></p> <p>The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.</p>
<p><i>Public Health Initiative(s): Reduce Infant Mortality Rate, Reduce the Incidence of LBW/VLBW, Reduce the Incidence of Birth Defects</i></p> <p>MEASURE(S): HK Perinatal Screening and Education/Counseling</p>
<p>The percentage of pregnant members who delivered between November 6 of the year prior to the measurement year and November 5 of the measurement year who received assessment and education/ counseling regarding the following: alcohol use, drug abuse, nutrition, OTC/prescription medication, domestic violence and smoking cessation, and depression during one of their first two prenatal care visits or during one of their first two prenatal care visits following enrollment in the MCO, as documented in the medical record. (Note these are reported as six separate numerators)</p>
<p><i>Public Health Initiative: Increase the proportion of adults who have had blood cholesterol checked within the preceding five years</i></p> <p>MEASURE: HK Cholesterol Screening for Adults</p>

<p>The percentage of male enrollees age &gt; 35 years and female enrollees age &gt; 45 years who had an outpatient office visit and appropriate cholesterol screening documented in the measurement year or during the four years prior.</p> <p><i>Public Health Initiative(s): Increase the proportion of PCPs who routinely monitor and screen for abuse of alcohol, tobacco, &amp; drugs; Reduce the incidence of sexually transmitted diseases; Increase the incidence of sexually active individuals, aged 15 – 19 years, who use barrier method contraception to prevent STD and pregnancy</i></p> <p>MEASURE: HK Adolescent Screening/Counseling</p>
<p>The percentage of adolescents 12-17 years of age who had a well-care/preventive visit in measurement year and received preventive screening/counseling regarding: tobacco, alcohol/substances; sexual activity and mental health screening/assessment. (Note: these are reported as four separate numerators)</p> <p><i>Public Health Initiative: Improve access to a continuum of comprehensive, high quality health care; promote health and prevent secondary conditions among persons with disabilities, including eliminating disparities</i></p> <p>MEASURE: Individuals with Special Health Care Needs (ISHCN)-Children and Adolescents</p>
<p>The percentage of child and adolescent members, in the SSI category of aid, who received the services related to access to care and preventive care, as defined in the HEDIS® specifications.</p> <p><u>Access:</u></p> <p>§ Children's and Adolescent's Access to Primary Care Practitioners</p> <p><u>Preventive Care:</u></p> <p>§ Well-Child Visits in the First 15 Months of Life</p> <p>§ Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life</p> <p>§ Adolescent Well-Care Visits</p> <p>§ Annual Dental Visit</p>
<p><i>Public Health Initiative: Increase the proportion of children ages 18 years and under who have a specific source of primary care; 907 KAR 1:034. Early and periodic screening, diagnosis, and treatment services</i></p> <p>MEASURE: Well-Care for Children and Adolescents (On hold RY2012, not reported)</p>
<p><i>HEDIS® Well-Child Visits in the First 15 Months of Life</i></p> <p>The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.</p>
<p><i>HEDIS® Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life</i></p> <p>The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.</p>
<p><i>HEDIS® Adolescent Well-Care Visits</i></p> <p>The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.</p>
<p><i>Public Health Initiative: Increase the proportion of children ages 18 years and under who have a specific source of primary care; 907 KAR 1:034. Early and periodic screening, diagnosis, and treatment services</i></p> <p>MEASURE: Children's and Adolescents' Access to PCPs (Ages 12 months – 19 years)</p>
<p><i>HEDIS® Children and Adolescents' Access to Primary Care Practitioners</i></p> <p>The percentage of members 12 months–19 years of age who had a visit with a primary care practitioner (PCP). The organization reports four separate numerators:</p> <p>§ Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.</p> <p>§ Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.</p>

<sup>1</sup> FOR REPORTING PURPOSES ONLY – the health plan is required to report rates for these measures for informational purposes only. The health plan is not required to demonstrate improvement for these measures per contract terms.

Figure 4 shows Passport Health Plan's reported rates for the Healthy Kentuckians measures for Reporting Years 2010-2012.

**Figure 4: Healthy Kentuckians Performance Measures 2010-2012**

Measure	Passport Health Plan		
	2010	2011	2012
HEDIS® Adult BMI Assessment (ABA)	39.01%	48.76%	60.62%
HK Weight Assessment/Counseling for Nutrition and Physical Activity			
Documentation of height and weight	74.61%	68.99%	71.90%
Healthy weight for height	17.54%	20.20%	21.23%
Assessment/counseling for nutrition	31.94%	31.24%	32.52%
Assessment/counseling for physical activity	28.27%	26.74%	30.53%
HK Cholesterol Screening for Adults	84.15%	82.82%	83.30%
HK Weight Assessment/Counseling for Nutrition and Physical Activity: Height and Weight			
3-11 Years	88.54%	79.93%	82.65%
12-17 Years	89.05%	85.71%	84.28%
3-17 Years	88.71%	81.90%	83.22%
HEDIS® Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile (WCC)			
3-11 Years	5.90%	32.44%	43.20%
12-17 Years	8.76%	42.21%	44.03%
3-17 Years	6.82%	35.76%	43.49%
HK Weight Assessment/Counseling for Nutrition and Physical Activity: Healthy Weight for Height			
3-11 Years	51.04%	53.56%	57.20%
12-17 Years	40.88%	50.00%	44.78%
3-17 Years	47.76%	52.29%	52.79%
HEDIS® Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Nutrition (WCC)			
3-11 Years	52.78%	54.85%	55.10%
12-17 Years	47.45%	49.35%	48.43%
3-17 Years	51.06%	52.98%	52.76%
HEDIS® Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Physical Activity (WCC)			
3-11 Years	43.06%	37.12%	39.12%
12-17 Years	44.53%	52.60%	54.09%
3-17 Years	43.53%	42.38%	44.37%

Measure	Passport Health Plan		
	2010	2011	2012
HK Adolescent Screening/Counseling			
Tobacco	66.42%	63.00%	73.00%
Alcohol/Substances	67.15%	65.00%	67.00%
Sexual Activity	57.66%	60.00%	57.00%
Mental Health Assessment/Screening	39.42%	60.00%	63.00%
HK Prenatal Education/Counseling			
Alcohol Use	26.78%	NR	68.53%
Drug Abuse	25.42%	54.13%	64.51%
Nutrition	33.22%	58.26%	58.04%
OTC/Prescription Medication	20.34%	52.98%	46.43%
Domestic Violence	37.29%	48.85%	61.83%
Depression	NA	NA	65.63%
Members screened and identified as non-smokers	49.15%	33.94%	30.13%
Members screened and identified as smokers who received counseling for smoking cessation	41.22%	62.15%	76.24%
Screening and/or counseling for tobacco	69.83%	75.00%	97.77%
HEDIS <sup>®</sup> Controlling High Blood Pressure	64.30%	63.93%	63.01%
HEDIS <sup>®</sup> Annual Dental Visit	57.93%	61.02%	60.01%
HEDIS <sup>®</sup> Lead Screening for Children	83.22%	83.19%	83.00%
HEDIS <sup>®</sup> Well-Child- 15 Months (6+ Visits)	72.45%	72.32%	66.93%
HEDIS <sup>®</sup> Well-Child 3-6 Years	76.70%	75.29%	68.32%
HEDIS <sup>®</sup> Adolescent Well-Care	55.84%	56.82%	52.39%
HEDIS <sup>®</sup> Children's Access to PCPs			
12-24 months	98.05%	98.25%	96.02%
25 months-6 years	90.92%	90.61%	86.64%
7-11 years	92.28%	92.87%	91.00%
12-19 years	89.53%	91.34%	90.11%

NR: Not Reported

NA: Not Available

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

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

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

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

The Prenatal Screening/Counseling indicators will be revised for RY 2013 to include three components: evidence of screening, positive findings, and intervention/treatment for positive findings.

### NCQA HEDIS® 2013 Compliance Audit

HEDIS® reporting is a contract requirement for Kentucky’s Medicaid plans. In addition, the plans’ HEDIS® measure calculation is audited annually by an NCQA-licensed audit organization, in accordance with NCQA’s HEDIS® Compliance Audit specifications.

As part of the HEDIS® 2013 Compliance Audit, auditors assessed compliance with NCQA standards in the six designated Information Systems (IS) categories, as follows:

- § IS 1.0: Medical Services Data - Sound Coding Methods and Data Capture, Transfer and Entry
- § IS 2.0: Enrollment Data – Data Capture, Transfer and Entry
- § IS 3.0: Practitioner Data - Data Capture, Transfer and Entry
- § IS 4.0: Medical Record Review Process – Training, Sampling, Abstraction and Oversight
- § IS 5.0: Supplemental Data – Capture, Transfer and Entry
- § IS 6.0: Member Call Center Data – Capture, Transfer and Entry
- § IS 7.0: Data Integration – Accurate HEDIS® Reporting, Control Procedures That Support HEDIS® Reporting Integrity

In addition, the following HEDIS® Measure Determination (HD) standards categories were assessed:

- § HD 1.0: Denominator Identification
- § HD 2.0: Sampling
- § HD 3.0: Numerator Identification
- § HD 4.0: Algorithmic Compliance
- § HD 5.0: Outsourced or Delegated HEDIS® Reporting Functions

### HEDIS® 2013 MEASURES

DMS required all MCOs to report HEDIS® measures for the current reporting year. The measures required for reporting are listed by domain. MCO rates for all measures are presented in this section.

#### Board Certifications

- § Family Medicine
- § Internal Medicine
- § OB/GYN
- § Pediatricians
- § Geriatricians
- § Other Physicians

#### Prevention and Screening

- § Adult BMI Assessment (ABA)
- § Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)
- § Childhood Immunization Status (CIS)
- § Immunization for Adolescents (IMA)
- § HPV Vaccine for Female Adolescents (HPV)
- § Lead Screening in Children (LSC)
- § Breast Cancer Screening (BCS)
- § Cervical Cancer Screening (CCS)
- § Chlamydia Screening in Women (CHL)

#### Respiratory

- § Appropriate Testing for Children with Pharyngitis (CWP)
- § Appropriate Treatment for Children with URI (URI)
- § Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
- § Use of Spirometry Testing in the Assessment and Diagnosis of COPD (PCE)
- § Pharmacotherapy Management of COPD Exacerbation (PCE)
- § Use of Appropriate Medications for People With Asthma (ASM)
- § Medication Management for People With Asthma (MMA)
- § Asthma Medication Ratio (AMR)

#### Cardiovascular

- § Cholesterol Management for Patients with Cardiovascular Conditions (CMC)
- § Controlling High Blood Pressure (CBP)
- § Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

#### Diabetes

- § Comprehensive Diabetes Care (CDC)

#### Musculoskeletal

- § Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)
- § Use of Imaging Studies for Low Back Pain (LBP)

#### Behavioral Health

- § Antidepressant Medication Management (AMM)
- § Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- § Follow-Up After Hospitalization for Mental Illness (FUH)
- § Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)
- § Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)
- § Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)
- § Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)

#### Medication Management

- § Annual Monitoring for Patients on Persistent Medications (MPM)

#### Access /Availability of Care

- § Adults' Access to Preventive/Ambulatory Health Services (AAP)
- § Children and Adolescents' Access to Primary Care Practitioners (CAP)

- § Annual Dental Visit (ADV)
- § Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)
- § Prenatal and Postpartum Care (PPC)
- § Call Answer Timeliness (CAT)

Use of Services

- § Frequency of Ongoing Prenatal Care (FPC)
- § Well-Child Visits in the First 15 Months of Life (W15)
- § Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- § Adolescent Well-Care Visit (AWC)

The HEDIS® national benchmarks for HMOs are included for comparison, where available. These benchmarks represent the most current reporting year available, HEDIS 2012.

HEDIS® Compliance Audits result in audited rates or calculations at the measure level and indicate if the measures can be publicly reported. The auditor approves the rate or report status of each measure and survey included in the audit, as shown below:

- (R) – a rate or numeric result. The organization followed the specifications and produced a reportable rate or result for the measure.
- Small Denominator (SS) – the organization followed the specifications but the denominator was too small (< 30) to report a valid rate.
- Benefit Not Offered (NB) – the organization did not offer the health benefit required by the measure.
- Not Reportable (NR) – the organization calculated the measure but the rate was materially biased, or the organization chose not to report the measure or was not required to report the measure.
- (NA) – Not Available

This is the first year that the MCO's have reported HEDIS with the exception of Passport Health Plan. As such, it may be difficult to compare these rates to national benchmarks and their peers. In future years such comparison will be more reliable.

HEDIS® *Board Certification* rates illustrate the percentage of physicians in the provider network that were board certified as of the last day of the measurement year (December 31, 2012). Figure 5 presents the HEDIS® Board Certification rates for measurement year (MY) 2012 along with national benchmark data.

**Figure 5: HEDIS® Board Certification Rates**

Measure	CoventryCares of Kentucky	Kentucky Spirit Health Plan	Passport Health Plan	WellCare of Kentucky	HEDIS® 2012 National Benchmarks					
					Average	P10	P25	P50	P75	P90
Family Medicine	49.18%	NR	78.39%	38.49%	76.87%	59.27%	69.98%	78.93%	84.83%	91.73%
Internal Medicine	73.03%	NR	77.91%	41.89%	79.32%	66.46%	74.29%	80.58%	86.24%	91.37%
OB/GYN	66.89%	NR	71.04%	43.52%	78.41%	67.59%	74.40%	80.42%	84.67%	90.00%
Pediatricians	78.81%	NR	79.69%	39.00%	82.26%	69.77%	78.47%	83.64%	89.24%	93.10%
Geriatricians	58.62%	NR	100.00%	63.33%	75.61%	52.38%	66.67%	77.78%	87.50%	100.00%
Other Physician Specialists	70.66%	NR	67.19%	38.30%	80.08%	67.84%	75.99%	82.14%	87.21%	90.51%

Board Certification rates were low overall when compared to national averages, and represent an opportunity for improvement. WellCare of Kentucky only surpassed the 10<sup>th</sup> percentile benchmark for Geriatric providers and CoventryCares of Kentucky did not exceed the national average for any provider type. Passport Health Plan met the 90<sup>th</sup> percentile for Geriatricians, and performed better than the national average for Family Medicine Board Certifications. For reporting MY 2012, Kentucky Spirit Health Plan did not report Board Certification rates.

HEDIS® 2013 Effectiveness of Care measures evaluate how well a health plan provides preventive screenings and care for members with acute and chronic illnesses, including: respiratory illnesses, cardiovascular illnesses, diabetes, behavioral health conditions and musculoskeletal conditions. In addition, medication management measures are included. Figure 6 presents the HEDIS® Effectiveness of Care rates for measurement year (MY) 2012 along with national benchmark data.

**Figure 6: HEDIS® Effectiveness of Care Rates**

Measure	CoventryCares of Kentucky	Kentucky Spirit Health Plan	Passport Health Plan	WellCare of Kentucky	HEDIS® 2012 National Benchmarks					
					Average	P10	P25	P50	P75	P90
<b>Prevention and Screening</b>										
Adult BMI Assessment (aba)	SS	SS	76.38%	SS	52.57%	4.41%	46.90%	57.94%	70.60%	78.35%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)										
<i>BMI Percentile</i>	18.29%	24.77%	60.49%	25.00%	45.99%	1.55%	29.20%	47.45%	66.67%	77.13%
<i>Counseling for Nutrition</i>	30.09%	32.64%	64.02%	31.02%	50.08%	0.82%	42.82%	54.88%	67.15%	77.61%
<i>Counseling for Physical Activity</i>	24.31%	23.61%	44.37%	29.40%	40.63%	0.16%	31.63%	43.29%	56.20%	64.87%
Childhood Immunization Status: Combo 3 (cis)	68.75%	63.08%	82.74%	59.16%	70.64%	58.88%	64.72%	71.93%	77.49%	82.48%
Immunizations for Adolescents (ima)										
<i>Meningococcal</i>	74.31%	54.44%	75.00%	79.86%	63.18%	42.86%	53.04%	64.23%	73.89%	82.84%
<i>Tdap/Td</i>	78.70%	55.79%	86.95%	80.56%	75.80%	53.53%	70.60%	78.83%	85.16%	90.27%
<i>Combination #1</i>	71.99%	50.97%	73.45%	77.08%	60.54%	39.77%	50.36%	62.29%	70.83%	80.91%
Human Papillomavirus Vaccine for Female Adolescents (hvp) <sup>1</sup>	13.92%	3.39%	29.40%	11.81%	NA	NA	NA	NA	NA	NA
Lead Screening in Children (lsc)	65.51%	61.92%	82.30%	59.63%	67.81%	39.23%	57.52%	71.41%	81.86%	86.56%
Breast Cancer Screening (bcs)	SS	SS	51.67%	SS	50.43%	36.80%	44.82%	50.46%	56.58%	62.76%
Cervical Cancer Screening (ccs)	47.89%	38.67%	64.11%	46.28%	66.72%	51.85%	61.81%	69.10%	73.24%	78.51%
Chlamydia Screening in	48.98%	51.92%	65.00%	47.85%	58.00%	47.62%	52.70%	58.40%	63.89%	68.83%

Measure	CoventryCares of Kentucky	Kentucky Spirit Health Plan	Passport Health Plan	WellCare of Kentucky	HEDIS® 2012 National Benchmarks					
					Average	P10	P25	P50	P75	P90
Women (chl)										
<b>Respiratory</b>										
Appropriate Testing for Children with Pharyngitis (cwp)	63.95%	60.19%	73.57%	64.74%	66.66%	49.98%	58.50%	70.00%	76.37%	83.86%
Appropriate Treatment for Children With URI (uri)	56.40%	58.06%	77.74%	61.81%	85.32%	77.36%	80.64%	85.34%	89.96%	93.20%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	11.53%	31.30%	31.99%	30.81%	24.30%	16.45%	18.98%	22.14%	26.67%	33.33%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	SS	SS	33.57%	SS	32.02%	20.47%	25.87%	31.90%	38.38%	44.01%
Pharmacotherapy Management of COPD Exacerbation (pce)										
<i>Systemic Corticosteroid</i>	66.74%	37.64%	38.20%	35.37%	64.11%	48.84%	57.14%	66.67%	72.76%	76.27%
<i>Bronchodilator</i>	84.36%	45.29%	56.01%	45.36%	80.45%	71.32%	75.54%	82.22%	85.71%	88.10%
Use of Appropriate Medications for People With Asthma (asm)	SS	SS	87.88%	SS	84.99%	79.72%	82.54%	85.87%	88.19%	90.56%
Medication Management for People With Asthma (mma) <sup>1</sup>										
<i>Total - Medication Compliance 50%</i>	SS	SS	68.37%	SS	NA	NA	NA	NA	NA	NA
<i>Total - Medication Compliance 75%</i>	SS	SS	47.17%	SS	NA	NA	NA	NA	NA	NA
Asthma Medication Ratio	SS	SS	68.23%	SS	NA	NA	NA	NA	NA	NA

Measure	CoventryCares of Kentucky	Kentucky Spirit Health Plan	Passport Health Plan	WellCare of Kentucky	HEDIS® 2012 National Benchmarks					
					Average	P10	P25	P50	P75	P90
(amr) <sup>1</sup>										
<b>Cardiovascular</b>										
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)										
<i>LDL-C Screening Performed</i>	SS	SS	79.91%	SS	81.99%	76.00%	78.49%	82.48%	85.12%	88.83%
<i>LDL-C Control (&lt;100 mg/dL)</i>	SS	SS	44.59%	SS	42.08%	28.40%	35.13%	42.39%	49.18%	55.56%
Controlling High Blood Pressure (cbp)	49.11%	43.14%	62.97%	58.68%	56.78%	42.22%	50.00%	57.52%	63.65%	69.11%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	87.50%	59.65%	73.42%	72.62%	80.49%	66.67%	72.92%	83.47%	88.24%	91.20%
<b>Diabetes</b>										
Comprehensive Diabetes Care (cdc)										
<i>Hemoglobin A1c (HbA1c) Testing</i>	80.37%	80.79%	84.08%	86.64%	82.53%	74.90%	78.54%	82.38%	87.01%	91.13%
<i>HbA1c Poor Control (&gt;9.0%)</i>	52.82%	62.03%	35.57%	44.54%	43.04%	58.24%	50.31%	41.68%	34.33%	28.95%
<i>HbA1c Control (&lt;8.0%)</i>	40.18%	32.45%	55.97%	45.32%	48.08%	35.04%	42.09%	48.72%	55.70%	59.37%
<i>HbA1c Control (&lt;7.0%)</i>	32.08%	NR	41.85%	32.58%	35.42%	25.40%	30.43%	36.72%	41.64%	44.01%
<i>Eye Exam (Retinal) Performed</i>	37.14%	42.83%	52.74%	35.52%	53.35%	36.25%	45.03%	52.88%	61.75%	69.72%
<i>LDL-C Screening Performed</i>	71.39%	71.30%	76.99%	79.18%	75.00%	64.38%	70.34%	76.16%	80.88%	83.45%
<i>LDL-C Control (&lt;100 mg/dL)</i>	26.48%	23.18%	42.54%	35.08%	35.23%	23.06%	28.47%	35.86%	41.02%	46.44%
<i>Medical Attention for Nephropathy</i>	75.34%	67.99%	79.48%	80.62%	77.84%	68.43%	73.48%	78.71%	83.03%	86.93%
<i>Blood Pressure Control (&lt;140/80 mm Hg)</i>	34.25%	27.81%	42.04%	39.64%	39.41%	27.31%	33.09%	39.10%	46.20%	54.99%
<i>Blood Pressure Control</i>	54.19%	46.36%	64.68%	58.02%	60.95%	47.02%	54.48%	63.50%	69.82%	75.44%

Measure	CoventryCares of Kentucky	Kentucky Spirit Health Plan	Passport Health Plan	WellCare of Kentucky	HEDIS® 2012 National Benchmarks					
					Average	P10	P25	P50	P75	P90
(<140/90 mm Hg)										
<b>Musculoskeletal</b>										
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	63.01%	37.13%	44.21%	44.62%	68.88%	57.45%	63.54%	69.28%	75.09%	80.98%
Use of Imaging Studies for Low Back Pain (lbp)	68.84%	68.30%	68.09%	66.38%	75.78%	69.52%	72.04%	75.67%	79.38%	82.04%
<b>Behavioral Health</b>										
Antidepressant Medication Management (amm)										
<i>Effective Acute Phase Treatment</i>	64.54%	45.75%	60.50%	57.70%	51.11%	43.40%	46.98%	49.42%	52.74%	61.58%
<i>Effective Continuation Phase Treatment</i>	44.44%	29.74%	46.60%	46.23%	34.43%	26.73%	29.96%	32.42%	37.31%	42.94%
Follow-Up Care for Children Prescribed ADHD Medication (add)										
<i>Initiation Phase</i>	SS	SS	29.12%	SS	38.83%	22.97%	32.93%	39.19%	44.46%	52.48%
<i>Continuation and Maintenance (C&amp;M) Phase</i>	SS	SS	28.83%	SS	45.87%	21.79%	38.36%	47.09%	56.10%	63.11%
Follow-Up After Hospitalization for Mental Illness (fuh)										
<i>30-Day Follow-Up</i>	69.15%	54.56%	NB	61.74%	64.99%	36.04%	57.29%	67.65%	77.47%	84.28%
<i>7-Day Follow-Up</i>	41.81%	30.32%	NB	35.92%	46.50%	24.03%	32.20%	46.06%	57.68%	69.57%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using	77.39%	75.33%	75.96%	80.84%	NA	NA	NA	NA	NA	NA

Measure	CoventryCares of Kentucky	Kentucky Spirit Health Plan	Passport Health Plan	WellCare of Kentucky	HEDIS® 2012 National Benchmarks					
					Average	P10	P25	P50	P75	P90
Antipsychotic Medication (ssd) <sup>1</sup>										
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd) <sup>1</sup>	60.28%	71.86%	60.87%	70.38%	NA	NA	NA	NA	NA	NA
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc) <sup>1</sup>	SS	SS	80.00%	SS	NA	NA	NA	NA	NA	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa) <sup>1</sup>	69.48%	61.39%	57.63%	68.79%	NA	NA	NA	NA	NA	NA
<b>Medication Management</b>										
Annual Monitoring for Patients on Persistent Medications (mpm)										
<i>ACE Inhibitors or ARBs</i>	89.51%	87.29%	91.01%	90.03%	85.86%	80.15%	83.72%	86.89%	89.18%	91.33%
<i>Digoxin</i>	90.72%	84.78%	91.45%	90.24%	90.28%	83.33%	87.93%	90.95%	93.41%	95.56%
<i>Diuretics</i>	89.01%	89.20%	91.02%	90.93%	85.39%	78.52%	83.19%	86.40%	88.93%	91.30%
<i>Anticonvulsants</i>	63.74%	66.02%	59.94%	67.13%	65.16%	53.72%	61.70%	65.29%	70.27%	74.71%
<i>Total</i>	86.82%	85.66%	87.59%	88.27%	83.86%	78.45%	81.16%	84.81%	87.02%	88.55%

<sup>1</sup>Measures are new as of HEDIS® 2013. No benchmark rates available.

The results of the HEDIS® Effectiveness of Care measures for measurement year (MY) 2012 tended to be below the national averages. Performance was below the national average for all plans for the following measures: Cervical Cancer Screening in Women, Appropriate Treatment for Children with URI, CDC Eye Exam (Retinal) Performed and Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis. Further, all plans' rates for the Use of Imaging Studies for Low Back Pain measure were below the 10<sup>th</sup> percentile benchmark.

All plans performed above the national average for the Annual Monitoring for Patients on Persistent Medications: Total measure. Passport Health Plan exceeded the 90<sup>th</sup> percentile for Childhood Immunization Status: Combination #3. CoventryCares of Kentucky, Passport Health Plan, and WellCare of Kentucky exceeded the 75<sup>th</sup> percentile for Immunizations for Adolescents: Meningococcal and Combination #1. Kentucky Spirit Health Plan, Passport Health Plan, and WellCare of Kentucky each exceeded the 75<sup>th</sup> percentile for Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis. CoventryCares of Kentucky exceeded the 90<sup>th</sup> percentile for Antidepressant Medication Management: Effective Acute Phase Treatment and Effective Continuation Phase Treatment, while Passport Health Plan and WellCare of Kentucky both exceeded the 75<sup>th</sup> percentile for these measures. For several measures, the plans that began operation in 2011 did not report rates due to small sample sizes.

HEDIS® Access/Availability of Care measures examines the percentages of children and adults who access their PCPs for preventive services, as well as the prenatal and postpartum services for the Medicaid product line. Figure 7 presents the HEDIS® Effectiveness of Care rates for MY 2012 along with national benchmark data.

**Figure 7: HEDIS® Access and Availability**

Measure	CoventryCares of Kentucky	Kentucky Spirit Health Plan	Passport Health Plan	WellCare of Kentucky	2012 National Benchmarks					
					Average	P10	P25	P50	P75	P90
<b>Adults' Access to Preventive/Ambulatory Health Services (aap)</b>										
<i>20-44 Years</i>	88.38%	82.03%	85.12%	88.15%	80.04%	67.40%	77.96%	82.34%	85.43%	88.52%
<i>45-64 Years</i>	93.70%	86.64%	90.68%	93.26%	86.05%	78.26%	84.09%	87.31%	89.94%	90.96%
<i>65+ Years</i>	88.79%	86.78%	92.07%	93.68%	83.47%	63.72%	79.24%	87.79%	91.11%	93.10%
<i>Total</i>	90.45%	84.42%	88.22%	90.97%	81.92%	70.66%	79.85%	83.90%	86.67%	89.41%
<b>Children and Adolescents' Access to Primary Care Practitioners (cap)</b>										
<i>12-24 Months</i>	97.94%	96.89%	97.85%	97.72%	96.07%	93.06%	95.56%	97.02%	97.88%	98.39%
<i>25 Months - 6 Years</i>	93.93%	91.34%	89.37%	93.61%	88.19%	83.16%	86.62%	89.19%	91.40%	92.63%
<i>7-11 Years</i>	SS	SS	91.95%	SS	89.54%	83.37%	87.56%	90.58%	92.88%	94.51%
<i>12-19 Years</i>	SS	SS	91.64%	SS	87.89%	81.78%	86.04%	89.21%	91.59%	93.01%
<b>Annual Dental Visit (adv)</b>	61.07%	48.87%	60.95%	61.79%	45.42%	13.12%	38.10%	49.61%	58.34%	69.07%
<b>Initiation and Engagement of AOD Dependence Treatment (iet)</b>										
<i>Initiation of AOD Treatment: Total</i>	34.84%	42.72%	NB	38.33%	39.19%	29.93%	34.30%	38.80%	43.62%	49.44%
<i>Engagement of AOD Treatment: Total</i>	6.94%	7.64%	NB	6.76%	11.93%	2.41%	5.84%	11.72%	18.56%	21.24%

Measure	CoventryCares of Kentucky	Kentucky Spirit Health Plan	Passport Health Plan	WellCare of Kentucky	2012 National Benchmarks					
					Average	P10	P25	P50	P75	P90
Prenatal and Postpartum Care (ppc)										
<i>Timeliness of Prenatal Care</i>	91.65%	87.35%	85.91%	89.10%	82.75%	72.02%	80.54%	86.13%	90.39%	93.33%
<i>Postpartum Care</i>	58.93%	63.47%	69.35%	56.61%	64.12%	52.43%	58.70%	64.98%	71.05%	74.73%
Call Answer Timeliness (cat)	75.60%	89.50%	69.89%	82.51%	83.21%	68.38%	80.09%	85.37%	89.62%	93.57%

Statewide, performance measures related to Access and Availability demonstrated strength of the MCOs. Measures in which all four plans performed above the national average include: Adult Access to Preventative/Ambulatory Health Services for all age groups, Children and Adolescents' Access to Primary Care Practitioners for age groups 12-24 Months and 25 Months-6 Years, Annual Dental Visit and Prenatal and Postpartum Care: Timeliness of Prenatal Care.

Although strong performance was demonstrated for several Access and Availability rates, there remains opportunity for improvement. CoventryCares of Kentucky, Kentucky Spirit Health Plan, and WellCare of Kentucky had rates below the national average for the Postpartum Care measure, as well as the Initiation and Engagement of AOD Dependence Treatment - Engagement of AOD Treatment: Total. In addition, three plans, CoventryCares of Kentucky, Passport Health Plan, and WellCare of Kentucky reported rates below the national average for the Call Answer Timeliness measure.

HEDIS® Use of Services contains four measures that have the same structure as the Effectiveness of Care domain measures, including: *Frequency of Ongoing Prenatal Care*; *Well-Child Visits In the First 15-Months of Life*; *Well-Child Visits In the Third, Fourth, Fifth and Sixth Years of Life*; and *Adolescent Well-Care Visits*. They are subject to the same guidelines as the Effectiveness of Care domain for calculation, including the inclusion of all claims. They are also reported as percentages with a higher percentage indicating better performance.

**Figure 8: HEDIS® Use of Services**

Measure	CoventryCares of Kentucky	Kentucky Spirit Health Plan	Passport Health Plan	WellCare of Kentucky	2012 National Benchmarks					
					Average	P10	P25	P50	P75	P90
Frequency of Ongoing Prenatal Care: 81+ Percent (fpc)	80.74%	75.41%	78.08%	74.88%	60.93%	39.42%	52.55%	64.65%	72.99%	82.75%
Well-Child Visits in the First 15 Months of Life: 6+ Visits (w15)	62.73%	41.96%	67.98%	42.59%	61.75%	43.80%	54.31%	62.95%	70.70%	77.31%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	55.79%	58.14%	70.68%	61.81%	72.03%	61.07%	65.51%	72.26%	79.32%	83.04%
Adolescent Well-Care Visits (awc)	45.83%	35.28%	52.46%	38.89%	49.71%	35.52%	42.11%	49.65%	57.61%	64.72%

Notable Utilization rates include all four plans exceeding the 75<sup>th</sup> percentile benchmark for the following measure: Frequency of Ongoing Prenatal Care: 81+ Percent. However, Kentucky Spirit Health Plan failed to exceed the 10<sup>th</sup> percentile benchmark for Well-Child Visits in the First 15 Months of Life: 6+ Visits, Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life and Adolescent Well-Care Visits. None of the plans reported rates above the national average for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life measure.

The other measures in the Use of Services domain typically summarize utilization for the Medicaid population in terms of Member Months (MM), which is the sum of each member's "contribution" to the total yearly membership. A continuous enrollment criterion does not apply for these measures and the services included are only those for which the MCO has paid or expects to pay. Calculations are typically reported for Medicaid as rates per 1,000 MM. Those measure rates are not included in this report.

CONSUMER SATISFACTION (CAHPS®) MEASURES REPORTING YEAR 2013

DMS requires that all plans conduct an annual assessment of member satisfaction with the quality of and access to services using the CAHPS® survey. MCOs contract with an NCOA certified survey vendor to conduct this member satisfaction survey for both the adult and child member population to assess both satisfaction with the MCO and with participating providers. Questions are grouped into categories to reflect satisfaction with service and care. Using AHRQ’s nationally recognized survey allows for uniform measurement of consumers’ health care experiences and for comparison of results to benchmarks. Through Quality Compass, NCQA releases benchmarks for both the adult satisfaction survey and the child/adolescent satisfaction survey. Findings and interventions are reported to DMS and upon request, disclosed to members.

CAHPS® 5.0 Adult Survey

The adult member satisfaction survey was sent to a random sample of members aged 18 years and older as of December 31, 2012, and who were continuously enrolled for at least five of the last six months of 2012.

Figure 9: CAHPS® Adults

Measure <sup>1</sup>	Coventry Cares of Kentucky	Kentucky Spirit Health Plan	Passport Health Plan	WellCare of Kentucky	HEDIS® 2012 National Benchmarks					
					Average	P10	P25	P50	P75	P90
Getting Needed Care <sup>2</sup>	83.81%	84.59%	86.88%	84.48%	75.50%	65.48%	69.65%	76.68%	80.56%	84.39%
Getting Care Quickly <sup>2</sup>	84.06%	82.13%	85.81%	86.48%	80.33%	74.26%	78.23%	81.28%	83.51%	85.53%
How Well Doctors Communicate <sup>2</sup>	90.73%	90.14%	89.36%	88.77%	87.81%	83.91%	85.91%	88.00%	89.99%	91.86%
Customer Service <sup>2</sup>	86.58%	86.23%	92.41%	84.41%	80.42%	74.29%	76.89%	80.74%	83.19%	86.67%
Shared Decision Making <sup>2</sup>	55.54%	45.69%	52.34%	48.19%	60.87%	55.55%	58.17%	60.61%	63.28%	66.41%
Rating of All Health Care	67.98%	65.67%	71.99%	69.71%	69.88%	62.46%	67.00%	69.96%	73.58%	76.20%
Rating of Personal Doctor	77.53%	80.69%	81.55%	82.89%	77.08%	71.62%	74.78%	76.96%	79.42%	82.77%
Rating of Specialist Seen Most Often	80.37%	80.43%	85.53%	76.29%	77.66%	72.55%	75.00%	77.48%	80.32%	83.08%
Rating of Health Plan	66.03%	66.67%	84.08%	75.52%	73.46%	65.32%	69.22%	73.86%	77.21%	81.23%

<sup>1</sup> Note: for “Rating of” measures, Medicaid rates are based on ratings of 8, 9 and 10; for measures that call for respondents to answer with “Always,” “Usually,” “Sometimes” or “Never” the Medicaid rate is based on responses of “Always” or “Usually”.

<sup>2</sup> These indicators are composite measures.

Performance on the CAHPS 5.0 Adult survey demonstrated strengths for each of the plans. For the following measures, all plans reported rates above the national average: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service and Rating of Personal Doctor. All plans scored below the 10<sup>th</sup> percentile for the Shared Decision Making measure.

### CAHPS<sup>®</sup> 5.0 Child Survey

The child and adolescent member satisfaction survey was sent to the parent/guardian of randomly sampled members at age 17 years and younger as of December 31, 2012, and who were continuously enrolled for at least five of the last six months of 2012.

**Figure 10: CAHPS<sup>®</sup> Children**

Measure <sup>1</sup>	Coventry Cares of Kentucky	Kentucky Spirit Health Plan	Passport Health Plan	WellCare of Kentucky	HEDIS <sup>®</sup> 2012 National Benchmarks					
					Average	P10	P25	P50	P75	P90
Getting Needed Care <sup>2</sup>	90.61%	83.41%	88.36%	91.49%	79.25%	71.89%	75.09%	79.64%	84.07%	86.71%
Getting Care Quickly <sup>2</sup>	94.27%	89.85%	93.60%	94.23%	87.28%	79.94%	85.31%	88.40%	90.27%	92.01%
How Well Doctors Communicate <sup>2</sup>	93.37%	92.18%	94.73%	94.46%	91.79%	88.33%	91.01%	92.12%	93.44%	94.32%
Customer Service <sup>2</sup>	88.99%	85.30%	90.89%	85.22%	83.02%	77.12%	81.36%	82.69%	84.71%	88.99%
Shared Decision Making <sup>2</sup>	53.88%	45.58%	49.48%	45.45%	68.41%	63.59%	65.93%	69.07%	70.68%	72.90%
Rating of All Health Care	79.87%	79.05%	87.05%	82.22%	83.04%	78.93%	80.83%	83.43%	85.10%	86.79%
Rating of Personal Doctor	88.45%	83.77%	88.64%	86.84%	86.44%	82.94%	84.73%	86.74%	88.50%	89.47%
Rating of Specialist Seen Most Often	89.44%	79.23%	85.78%	81.03%	82.35%	75.93%	78.29%	82.30%	86.09%	87.27%
Rating of Health Plan	80.46%	75.34%	92.19%	77.94%	83.72%	78.65%	81.12%	84.40%	86.61%	88.56%

<sup>1</sup> Note: for "Rating of" measures, Medicaid rates are based on ratings of 8, 9 and 10; for measures that call for respondents to answer with "Always," "Usually," "Sometimes" or "Never" the Medicaid rate is based on responses of "Always" or "Usually".

<sup>2</sup> These indicators are composite measures.

Performance on the CAHPS 5.0 Child survey demonstrated strengths for most of the plans. For the following measures, all plans reported rates above the national average: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate and Customer Service. Passport Health Plan exceeded the 90<sup>th</sup> percentile for all measures except Shared Decision Making, Rating of Personal Doctor and Rating of Specialist Seen Most

Often. For the Shared Decision Making measure, all plans reported notably low rates, all failing to exceed the 10<sup>th</sup> percentile. Further, Kentucky Spirit Health Plan did not meet the national average for 5 of the 9 listed measures.

## Validation of Performance Improvement Projects

This section of the report presents the results of IPRO's evaluation of the Medicaid Performance Improvement Projects (PIPs) submitted for calendar year 2012. The assessments were conducted using a tool developed by IPRO and consistent with CMS EQR protocols for PIP validation.

The following narratives summarize the PIPs proposed, conducted, or finalized by the Kentucky MCOs during 2011-2012, and IPRO's validation results.

### CoventryCares of Kentucky Performance Improvement Projects 2012

#### *CoventryCares of Kentucky PIP #1: Decreasing Non-Emergent/Inappropriate Emergency Room Utilization*

Status: Proposal

Submitted: 11/16/12

Revised: 12/20/12

Timeline: 1/1/12-12/31/13

#### Study Topic Selection

Non-urgent and avoidable emergency department utilization was chosen as a focus for this PIP as a result of increasing non-urgent and avoidable ED use by both adult and child members, and the high costs associated with these visits. Literature cited indicates that Kentucky's ED utilization rate for 2012 was 64.71 per 1,000 member months, higher than the HEDIS® national average of 53.17 per 1,000 member months.

#### Study Question(s) and Indicator(s)

The study will aim to address the following questions:

- Will member education regarding appropriate ED utilization decrease inappropriate and avoidable ED utilization as evidenced by a 2% reduction in CoventryCares of Kentucky "ED Visits per 1,000 Members" rate for year 2013?
- Does enrollment in case management for members who overutilize the ED for inappropriate and avoidable visits (defined as having 9 or more ED visits/year) decrease their use of ED visits by 10% from the baseline measure?

The following indicators will be used to judge the effectiveness of the planned interventions:

- CoventryCares of Kentucky's "ED Visits per 1,000 Members" rate.
- Number of CoventryCares of Kentucky who overutilize the ED (defined as having 9 or more ER visits/year) visits during the measurement year.

#### Study Population and Sampling

No sampling will be used to conduct this project. The study will include all Medicaid members, regardless of age, with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment.

#### Data Collection Procedures and Timeline

The NCQA HEDIS® data will be used to measure the Emergency Department utilization component of the ambulatory care measurement. In addition to the HEDIS® measure, members who over-utilize the ED, defined by 9 or more visits per year, will be identified by the ICD-9 codes. The baseline year will be from January 1, 2012 through December 31, 2012. The re-measurement year will be from January 1, 2013 through December 31, 2013.

#### Interventions/Improvement Strategies

Planned interventions for this PIP include bringing awareness to providers regarding the volume of patients over-utilizing the ED and educating the providers and members about the availability of urgent care/after-hours services, appropriate ED utilization and preventative health guidelines and immunization schedules via newsletters, brochures, CCKY website and utilization of other departments such as Case Management. The plan will partner with local hospitals and develop cooperative interventions to reduce over-utilization and inappropriate utilization.

Further interventions will involve the use of Case Managers to assist members with locating in-network PCPs and Specialists, as well as sending reminder letters to “high fliers” regarding follow-up visits with their PCPs. Barriers to access, such as transportation will be addressed by assisting members with locating and scheduling transportation services to PCP offices. Initial assessment forms will include a transportation check box to evaluate and track transportation needs.

#### Strengths

- Strong project rationale, including statewide and plan-specific data indicating the need for improvement.
- Possible barriers to care leading to ED use and evidence regarding effective interventions are identified.
- The proposal includes strong evidence of topic relevance to plan.

#### Opportunities for Improvement

- Numerator selection for the indicator lacks clarity and may make interpretation of the results difficult to distinguish as it currently combines two cohorts, members with frequent visits (>9 visits) and “High Fliers” (12+ visits). These groups have different distributions of diagnoses and will therefore likely have different barriers, for which the proposal includes different interventions for each cohort, yet the proposal does not offer a clear distinction.
- The plan does not state if and how member condition severity will be reported and interpreted, or how it relates to the project.
- No process measures are included in proposal.

#### *CoventryCares of Kentucky PIP #2: Major Depression: Antidepressant Medication Management and Compliance*

Status: Proposal

Submitted: 11/16/12

Revised: 12/20/12

Timeline: 1/1/12-12/31/13

### Study Topic Selection

CoventryCares of Kentucky selected a topic which will address a problem that is highly prevalent in Kentucky. Per the literature cited in the proposal, Kentucky ranks as one of the worst states in the nation for prevalence and seriousness of depression (49<sup>th</sup> out of 50), as well as suicide rates (34<sup>th</sup> out of 50). The plan identified that rates of adherence to antidepressant therapy are in need of improvement among its adult members, and the study will focus on members age 18 years and older.

### Study Question(s) and Indicator(s)

The study will aim to address the following questions:

- Will provider and member education and reminders lead to better and more effective treatment for major depression?
- Will provider and member education regarding major depression increase compliance with antidepressant medication prescribed by the PCP by 2% over the base-line measurement as defined by KY HEDIS® data?
- Will provider and member education lead to a compliant Medication Possession Ratio (MPR) of 0.8 or greater?

The following indicators will be used to judge the effectiveness of the planned interventions:

- The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).
- The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).
- Medication Possession Ratio of members on antidepressant therapy.

### Study Population and Sampling

No sampling will be used to conduct this project. The study will include all continuously enrolled Medicaid members meeting HEDIS® 2013 specifications aged 18 years of age or older. The population of interest will be all members 18 years of age and older with a new episode of Major Depression who were treated with antidepressant medication, as identified by HEDIS® 2013 Technical Specifications for Antidepressant Medication Management (AMM).

### Data Collection Procedures and Timeline

Administrative data collection will be utilized through a programmed pull from claims and encounters, per the HEDIS® specification. The data collection and analysis cycle will be completed once a year. The baseline year will be from January 1, 2012 through December 31, 2012. The re-measurement year will be from January 1, 2013 through December 31, 2013. Interim evaluative reports will be conducted quarterly and submitted in coordination with the quarterly state reports.

### Interventions/Improvement Strategies

Planned interventions include the completion of a Behavioral Health Screening Tool for new members enrolled in Case Management, as well as identification of members in need of referrals to MHNNet. CoventryCares of Kentucky, in collaboration with MHNNet, will perform Coordination of Care Screenings and Referral Form reviews of member records to assess presence of diagnostic triggers for depression and provide members and providers with educational materials regarding identification of, diagnosis of and importance of depression management via mailings, member website, provider website and provider fax blasts.

In addition, CoventryCares of Kentucky will coordinate with the pharmaceutical department, MHNet and the Medical Director to identify adherence and omission gaps, as well as identify prescribing patterns of PCPs.

#### Strengths

- There is a strong rationale with multiple literature citations and specific data related to plan membership.
- The rationale clearly outlines topic relevance to the plan.
- The interventions address providers and members.
- The plan intends to evaluate disparities.

#### Opportunities for Improvement

- The plan does not clearly outline the numerator and denominator that will be used to monitor compliance with the Medication Possession Ratio, nor does it specify any process measures.
- The proposal does not make clear the plan's interventions to address the barrier of cultural diversity and linguistics.
- The plan may consider including interventions aimed at follow-up for members known to be newly prescribed anti-depressants in order to accentuate the importance of adherence and discourage premature discontinuation.

### Kentucky Spirit Health Plan Performance Improvement Projects 2012

#### *Kentucky Spirit Health Plan PIP #1: Improving Cervical Cancer Screening Rates*

Status: Proposal

Submitted: 10/19/12

Revised: 12/28/12

Timeline: 1/1/12–12/31/14

#### Study Topic Selection

Based on data from Healthy Kentuckians 2010, the Kentucky Cancer Registry shows that cervical cancer has one of the highest incidence rates. Further, from 2000 to 2010, a small but significant downward trend was noted in the number of women who reported having a Pap test within the past year, nationally, lending toward a continued need for focus on the importance of cervical screening.

#### Study Question(s) and Indicator(s)

The study will aim to address the following question:

- Will targeted interventions by Kentucky Spirit Health Plan to female members 24 - 64 years of age result in an increase in cervical cancer screening rates?

The following indicator will be used to assess the effectiveness of the planned interventions:

- Rate of incidence of Pap tests performed during the measurement year, or two years prior to the measurement year, as documented through administrative data.

### Study Population and Sampling

The study population includes a sample of eligible women 24-64 years of age as of December 31 of the measurement year enrolled in Medicaid. The population excludes any women who underwent a hysterectomy with no residual cervix.

### Data Collection Procedures and Timeline

Data from the eligible population will be reviewed via hybrid methodology of administrative data and medical record review. Based on 2013 HEDIS® technical specifications for cervical cancer screening:

- Denominator will consist of a sample drawn from the eligible population of members.
- Numerator will consist of incidence of Pap test performed during the measurement year or two years prior to the measurement year as documented through administrative data.

The baseline measurement period will be January 1, 2012 through December 31, 2012. Re-measurement will occur annually thereafter, following the measurement period end (December 31, 2013 and December 31, 2014).

### Interventions/Improvement Strategies

Planned interventions include assessment of members' access to in-network and out-of-network providers, state transportation services for remote populations and availability of male/female providers to conduct testing. The plan will utilize Case Management to identify members, including new members, who have not had a recent cervical cancer screening, develop a report identifying such members and perform a phone campaign to contact all delinquent members.

Further, the plan will supplement population based, community education with member-specific education via the member newsletter, KSHP web site and direct mailing, as well as provide necessary one-on-one education and offer assistance with scheduling appointments and arranging transportation needs. Lastly, the plan will deliver education regarding cervical cancer screening to providers via provider newsletters, workshops and Member Connections staff.

### Strengths

- Identification of Kentucky's high incidence and mortality rate of cervical cancer, as well as younger median age of cervical cancer development compared to "most other states", provides strong project relevance.
- Study Aim is relevant to the topic and a quantifiable goal was stated.
- Interventions address barriers.

### Opportunities for Improvement

- The proposal identifies the HEDIS® Cervical Cancer Screening (CCS) measure as the intended indicator; however, the definition of this measure appears incomplete in the proposal.
- There is some redundancy regarding interventions in the table addressing barriers.

## *Kentucky Spirit Health Plan PIP #2: Prenatal and Postpartum Depression Screening and Management*

Status: Proposal

Submitted: 10/19/12

Revised: 1/3/13, 1/28/13, 3/4/13

Timeline: 1/1/12-12/31/14

Kentucky Technical Report FINAL

Page 80

### Study Topic Selection

The selected topic, regarding depression during the prenatal and postpartum periods for women, was chosen due to the high volume of prenatal and postpartum members served by the plan who may be at risk for depression symptoms. As the literature shows that depression is the leading cause of disease-related disability among women, and that 12.9% of women experience depression during the postpartum period, the study is intended to find women with moderate to high depression risk based on the Edinburgh Screener, and provide appropriate services for them.

### Study Question(s) and Indicator(s)

The study will aim to address the following question:

- Will targeted screening and engagement attempts with pregnant and newly delivered women result in an increase in utilization of behavioral health depression management?

The following indicators will be used to assess the effectiveness of planned interventions:

- The percentage of pregnant women who completed an Edinburgh survey.
- The percentage of members in their postpartum period who completed an Edinburgh survey.
- The percentage of pregnant members who scored moderate or high on the survey and were successfully engaged in behavioral health Case Management outreach and engagement activities.
- The percentage of delivered members who scored moderate or high on the survey and were successfully engaged in behavioral health Case Management outreach and engagement activities.
- The percentage of pregnant women who engaged in behavioral health Case Management outreach who had a claim for a behavioral health service within 45 days of the completed depression screen.
- The percentage of delivered women who engaged in behavioral health Case Management outreach who had a claim for a behavioral health service within 45 days of the completed depression screen.

### Study Population and Sampling

No sampling will be used in the study. The study will include all women who were pregnant or delivered during the study period. The population of interest will be limited to those women who completed the Edinburgh survey.

### Data Collection Procedures and Timeline

In order to assess the member's risk level, Cenpatico provides the Edinburgh Depression Screening tool to Kentucky Spirit Health Plan for inclusion in the Kentucky Spirit Health Plan Start Smart mailing and to OB Case Managers. The tool is also made available electronically. The results of the completed surveys are stored electronically by Cenpatico BH QA.

Cenpatico uses its claims warehouse, EDW, to extract a member-specific claims report for each member identified as eligible for the study population to determine the rate of engagement in behavioral health services. The claims data is pulled via a standardized, programmed data extraction report that is structured with front-end edits for logic and consistency.

The baseline measurement period will be January 1, 2012 through December 31, 2012. Re-measurement will occur annually thereafter, 30 days following the measurement period ending (December 31, 2013 and December 31, 2014) to allow for claims lag and analysis.

### Interventions/Improvement Strategies

Planned interventions include development of Depression Screening Tools for inclusion in the Start Smart member packets, completion of depression screening for pregnant members who do not have a notification of pregnancy (NOP), member and provider education regarding depression screenings for pregnant women via member newsletters and provider website. In addition, the plan will educate members on services offered by Cenpatico and engage Member Connections to locate members and make house calls to reach pregnant members for completion of the NOP and Edinburgh Depression Screening tool.

### Strengths

- The rationale for the topic selection is strong with reference that supports the topic, and relevance to the plan population is clear.
- The description of the Perinatal Depression Screening Program is comprehensive.

### Opportunities for Improvement

- The procedures indicate that surveys will be provided to clinician offices and will be available electronically to care managers (new methods). Members may be more likely to complete a screening administered by a clinician than a mailed survey. The plan should clarify whether/how surveys completed by clinicians and case managers will be incorporated and if these are included in numerators. In this case, the denominators should be stated as all identified pregnant/delivered women rather than mailed surveys.
- The plan might consider including the Edinburgh tool and scoring methodology as attachments to the final report.
- The plan might consider revising the measurement periods from the CY to Q3 of the year prior thru Q3 of the measurement year to allow lag time (Q4) for collection of data.

## Passport Health Plan (PHP)

### Performance Improvement Projects 2011-2012

#### *Passport Health Plan PIP #1: Reduction of Inappropriately Prescribed Antibiotics in Children with Pharyngitis and Upper Respiratory Infections*

Status: Proposal

Submitted: 8/31/12

Timeline: 1/1/2011-12/31/13

### Study Topic Selection

Passport Health Plan, IPRO and DMS collaborated in selecting the topic for this study. In 2011, Passport Health Plan identified URI and pharyngitis as two of the top 5 diagnoses for emergency room visits, with 17% of the total cost of prescriptions being for members 18 years or younger with a diagnosis of URI or Pharyngitis. The 2011 HEDIS® results for Appropriate Treatment for Children with URI indicate that an average of 26% were inappropriate prescription habits. Further, as approximately 73% of the Region 3 Medicaid membership is below 22 years of age, careful surveillance of performance measures related to children is crucial.

### Study Question(s) and Indicator(s)

The study aims to answer the following questions:

- Can a multidisciplinary strategy targeting the appropriate use of antibiotics for URI and Pharyngitis in children:
  - Increase provider adherence to the appropriate clinical practice guidelines?
  - Result in a decrease of inappropriate prescribing of antibiotics?
  - Minimize unnecessary pharmaceutical costs?
  - Improve the overall health and quality of life of our members by decreasing antibiotic resistance?

The following indicators will be used to assess the effectiveness of the planned interventions:

- HEDIS® Appropriate Treatment for Children with Upper Respiratory Infections (URI) measure.
- HEDIS® Appropriate Testing for Children with Pharyngitis measure.

### Study Population and Sampling

No sampling is necessary for this study. The population for this study is identified by using the 2012 HEDIS® Technical Specifications Appropriate Treatment for Children with Upper Respiratory Infections (URI) and Appropriate Testing for Children with Pharyngitis.

### Data Collection Procedures

Data is collected via Passport Health Plan's annual HEDIS® review. Administrative data is used to identify both the denominator of the eligible population and numerator as stated in the HEDIS® specifications for each measure.

Calendar year 2011 data will serve as baseline. Re-measurement will occur annually.

### Interventions/Improvement Strategies

Planned interventions include distribution of pharmacy newsletters, letters to providers, educational information during on-hold waiting time and an updated Passport Health Plan website containing information and quick reference guides regarding URI and CPG. Further, the plan will collaborate with the Pharmacy Department to conduct outreach/education with provider groups and immediate care centers on appropriate antibiotic usage.

### Strengths

- The project differentiates and targets the care provided relative to the indicators by PCPs, urgent care centers, and emergency departments.
- The project targets an important public health issue – inappropriate use of antibiotics, which results in an increase in antibiotic-resistant organisms.
- The project aims to improve clinical care, as well as reduce unnecessary drug costs.
- The project addresses prevalent diagnoses (URI and Pharyngitis) among a large proportion of the membership (child members).
- Passport Health Plan supported its project topic selection with a rationale that included:
  - An analysis of drug costs
  - Historical performance on HEDIS® measures, including trends and benchmarking
  - Clinical evidence

- A description of the topic prioritization process
- Literature citations

#### Opportunities for Improvement

- Most of the interventions are passive in nature, i.e., newsletter articles, mailed educational letters, posting information and guidelines on the website, and an on-hold message.
- There do not appear to be any interventions directed at members.

#### *Passport Health Plan PIP #2: Reduction of Emergency Room Care Rates*

Status: Interim Report

Proposal Submitted: 9/1/11

Interim Report Submitted: 8/31/12

Timeline: 1/1/10-12/31/12

#### Study Topic Selection

Passport Health Plan selected a topic that will address a problem that is highly prevalent among the plan's members, as well as nationwide. Literature cited indicates that, as of a 2008 nationwide study, only 13% of Emergency Department (ED) visits result in hospital admission. Further, Kentucky ranked 6<sup>th</sup> in the United States for increased emergency room visits in 2003. As higher emergency utilization rates contribute to higher health care costs, it is imperative to reduce inappropriate and preventable uses of the ED.

#### Study Question(s) and Indicator(s)

The study will aim to answer the following question:

- Can a multidisciplinary strategy targeting the appropriate use of Emergency Room care result in decreased Emergency Room usage?

The following indicator is used to assess the effectiveness of interventions:

- HEDIS® Ambulatory Care/Emergency Room Visits measure as defined by the number of Emergency Room visits that did not result in an inpatient stay, divided by the total number of member months for the measurement year.

#### Study Population and Sampling

No sampling was necessary for this study. The population for this study was identified using the 2011 HEDIS® Technical Specifications for Ambulatory Care/Emergency Room Visits measure.

#### Data Collection Procedures

Data is collected via Passport Health Plan's annual HEDIS® review. Administrative data is used to identify Emergency Room visits. In addition to these rates, the plan collects data from the DMS Lock-In Program, which identifies members having utilized at least 3 different EDs for non-emergency services, as well as the High ER Utilization Report, which identifies members with 8 or more ER visits within a 12 month period.

Calendar year 2010 data will serve as baseline. Re-measurement will occur annually.

### Interventions/Improvement Strategies

Interventions include distribution of provider reports identifying members with 8 or more ER visits in the past 12 months, referrals to Case Management of such members and placement of Case Managers in provider offices with high volume of members, high ER utilization and high care gaps.

In addition, member-targeted interventions will include member outreach and/or referrals for members presenting to U of L, Kosair and Hardin Memorial Hospital ED for non-urgent care, asthma or pregnancy and distribution of educational materials to members/caregivers on ways to handle common non-urgent medical issues, as well as informative member newsletters and on-hold messages.

Lastly, Passport Health Plan will implement a 24-hour nurse line with vendor, McKesson.

### Data Analysis and Results

Results from the first re-measurement period are shown below:

Indicator	Baseline Results CY 2010			Re-measurement CY 2011			Increase/ Decrease Visits per Members/ Months	Goal Rate by Completion per Members/ Months
	n	d	Rate	n	d	Rate		
Emergency Room Visits	140,029	1,990,660	70.35	156,114	2,084,713	74.89	↑ 4.54	68.01

n = numerator; d = denominator; CY = calendar year

### Achievement of Improvement

No improvement achieved at first re-measurement. Between Baseline CY 2010 and 1st re-measurement CY 2011, there has been an increase in the number of Emergency Room visits. The results were not surprising due to an approximate 3.00% increase of the Passport Health Plan membership from the previous year.

### Overall Credibility of Results

There were no validation findings which indicate that the credibility of the PIP results is at risk.

### Strengths

- Passport Health Plan chose a topic representing an important opportunity for improvement, based on increasing Emergency Room visit rates and above average Emergency Room visit rates as compared to the Medicaid national mean.
- The PIP is based on a strong rationale with identification of the most common diagnoses for ED visits by Passport Health Plan members and reference to reports in the literature.
- The plan implemented a strong intervention strategy involving placing care management staff onsite at selected provider practices to reduce barriers and gaps in care and reduce inappropriate ED utilization, as well as developing and implementing a Lock-In program for members with high ED utilization.

### Opportunities for Improvement

- The timeline for the baseline and re-measurement periods should be clarified/corrected. Since this is a 2012 PIP, the baseline year should be either the project year (CY2012) or the year prior (CY 2011). The baseline period CY 2010 does not meet the project timeline requirements, per the DMS contract § 5.6 Performance Improvement Projects.
- Some interventions lacked a full description, including how such interventions will impact ED visit rates. The project could benefit from additional interventions, or revisions to the existing interventions, to address any additional barriers identified during the project implementation.

### *Passport Health Plan PIP #3: Dental Care in Children with Special Health Care Needs*

Status: Interim Report

Submitted: 9/1/10

Interim Reports: 9/1/11, 9/1/12

Timeline: 1/1/10-12-31-12

### Study Topic Selection

This project was chosen as Passport Health Plan's data indicated that children with special health care needs (SSI without Medicare) were less likely to receive dental visits than children without special health care needs (all others).

### Study Question(s) and Indicator(s)

The study aims to answer the following question:

- Can a multidisciplinary strategy targeting the special health care needs of members result in increased, necessary preventive dental care?

The objectives of this project are in support of the plan's mission to improve the health and quality of life of members by:

- Increasing the rate of children with special health care needs who receive an annual dental visit to be consistent or greater than those without special health care needs.
- Increasing the rate of children with special health care needs receiving dental care six percentage points from the CY 2009 rate of 50.76 percent (56.76%) by project completion.

The following indicator is used to assess the effectiveness of the interventions:

- HEDIS® measure for Annual Dental Visits, as defined in the HEDIS® 2010 Technical Specifications.

### Study Population and Sampling

No sampling will be used in this study. Members eligible for participation in this project are those that meet the HEDIS® measure, Annual Dental Visits criteria and who Passport Health Plan identifies as SSI without Medicare. Using these criteria, members are targeted for interventions and are automatically included in project interventions.

### Data Collection Procedures

Data is collected via Passport Health Plan's annual HEDIS® review. Additionally, member demographic data is received from DMS to better identify health care disparities within the subpopulation, such as race and ethnicity, impacting these members from obtaining the necessary preventive dental care.

### Interventions/Improvement Strategies

Interventions for this study include onsite provider education and training regarding appropriate health care for members who have language access issues, integration of preventive dental care into the treatment plans of members currently enrolled in care coordination, stratification of members with known cultural differences who require providers with matching cultural beliefs and telephonic and written outreach to members lacking a dental visit due to language barrier.

In addition, the plan will initiate Cultural and Linguistic Support (CLS) Program activities, upgrade member documentation systems for better collection of member data and participate in community events for EPSDT outreach to educate the public regarding dental exams, as well as transportation services. To bring awareness to providers, the plan will conduct an EPSDT Provider Compliance Audit. Further, plan staff will attend scheduled in-school physical exam visits to obtain documentation related to oral health and identify members in need of a dental exam.

### Data Analysis and Results

The figure below shows the result of the first re-measurement period. Annual Dental Visit rates for both SSI members and all other members decreased slightly from the baseline measurement.

Indicators	Baseline Results CY 2010			1st Re-Measurement CY 2011			Increase/ Decrease Percentage Points
	n	d	Rate	n	d	Rate	
Annual Dental Visit SSI	4,678	8,997	52%	4,954	9,550	51.87%	↓0.13%
Annual Dental Visit All Others	42,175	67,781	62.22%	49,847	80,491	61.93%	↓0.29%

n = numerator; d = denominator; CY = calendar year

### Achievement of Improvement

- No quantifiable improvement achieved at first re-measurement. Between Baseline CY 2010 and 1st re-measurement CY 2011, there has been a slight decrease in both indicators. The plan attributed the results to an approximate 0.2% increase of the Passport Health Plan membership in 2011. It was determined that 'face' validity of the results was evident.

### Strengths

- Passport Health Plan chose to address a problem that is a significant health issue in Kentucky, particularly for disadvantaged populations, supported by literature citations, Passport Health Plan historical performance with comparisons between rates for CSHCN and others, and Healthy Kentuckians goals and performance data.
- Passport Health Plan identified the following barriers: lack of complete race, ethnicity, and language data for members; lack of member knowledge regarding the importance of dental care; lack of provider knowledge regarding EPSDT standards for dental care and CLAS requirements; lack of available dental care information in PCP record; lack of member knowledge regarding transportation and dental benefits.
- Interventions targeted at members, providers and Passport Health Plan systems and staff.

## Opportunities for Improvement

- It is not clear how and to what extent an influx of new members would affect the rates. New members would need to meet the same continuous enrollment criteria as existing members, and therefore, be eligible to receive these services. This impact should be quantified and, if not substantial, other barriers explored that might explain lack of improvement in the rate.

## *Passport Health Plan PIP #4: Smoking Cessation, Yes You Can!*

Status: Complete

Submitted: 9/1/08

Interim Reports: 9/1/10, 9/1/11

Final Report: 8/31/12

## Study Topic Selection

Passport Health Plan chose to address a problem that is highly prevalent in Kentucky. Literature citations indicated that 28.7% of the state's population is identified as smokers and that smoking is the leading cause of preventable death in the U.S. The project addressed a need that was previously not met – smoking cessation assistance, as the Medicaid program did not provide this benefit at the time of initiation of the project.

## Study Question(s) and Indicator(s)

IPRO, DMS and Passport Health Plan collaborated to define the indicators used for this project. The project assessed the referral sources for members who enrolled in the 'Yes You Can!' smoking cessation program and measured the continuous smoke-free status of members who completed the 12-week program at various check points: 7 days, 30 days, 60 days, 3 months, 6 months, 9 months and one year. In developing and refining the indicators, the North American Quitline Consortium resources were used as a guide.

## Study Population and Sampling

There was no sampling conducted for this project. All members who were eligible and joined the program were included in the population. Members were excluded for the following reasons: disenrollment from Passport Health Plan, dropping out of the program and member could not be reached.

## Data Collection Procedures

The data source for this project was the 'Yes You Can!' Smoking Cessation Program database, which was approved by the QI Workgroup (DMS, IPRO and Passport Health Plan). Program staff utilized this database to capture information gathered from participant interviews on referral sources and quit rates. Referral sources included Passport Health Plan internal departments, providers, members (self-referral), hospital asthma educators, pharmacies and Personal Information Form (PIF). Quit rates were self-reported and determined as continuously smoke-free at completion of the program and at 3 months, 6 months and 12 months after continuously smoke-free status was obtained. Passport Health Plan smoking cessation coaches asked the standardized question, "As of today, how long have you been smoke free?" to each participant.

Initiation and development of the project was in 2008 with the baseline period as calendar year 2009, interim measurement period as calendar year 2010 and final measurement period as calendar year 2011. All three measurement phases utilized the same methodology.

### Interventions/Improvement Strategies

Interventions included a comprehensive program to assist members with smoking cessation, including outreach, readiness assessment, educational resources and ongoing telephonic support. Member education was provided via the newsletter and on-hold SoundCare messages. Providers were educated regarding the availability of the program, and were provided with referral methods, prescribed nicotine replacement therapy and were given feedback regarding the members' progress.

In addition, Passport Health Plan collaborated with 8 Walgreen's pharmacies. When the pharmacies identified a member with positive smoking status, the member was asked about the desire to quit smoking. With the member's agreement, the pharmacy notified the PCP and requested a prescription for nicotine replacement therapy. The Walgreen's also initiated outreach to members regarding the smoking cessation program when a prescription for nicotine replacement therapy was filled.

### Data Analysis and Results:

Some of the reported results are presented in the table below:

**Figure 11: PIP Performance Measures**

Indicator(s)	Baseline Rate 1/1/2009 – 12/31/2009	Interim Rate 1/1/2010 – 12/31/2010	Final Rate 1/1/2011 – 12/31/2011	Target or Goal*	Target or Goal Met?
The number of participants who enrolled in the program.	207	147	311	N/A	N/A
The number of participants who enrolled in the program who completed the 12-week program.	30% (62/207)	43% (279/573)	32% (99/311)	N/A	N/A
The number of participants who enrolled in the program who were smoke free at 30 days.	98% (61/62)	99% (145/146)	98% (97/99)	N/A	N/A
The number of participants who enrolled in the program that were smoke free at 3 months.**	71% (44/62)	99% (102/103)	76% (75/99)	N/A	N/A

\*The plan's indicators did not have quantifiable targets.

\*\*The denominator is lower, as the members who were not contacted were excluded.

N/A=Not Available

### Achievement of Improvement

Although there was no quantifiable improvement, this project was meant to assess referral, enrollment and completion for the smoking cessation program, as well as tobacco-free status at various check points. Members were provided access to services not previously available that would have a positive impact on their overall health. Reported quit rates of members who remained in the program and were able to be reached were very high.

### Achievement of Sustained Improvement

Passport Health Plan reported that enrollment in the program declined during the 2010-2011 period (573 to 311) when the new law enabled members to obtain smoking cessation medications without prior authorizations and without enrolling in the quit program. However, the overall program completion rate remained stable and increased by 2 percentage points (30% to 32%) baseline (2009) to re-measurement (2011) (with the highest rate being 43% in 2010).

Throughout the 3 years, the program completion rate was highest for members self-referred or referred by their PCP.

#### Overall Credibility of Results

- It was determined that ‘face’ validity of the results was evident.

#### Strengths

- Passport Health Plan chose to address a problem that was highly prevalent in Kentucky.
- The PIP addressed a need that was not previously met – smoking cessation assistance.
- Passport Health Plan used a comprehensive intervention strategy.
- The PIP was well received by members and providers and made a positive impact on members’ health.

#### Opportunities for Improvement

- Providing the number of exclusions for members who disenrolled, dropped out of the program and who could not be contacted, would have provided a better understanding of the quit rates reported beyond the three month time period.

### WellCare of Kentucky Performance Improvement Projects 2012

#### *WellCare of Kentucky PIP #1: Utilization of Behavioral Health Medication in Children*

Status: Proposal

Submitted: 9/1/12

Revised: 3/20/13, 7/2/13

Timeline: 1/1/13—12/31/15

#### Study Topic Selection

Behavioral health medication usage in the pediatric population has grown at a tremendous rate. Multiple types of providers are prescribing medication without a clinical evaluation and diagnostic assessment to determine proper treatment and follow-up. As a result, behavioral health medication may be used for purposes that were not originally intended and can result in high medical/pharmaceutical costs.

#### Study Question(s) and Indicator(s)

The study will aim to address the following questions:

- Does implementation of robust primary care provider interventions improve the occurrence of assessment and diagnosis prior to the prescribing of behavioral health medications to pediatric members?
- Does implementation of robust primary care provider and member interventions improve the management and treatment of behavioral health disorders and medication use in the pediatric population?

The following indicators will be used to assess the effectiveness of the planned interventions:

- The percentage of members who receive an ADHD diagnosis that have also been prescribed an ADHD medication.

- The percentage of members who have the recommended follow-up visits after initiation of ADHD medication therapy.

#### Study Population and Sampling

No sampling methods will be used for this study. The population will include all members 3 to 18 years of age, enrolled with the plan as of December 31 of the measurement year, who have been dispensed an ADHD medication.

#### Data Collection Procedures and Timeline

Administrative data from pharmacy and medical claims and encounters will be collected for this project. All data is collected according to plan policies and procedures to ensure validity and reliability. Data is also attested to for accuracy and validity by the data analyst.

Calendar year 2013 data will serve as the baseline and be measured in 1<sup>st</sup> quarter 2014. Re-measurement will occur annually.

#### Interventions/Improvement Strategies

Planned interventions include development and distribution of a provider tool kit to assist providers in behavioral health diagnosis, management and treatment plans; site visits to identify PCPs prescribing behavioral health medications and distribution of letters to prescribers who dispense ADHD and/or antidepressant medication without recommended follow-up visits.

Interventions aimed at improving member performance will include development and distribution of educational materials, as well as letters to members (or parents of members) who were dispensed behavioral health medication when recommended follow-up visits were not scheduled.

In addition, the plan will conduct training with the Provider Relations and Case Management teams regarding behavioral health prescribing patterns. These teams, once trained, will distribute additional materials to providers and members.

#### Strengths

- The PIP targets behavioral health care, an often ignored aspect of care for quality improvement and more specifically, pediatric behavioral health care (over/mis-prescribing and utilization of psychotropic medications).
- There is a strong rationale with multiple literature citations and specific data related to plan membership.
- The indicators include specific criteria for member age, diagnoses, and medications.
- The interventions address providers, members and health plan staff.

#### Opportunities for Improvement

- Timeframe should be revised to indicate the baseline year will be CY 2012. Once baseline measurement has been completed, the plan must document the performance goals for this PIP.
- Indicators are not fully described and lack timeframes necessary to effectively meet the objectives of the PIP. The proposal does not reference guidelines for follow-up visits specifically related to ADHD.

- Interventions more broadly address behavioral health diagnosis and management, and specifically target PCP prescribers of ADHD and/or antidepressant medication for some interventions. Indicators do not address PCP depression identification and management.

### *WellCare of Kentucky PIP #2: Inappropriate Emergency Department Utilization*

Status: Proposal

Submitted: 9/1/12

Revised: 1/4/13

Timeline: 1/1/12-12/31/14

#### Study Topic Selection

WellCare of Kentucky selected a topic that will address a problem that is highly prevalent among the plan's members, as well as nationwide. Literature cited shows admitting triage nurses classified 37 percent of all ED visits as having a non-urgent condition. This inappropriate ED utilization is both costly and inefficient, creating longer wait times for those members in need of urgent care. WellCare of Kentucky's project will aim to reduce non-urgent ED utilization.

#### Study Question(s) and Indicator(s)

The study will aim to answer the following question:

- Does implementation of robust member and provider interventions decrease the use of the ED for non-urgent conditions?

The following outcome performance indicators will be used to assess the effectiveness of the planned interventions:

- HEDIS® measure for Ambulatory Care - ED Visits as defined in the HEDIS® 2013 Technical Specifications.
- HEDIS® measure for Children and Adolescents' Access to Primary Care Practitioners as defined in the HEDIS® 2013 Technical Specifications.

In addition, the plan will utilize the following measures throughout the process of performing the PIP:

- Monitor rates of the top 10 ED diagnoses.
- Increase the number of members who access the 24 hour nurse advice line and avert use of the ER.
- Decrease the number of members who require Case Management outreach due to having 6 or more ER visits.

#### Study Population and Sampling

No sampling will be used to conduct this project. The study will include all continuously enrolled Medicaid members meeting HEDIS® 2013 specifications.

#### Data Collection Procedures and Timeline

Data for the outcome measures of this project will be collected according to the HEDIS® 2013 Technical Specifications for the administrative measures: Ambulatory Care – ED Visits, and Children and Adolescents Access to Primary Care Practitioners. HEDIS® rates will also be reviewed and audited by the plan's contracted HEDIS® auditor.

Data for the process measures will be collected by the Plan's 24/7 nurse line vendor, CareNet, and the Kentucky ER Visits report. The plan will also obtain data from Case Management's ED high utilization report.

Baseline date for this project will be measured in HEDIS® 2013.

#### Interventions/Improvement Strategies

Planned interventions include implementation of the Prudent Layperson Standard, identification of providers with high volumes of members seeking ED care, identification of and outreach to members with high ED utilization, promotion of the plan's 24/7 nurse triage line and development and distribution of educational materials regarding non-urgent care for members under 10 years of age.

In addition, the plan will evaluate and correct provider data and member assignments, as appropriate.

#### Strengths

- The PIP targets inappropriate emergency department utilization, which impacts both quality of care and cost of care for improvement.
- There is a strong rationale with multiple literature citations and specific data related to plan membership.
- The relevance to plan membership is supported by data, i.e., proportion of ED claims by age group and top ten diagnoses.
- The charts provide a very effective presentation of the project rationale.
- The interventions address providers, members and health plan staff.

#### Opportunities for Improvement

- High-utilizers' diagnoses may not be the same as the overall high-volume diagnoses. It would be beneficial to identify common diagnoses of high-utilizers, since those members appear to be a target of interventions, and this background information can potentially inform the intervention development.
- The HEDIS® indicator Ambulatory Care – Emergency Department Visits might be further stratified for purposes of this project. This will allow for more specific interventions which will increase the likelihood of achieving improvement.
- Several of the interventions appear to require ongoing plan activities, such as monitoring and resolving complaints and monitoring access to care. Interventions should include only activities implemented for this project for the purpose of decreasing Emergency Department utilization.
- Related to the aim of establishing a PCP linkage/medical home, the PIP could benefit from additional PCP assignment interventions. The plan might also consider collaboration with participating hospitals/EDs in order to receive concurrent notification of member ED visits.

## 5. Additional EQR Activities in Progress

In addition to the EQR activities described in this report, there are several tasks in progress, to be completed in 2013, as well as tasks that are ongoing. These include a Managed Care Program Progress Report, MCO Performance Dashboard, Annual Health Plan Report Card, EPSDT Validation Study, Postpartum and Neonatal Readmission Focus Studies, Validation of Patient-Level Claims, Validation of Managed Care Provider Network Submissions and a Comprehensive Evaluation Summary. Findings will be reported in the 2014 Annual EQR Technical Report. A summary of each activity follows:

### *Managed Care Program Progress Report*

IPRO will produce a Managed Care Program Progress report after all activities are completed for stakeholders, such as the Kentucky Legislature. IPRO will identify and recommend key performance measures for DMS' consideration to be included in the report. This report will be produced in a format required by DMS.

### *MCO Performance Annual Health Plan Report Card*

IPRO has produced a Health Plan Report Card (English and Spanish versions) in collaboration with DMS to be used by members to compare performance of the MCOs and to assist members in making a choice for MCO enrollment during the Open Enrollment period.

### *Postpartum and Neonatal Readmission Focus Studies*

#### Postpartum

The primary aim of the IPRO/KDMS Postpartum Readmission Focus Study is to describe the member characteristics, hospital practice patterns and discharge practices, and the provision of care management and postpartum services for members with postpartum hospital readmission(s) and evaluate adherence to clinical guidelines. In order to assess consistency with clinical guidelines recommendations, information will be abstracted from the record to evaluate adherence to ACOG guidelines pertinent to key clinical management indicators and to ACOG/American Academy of Pediatrics (AAP) guidelines for patient education and discharge planning (Lockwood and Lemons, 2007). Relevant performance measures will be calculated. Findings will be summarized by high risk member subgroups, health plan and facility, if possible, in order to facilitate targeted quality improvement interventions. A secondary aim is to identify risk factors for postpartum hospital readmission in order to comprehensively identify potential areas for improvement.

#### Neonatal

The aim of this study is twofold. The primary study aim is to provide a descriptive profile of maternal and infant characteristics of newborns with a hospital readmission within 30 days of birth hospital discharge, as well as to identify the types of inpatient, outpatient and care management services provided to these newborns. The secondary study aim is to identify risk factors for newborn readmission. Taken together, these two aims are intended to provide data-driven guidance to identify potential opportunities for improvement that can lead to reductions in neonatal readmissions. The primary study also will entail a retrospective review of hospital medical records of a sample of Medicaid Managed Care Organization (MCO)-enrolled newborns with hospital readmissions.

### *Validation of Patient-Level Claims*

In the first year of the contract, IPRO is assessing DMS' encounter data collection procedures for processing and validating MCO encounter data by the fiscal agent and identify any changes needed in the

process to meet CMS and industry standards. IPRO has received historical claims from the DMS that captures the utilization of the MCO members. Currently, a monthly validation report is being created.

### *EPSDT Validation Study*

The proposed study aims to compare administrative data and medical record documentation to validate encounter data codes relevant to the receipt of EPSDT screening of children enrolled in Kentucky Medicaid Managed Care.

Study questions:

1. Do encounter data codes used to indicate EPSDT (well child) screening visits reflect well child visits that include comprehensive health and developmental history (including mental health and substance use screening), comprehensive physical exam, and health education/anticipatory guidance?
2. Is mental health screening and follow-up of identified problems included in EPSDT visits?
3. Does submission of a CPT 96110 code reflect developmental screening using a standardized developmental screening tool?
4. Does submission of hearing and vision screening codes reflect age-appropriate hearing and vision screening?

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

DMS requires IPRO to verify the provider information submitted by Kentucky MCOs to the Managed Care Assignment Processing System (MCAPS), Kentucky's database for collecting provider panel information. MCOs must electronically submit provider data monthly for all plan-enrolled providers to the state's secure MCAPS. The state uses MCAPS data to evaluate the adequacy of the MCOs' networks, assess capacity, create PMs related to the MCOs' provider networks, and conduct access and availability studies; hence, the accuracy of the source data is essential.

IPRO is conducting an audit of the MCAPS to validate the accuracy of the data submissions for plan-participating PCPs and specialists using a two-phase mail audit. Responses are compared to information in the MCAPS and an error rate is computed for each data element that was validated. An aggregate report has been provided to DMS and an MCO specific report is in process.

### *Comprehensive Evaluation Summary*

IPRO will complete a comprehensive program review of DMS accountability strategy, monitoring mechanisms, and compliance assessment system of the Kentucky managed care program and compare the program and structure with other states. This will require interviews with key stakeholders, including MCO and DMS program managers. Key stakeholders will include, but not be limited to, the Department for Behavioral Health, Developmental and Intellectual Disability (DBHDID); Department of Public Health (DPH); and the Department of Insurance (DOI).

### *Individual Case Review*

A quality of care concern is defined as an occurrence associated with an adverse outcome or possible adverse outcome for the patient and where the care provided did not meet professionally recognized standard(s) of health care. MCO enrollees may lodge a complaint regarding a potential quality of care concern with the MCO. A process has been outlined by which MCO Quality of Care (QOC) concerns referred by Kentucky Department for Medicaid Services (DMS) will be reviewed by the EQRO medical staff for completeness and appropriateness of MCO investigation and follow-up action. In addition, the EQRO will review any and all QOC concerns identified during the conduct of other contract tasks (e.g., medical record review for focused study).

During this time period, there were no cases referred by DMS for a review of a potential quality of care concern.

## 6. MCO and DMS RESPONSE TO PRIOR RECOMMENDATIONS

Federal EQR regulations for external quality review results and detailed technical reports at 42 CFR §438.364 require that the EQR include, in each annual report, an assessment of the degree to which each health plan has addressed the recommendations for quality improvement made in the prior EQR technical report. The previous Technical Report issued for Kentucky evaluated only Passport Health Plan. The following table provides Passport Health Plan's and DMS's response to the recommendations issued in the Kentucky 2011 Technical Report, including an initial plan of action, how the plan was implemented, outcome and monitoring and actions planned for the future.

**Figure 12: Passport Health Plan Response to Recommendations Issued in 2011 Technical Report**

IPRO Recommendation	Passport Health Plan Response																																																																																																			
<p>Performance on the HEDIS<sup>®</sup> <i>Board Certification</i> measure improved from 2009 to 2010, but remains an opportunity for improvement, since most rates remained between the 25<sup>th</sup> and 50<sup>th</sup> percentiles.</p>	<p><b>Initial Plan of Action</b>            In response to reporting year 2010 results, provider data entry rules were updated to include loading the system default date for those practitioners with lifetime board certifications. In addition, practitioners with a hospital-based designation in the provider data system were excluded.</p> <p><b>How was this accomplished?</b>            Criteria to calculate the measure for reporting year 2011 was revised to take into account practitioners with a lifetime board certification and exclusion of those designated as hospital based practitioners.</p> <table border="1" data-bbox="617 867 1698 1247"> <thead> <tr> <th colspan="4" data-bbox="617 867 1150 906">HEDIS<sup>®</sup> 2012 Board Certification</th> <th colspan="6" data-bbox="1157 867 1698 906">2011 Quality Compass</th> </tr> <tr> <th data-bbox="617 906 800 945">CATEGORY</th> <th data-bbox="806 906 898 945">Denom</th> <th data-bbox="905 906 997 945">Cert</th> <th data-bbox="1003 906 1150 945">Rate</th> <th data-bbox="1157 906 1249 945">Avg.</th> <th data-bbox="1255 906 1348 945">10th</th> <th data-bbox="1354 906 1446 945">25th</th> <th data-bbox="1453 906 1545 945">50th</th> <th data-bbox="1551 906 1644 945">75th</th> <th data-bbox="1650 906 1698 945">90th</th> </tr> </thead> <tbody> <tr> <td data-bbox="617 945 800 1016">FAMILY MEDICINE</td> <td data-bbox="806 945 898 1016">225</td> <td data-bbox="905 945 997 1016">175</td> <td data-bbox="1003 945 1150 1016">77.78%</td> <td data-bbox="1157 945 1249 1016">76.45</td> <td data-bbox="1255 945 1348 1016">58.83</td> <td data-bbox="1354 945 1446 1016">67.98</td> <td data-bbox="1453 945 1545 1016">79.23</td> <td data-bbox="1551 945 1644 1016">84.67</td> <td data-bbox="1650 945 1698 1016">89.88</td> </tr> <tr> <td data-bbox="617 1016 800 1055">GERIATRICIAN</td> <td data-bbox="806 1016 898 1055">3</td> <td data-bbox="905 1016 997 1055">3</td> <td data-bbox="1003 1016 1150 1055">100.00%</td> <td data-bbox="1157 1016 1249 1055">74.95</td> <td data-bbox="1255 1016 1348 1055">52.17</td> <td data-bbox="1354 1016 1446 1055">65.34</td> <td data-bbox="1453 1016 1545 1055">76.92</td> <td data-bbox="1551 1016 1644 1055">90.00</td> <td data-bbox="1650 1016 1698 1055">100.00</td> </tr> <tr> <td data-bbox="617 1055 800 1127">INTERNAL MEDICINE</td> <td data-bbox="806 1055 898 1127">184</td> <td data-bbox="905 1055 997 1127">143</td> <td data-bbox="1003 1055 1150 1127">77.72%</td> <td data-bbox="1157 1055 1249 1127">79.35</td> <td data-bbox="1255 1055 1348 1127">66.37</td> <td data-bbox="1354 1055 1446 1127">74.29</td> <td data-bbox="1453 1055 1545 1127">80.07</td> <td data-bbox="1551 1055 1644 1127">86.26</td> <td data-bbox="1650 1055 1698 1127">92.19</td> </tr> <tr> <td data-bbox="617 1127 800 1166">OB/GYN</td> <td data-bbox="806 1127 898 1166">207</td> <td data-bbox="905 1127 997 1166">153</td> <td data-bbox="1003 1127 1150 1166">73.91%</td> <td data-bbox="1157 1127 1249 1166">77.32</td> <td data-bbox="1255 1127 1348 1166">63.46</td> <td data-bbox="1354 1127 1446 1166">71.52</td> <td data-bbox="1453 1127 1545 1166">80.16</td> <td data-bbox="1551 1127 1644 1166">85.45</td> <td data-bbox="1650 1127 1698 1166">90.25</td> </tr> <tr> <td data-bbox="617 1166 800 1205">PEDIATRIC</td> <td data-bbox="806 1166 898 1205">193</td> <td data-bbox="905 1166 997 1205">158</td> <td data-bbox="1003 1166 1150 1205">81.87%</td> <td data-bbox="1157 1166 1249 1205">81.87</td> <td data-bbox="1255 1166 1348 1205">69.61</td> <td data-bbox="1354 1166 1446 1205">76.64</td> <td data-bbox="1453 1166 1545 1205">83.39</td> <td data-bbox="1551 1166 1644 1205">88.71</td> <td data-bbox="1650 1166 1698 1205">92.86</td> </tr> <tr> <td data-bbox="617 1205 800 1243">OTHER</td> <td data-bbox="806 1205 898 1243">1738</td> <td data-bbox="905 1205 997 1243">1179</td> <td data-bbox="1003 1205 1150 1243">67.84%</td> <td data-bbox="1157 1205 1249 1243">77.99</td> <td data-bbox="1255 1205 1348 1243">65.55</td> <td data-bbox="1354 1205 1446 1243">71.51</td> <td data-bbox="1453 1205 1545 1243">78.75</td> <td data-bbox="1551 1205 1644 1243">87.56</td> <td data-bbox="1650 1205 1698 1243">91.42</td> </tr> <tr> <td colspan="4" data-bbox="617 1243 1150 1282">Total: 2,550 1,811 71.0%</td> <td colspan="6"></td> </tr> </tbody> </table> <p data-bbox="617 1289 1241 1351">Shaded boxes denote the Quality Compass percentile the measure met.</p> <p data-bbox="617 1357 1050 1386">Denom = denominator; Cert = Certified</p>										HEDIS <sup>®</sup> 2012 Board Certification				2011 Quality Compass						CATEGORY	Denom	Cert	Rate	Avg.	10th	25th	50th	75th	90th	FAMILY MEDICINE	225	175	77.78%	76.45	58.83	67.98	79.23	84.67	89.88	GERIATRICIAN	3	3	100.00%	74.95	52.17	65.34	76.92	90.00	100.00	INTERNAL MEDICINE	184	143	77.72%	79.35	66.37	74.29	80.07	86.26	92.19	OB/GYN	207	153	73.91%	77.32	63.46	71.52	80.16	85.45	90.25	PEDIATRIC	193	158	81.87%	81.87	69.61	76.64	83.39	88.71	92.86	OTHER	1738	1179	67.84%	77.99	65.55	71.51	78.75	87.56	91.42	Total: 2,550 1,811 71.0%									
HEDIS <sup>®</sup> 2012 Board Certification				2011 Quality Compass																																																																																																
CATEGORY	Denom	Cert	Rate	Avg.	10th	25th	50th	75th	90th																																																																																											
FAMILY MEDICINE	225	175	77.78%	76.45	58.83	67.98	79.23	84.67	89.88																																																																																											
GERIATRICIAN	3	3	100.00%	74.95	52.17	65.34	76.92	90.00	100.00																																																																																											
INTERNAL MEDICINE	184	143	77.72%	79.35	66.37	74.29	80.07	86.26	92.19																																																																																											
OB/GYN	207	153	73.91%	77.32	63.46	71.52	80.16	85.45	90.25																																																																																											
PEDIATRIC	193	158	81.87%	81.87	69.61	76.64	83.39	88.71	92.86																																																																																											
OTHER	1738	1179	67.84%	77.99	65.55	71.51	78.75	87.56	91.42																																																																																											
Total: 2,550 1,811 71.0%																																																																																																				

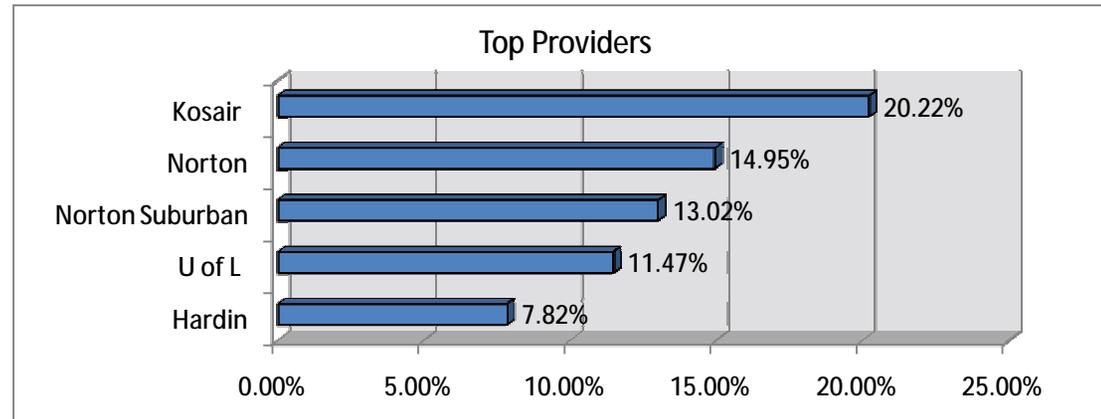
IPRO Recommendation	Passport Health Plan Response
	<p><b>Outcome and Monitoring</b> The Plan does not require practitioners to be board certified, only board eligible. The rate for reporting year 2011 increased 2.2 percentage points from the previous reporting year.</p> <p><b>Future Actions/Plans</b> Develop internal report to identify practitioners with a board certification and their expiration date. This will allow the Plan to obtain and verify their updated board certifications in between recertifying cycles.</p>
<p>Inpatient utilization remains an opportunity for improvement, with the metrics Days per 1000 MM, Discharges per 1000 MM, and Average Length of Stay all benchmarking at greater than the 90<sup>th</sup> percentile.</p>	<p><b>Initial Plan of Action</b> Conduct periodic review and analysis of utilization data and continue to explore opportunities for improvement. These efforts will include:</p> <ul style="list-style-type: none"> <li>• Monthly &amp; Quarterly review and analysis of Days and Admissions per 1,000 members</li> <li>• Monthly &amp; Quarterly review and analysis of Average Length of Stay (ALOS)</li> <li>• Evaluation of Utilization patterns to identify potential trends</li> <li>• Evaluation of adverse trends to develop Utilization plan of action/recommendations</li> </ul> <p><b>How was this accomplished?</b></p> <ul style="list-style-type: none"> <li>• Evaluation of monthly reports to monitor inpatient utilization. The reports identify the number of inpatient days per 1,000 members, admissions per 1,000 members, and Average Length of Stay (ALOS).</li> <li>• Analysis of trends related to admissions, specifically evaluating months where there was an increase in days/admits per 1,000</li> <li>• Provider evaluation to identify providers with highest utilization</li> <li>• Provider analysis</li> </ul> <p><b>Outcome and Monitoring</b></p> <p><u><i>Inpatient utilization</i></u> Both admissions and days per 1,000 members decreased from 2010 to 2011. Admits per 1,000 members decreased by 2.3% and days per 1,000 members decreased by 1.9%. Admits per 1,000 members was 123.29 in 2010 and 117.78 in 2011. Days per 1,000 members was 615.07 in 2010 and 593.00 in 2011.</p> <p><i>2011 Data:</i> Admits per 1,000 members was 117.7 and the average days per 1,000 members was 593.0. The Average Length of Stay was 5.04 days.</p> <p>The incidence of inpatient hospitalizations/days related to respiratory disease increased during the winter months (1st Quarter) of 2011. Days per 1,000 were at a high both in total and for respiratory disease in the 1<sup>st</sup> Quarter of 2011. Days per 1,000 in the 1st Quarter were, at a minimum, 26% higher than in other quarters of 2011.</p>

IPRO Recommendation	Passport Health Plan Response
	<p>Per the Centers for Disease Control and Prevention, the incidence of Respiratory Syncytial Virus (RSV) amongst infants and adults with compromised immune systems and those 65 and older is greatest during the winter months. It can be surmised that the increase in days and admissions per 1,000 members for the 1st Quarter of 2011 was directly related to respiratory diseases, the most common being RSV.</p> <p>Days per 1,000 is highest amongst members in the SSI without Medicare category of aid. Members in this category consist of the blind, aged and disabled who do not have Medicare benefits.</p> <p><u>Additional Analysis: C-Section Rates</u> The state of Kentucky is 7th in the nation for surgical births.</p> <p>Cesarean section (C-section) analysis was performed to evaluate the C-section rates amongst Passport Health Plan members. An analysis was performed on physician delivery data from Feb. 2011 to July 2011. During this time frame there were a total of 3,529 deliveries. Of the 3,529 deliveries evaluated, 2,259 (65%) were normal vaginal deliveries (NVD) and 1,270 (35%) were C-sections. An analysis was performed with review of the following data:</p> <ul style="list-style-type: none"> <li>• Total number of Deliveries, Normal Vaginal Deliveries (NVD) and C-sections</li> <li>• Physicians with &gt; 10 deliveries within any one month period were included in the analysis</li> <li>• The total number of deliveries, NVD and C-sections for physicians who met Criteria B</li> <li>• The analysis examined percentage of C-section rate amongst physicians</li> <li>• Physicians with greater than 10 deliveries within any one-month period were evaluated. During the report period, there were 36 physicians who met this criterion.</li> </ul> <p>There were a total of 1,460 deliveries for the 36 physicians accounting for 42% of the total deliveries for the six-month period. Of the 1,460 deliveries, 950 were NVD and 510 were C-sections. The average C-section rate for the 36 physicians during the report period was 35%. There were 6 physicians who had a 50% or greater C-section rate during the report period. One physician who specializes in Fetal and Maternal Medicine had a C-section rate of 86%.</p> <p><u>Top Providers</u> During the time period of 1/1/2011 through 6/30/2011, Kosair Children's Hospital had the highest admissions and bed days followed by Norton Hospital. Kosair Children's Hospital, Kentucky's only full-service pediatric care facility, accounted for 20.22% of all of Passport Health Plan Inpatient admissions.</p> <p>It is of interest to note that infants who are transferred to Kosair after delivery are assigned to Passport Health Plan. Thus, Passport Health Plan covers infants who are outside of Region 3 and who are admitted to Kosair post-delivery. Once the infant is discharged from Kosair, Passport Health Plan coverage terminates and they would be eligible for</p>

**IPRO Recommendation**

**Passport Health Plan Response**

coverage with another MCO.



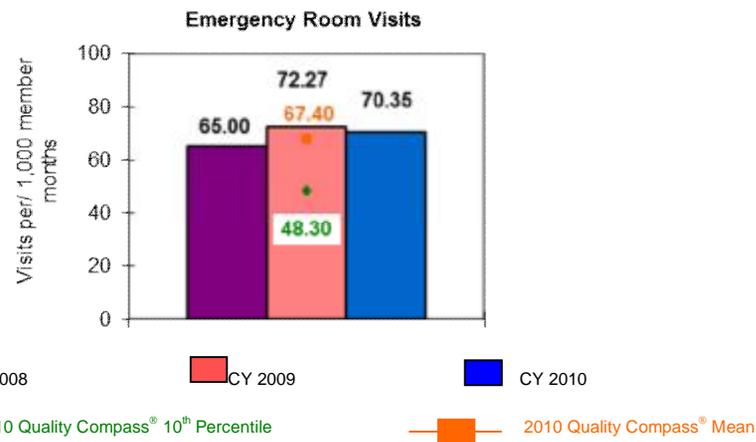
**Future Actions/Plans**

- Ensure high risk infants receive prophylactic palivizumab (Synagis) (medication used in the prevention of RSV). Refer infant to Case Management program for intervention.
- Ensure adults with compromised immune systems and those 65 and older receive annual flu shot. Refer high risk adults to Case Management for education and intervention.
- Passport Health Plan will continue to monitor utilization amongst the categories of aid, particularly in the category of SSI without Medicare as this is the group of members with highest utilization.
- Continue multidisciplinary case reviews for complex cases with on-site review nurses, concurrent review nurses, case management nurses, and physician advisors.
- Continue referrals of high risk members to Case and Disease Management for evaluation and intervention.
- Continue to refer members to the *Tiny Tot Transition Program*, which is conducted at Kosair Children's Hospital, University Hospital, and Suburban Hospital. The program is targeted at infants who remain in the hospital beyond the mother's stay. Many of these infants qualify for SSI without Medicare due to extreme prematurity.
- Implementation of *On-Site Discharge Planning* during 2012 at select facilities to ensure members have a full understanding of their medical needs post-discharge. The goals of the *On-Site Discharge Planning* program are:
  - Decrease admissions
  - Decrease re-admissions

IPRO Recommendation	Passport Health Plan Response
	<ul style="list-style-type: none"> <li>○ Increase PCP visits</li> <li>○ Decrease Emergency Room utilization</li> <li>○ Increase compliance with medications</li> <li>○ Improve health outcomes</li> <li>● Continue to monitor admits and days per 1,000 and ALOS for trends on a monthly and quarterly basis.</li> </ul> <p><u>C -Section Analysis</u></p> <ul style="list-style-type: none"> <li>● Possible chart audits on the physicians whose C-section rate is above a certain percentage to evaluate reason for C-section</li> <li>● Analysis of failed inductions resulting in C-section</li> <li>● Provide physician/provider/member education</li> <li>● Review payment options associated with C-section</li> </ul> <p><u>Top Facility</u></p> <ul style="list-style-type: none"> <li>● Evaluate coverage guidelines for non-Region 3 infants admitted to Kosair Children’s Hospital under Passport Health Plan</li> <li>● Maintain embedded Utilization Management staff at top 5 facilities</li> <li>● Implement embedded Discharge Planner(s) within the top 5 facilities during 2012</li> </ul>
<p>Passport Health Plan’s rates for Total Discharges and ED Visits, which exceeded the Medicaid mean, and Total Outpatient Visits, which was below the Medicaid mean, may reflect an opportunity for improvement in access to outpatient care.</p>	<p><b>Initial Plan of Action</b>  Based on the results of the ER utilization analysis, the Plan will develop an ER Cost Savings Proposal to include an outreach program at the top leading ER facilities for adults to include health coaching, care gaps, barriers to care, and assisting with scheduling PCP appointments.</p> <p>The Plan will utilize the Lock-in Program to automatically enroll members with four ER visits for non-urgent use or use of three different facilities for non-urgent ER use into the program which designates a specific hospital for the member. Additionally, the Plan will utilize its disease-specific programs to increase interventions to members with the identified AHRQ ambulatory care sensitive conditions to provide member education for appropriate self-management.</p>

**IPRO Recommendation**

**Passport Health Plan Response**



**How was this accomplished?**

A Health Plan Performance Improvement Project was developed for Reduction of Emergency Room Care Rates. The project topic is reduction in emergency room care rates with a special focus on decreasing inappropriate emergency room utilization and increasing primary care and urgent care usage. The Plan identified the following as top 5 diagnosis for emergency room visits:

Upper respiratory infection – Otitis Media – Abdominal pain – Acute Pharyngitis and Urinary Tract infection. Initial interventions began during the 1<sup>st</sup> Quarter of 2011.

**DESCRIPTION**

The denominator for emergency room (ER) visits equals the total number of member months for the measurement year. The numerator equals the number of emergency room visits that did not result in an inpatient stay. Multiple emergency room visits on the same date of service were counted as one visit. The calculation is in visits/1000 member months.

**FINDINGS**

Calendar year 2010 results, demonstrated a decrease of 1.92 visits per/1000 member months.

This is an inverted rate with a lower rate indicating better performance.

IPRO Recommendation	Passport Health Plan Response
	<p>During 1<sup>st</sup> Quarter of 2011, there were letters sent to 349 members seen for asthma in Kosair and Hardin Memorial Hospital</p> <p>Additionally, during 4<sup>th</sup> Quarter of 2011, Case Managers were embedded at select PCP offices to assist the Plan's members. The Plan's Case Managers are located at the PCP office and are available to assist members with any questions or concerns they may have.</p> <p>Future Actions/Plans</p> <ul style="list-style-type: none"> <li>• Proposal for new Utilization Management Program 2012 Emergency Room</li> <li>• Embedded Discharge Planning – Utilization Management</li> <li>• The Goals of Embedded Discharge Planning are: <ul style="list-style-type: none"> <li>○ Increase health outcomes</li> <li>○ Informed/educated member</li> <li>○ Avoidable admissions</li> <li>○ Reduction in adverse events post-discharge (I.E. Over utilization of ER – medication errors)</li> </ul> </li> <li>• The Objectives of Embedded Discharge Planning are: <ul style="list-style-type: none"> <li>○ Decrease in utilization of emergency room services for non-emergent issues</li> <li>○ Increased PCP visits</li> <li>○ Compliance with specialist visits</li> <li>○ Increased compliance with medications</li> </ul> </li> <li>• The Functions of Embedded Discharge Planning are: <ul style="list-style-type: none"> <li>○ Evaluate reason for emergency room visit</li> <li>○ Evaluate the member's discharge needs</li> <li>○ Discuss discharge plans with member</li> <li>○ Refer to appropriate agencies (i.e. PCP, Home Health, Community Resources etc.)</li> <li>○ Arrange for follow-up tests/appointments</li> </ul> </li> </ul>
<p>While Passport Health Plan has implemented a comprehensive QAPI program, EQRO findings were not incorporated into work plans and annual evaluations.</p>	<p>Initial Plan of Action To include EQRO findings in the annual QI Work Plan and evaluation.</p> <p>How was this accomplished? A statement was added to the Plan's QI Evaluation, QI Staff and Resources section, describing QI Department responsibilities "Reviewing and responding to external quality review organization's recommendations".</p>

IPRO Recommendation	Passport Health Plan Response
	<p><b>Outcome and Monitoring</b>  The QI Program evaluation is an annual assessment of the effectiveness of the QI Program which allows the Plan to determine how well it has utilized its resources in the recent past and to improve the quality of care, service, and cultural and linguistic appropriate services provided to Plan membership. When the program has not met its goals, barriers to improvement are identified and appropriate changes are integrated into the subsequent annual QI Work Plan. Feedback and recommendations from various committees are also integrated into the evaluation as well as the annual external review results conducted by the IPRO on behalf of DMS, accreditation status and annual reevaluation results. The final document is presented to the Quality Medical Management Committee, the Partnership Council, and the UHC Board for review and approval.</p> <p>Based on the results of the annual QI Program Evaluation and with input from all Passport Health Plan departments, an annual QI Work Plan addressing planned and ongoing quality initiatives is developed. The QI Work Plan includes objectives, goals, scope, and planned activities that address the quality and safety of clinical care, quality of services, CLAS, and reduction of health care disparities for the year. Planned monitoring of issues previously identified by internal and external customers are integrated including tracking of issues over time and the planned evaluation of the QI Program. Also included are persons responsible for each activity and the timeframe for achieving each activity. The final document is presented to the Quality Medical Management Committee, the Partnership Council, and the UHC Board for review and approval.</p> <p>The final 2010 QI Program Evaluation document was presented, reviewed and approved by the Quality Medical Management Committee, the Partnership Council, and the UHC Board in March of 2011, prior to the EQRO's final July 2011 recommendation.</p> <p><b>Future Actions/Plans</b>  Upon review of the Response to 2011 External Quality Review Technical Report Recommendations, it was noted that a statement regarding "Reviewing and responding to external quality review organization's recommendations" (as noted above) was added to the 2010 QI Program Evaluation. The EQRO annual evaluation findings were not incorporated in the 2010 QI Program Evaluation and 2011 Work Plan. The 2011 QI Program Evaluation and 2012 Work Plan were approved by the Quality Medical Management Committee, the Partnership Council, and the UHC Board in the 1<sup>st</sup> Quarter of 2012, but will be updated with the EQRO's recommendations and resubmitted to the appropriate committees for approval in July 2012.</p>
<p>Program integrity presents an opportunity for improvement in documentation of closed cases, depth/thoroughness of</p>	<p><b>Initial Plan of Action</b>  Passport Health Plan will review all requirements for Program Integrity investigation and reporting functions required by the DMS contract, and will seek feedback from DMS Program Integrity unit regarding documentation, reporting and records, related to fraud, waste, and abuse cases. Passport Health Plan will also update policy PI 1.0, Program Integrity</p>

IPRO Recommendation	Passport Health Plan Response
<p>investigations and supporting documentation, algorithms to identify fraud, waste and abuse, and annual disclosure for delegates.</p>	<p>Organizational Structure and Responsibilities, to include algorithms and MIS data audits utilized in preventing and detecting member and provider fraud, such as the following:</p> <ul style="list-style-type: none"> <li>• Regular review of claims data to detect abnormalities in provider billing and member utilization patterns</li> <li>• Periodic sampling of claims to determine propriety of payments</li> <li>• Sampling of services through member contact to ensure billed services were rendered (EOMB)</li> <li>• Utilization of newly implemented case tracking software system to conduct additional analysis and data manipulation</li> </ul> <p>Also, implementation and use of the STARS Case Tracking System, which was fully implemented in the 3<sup>rd</sup> Quarter of 2010, will allow for storage and documentation of case information and activity to be housed in one central location. Also, medical records are now stored in the imaging system, SIRS.</p> <p>Passport Health Plan will also revise the process described in Policy PI 1.15, Annual Financial Disclosure. Currently this policy requires only that Passport Health Plan obtain the Annual Disclosure Form from each delegate. The Policy will be revised to include a review of the excluded parties' databases found in the EPLS and OIG websites to ensure no entity or its officers have been excluded from participation in the Medicaid program. This information will be submitted to DMS on an annual basis.</p> <p>How was this accomplished?  Following the review of reporting requirements in the DMS contract, Passport Health Plan revised the quarterly fraud, waste and abuse report to include all contractual elements including the following:</p> <ul style="list-style-type: none"> <li>• Passport Health Plan case number</li> <li>• OIG case number (when applicable)</li> <li>• Business/recipient name</li> <li>• Date complaint received</li> <li>• Date opened</li> <li>• Date closed</li> <li>• Summary of complaint</li> <li>• Is complaint substantiated?</li> <li>• Action taken by Passport Health Plan (only most current update)</li> <li>• Amount of overpayment , if any</li> <li>• Sanctions/withholds applied to providers/members</li> <li>• Revisions to policies to reduce potential for similar situations</li> <li>• Provider/member appeal regarding overpayment/sanctions, including date appeal was requested, date hearing held, date of final decision and outcome</li> </ul>

IPRO Recommendation	Passport Health Plan Response
	<p>In addition to revising the quarterly report to include all required reporting elements, Passport Health Plan also began reporting “data mining activities” in the quarterly report to DMS. The audit and data mining activities reporting includes any review of MIS data to identify the following:</p> <ul style="list-style-type: none"> <li>• Outliers for a given procedure</li> <li>• The most frequently billed procedures within a given specialty</li> <li>• The top providers utilizing the most frequently billed procedure codes; and/or</li> <li>• The top providers for a frequent type of bill.</li> </ul> <p>Passport Health Plan also requested feedback from DMS regarding its Program Integrity activities. DMS provided Passport Health Plan with its Program Integrity manual for review.</p> <p><b>Outcome and Monitoring</b>  Passport Health Plan held monthly meetings with AmeriHealth Mercy Health Plan’s (AMHP’s) Corporate and Financial Investigations Unit to discuss case progress and review any issues related to open member and provider cases. Passport Health Plan would follow up with AMHP regarding case documentation following quarterly Program Integrity meetings, with DMS, in which any feedback was received from DMS.</p> <p>Improvements in reporting and documentation of case activity continue, and we continue to seek guidance from the DMS Program Integrity Unit and the OIG. In addition to continuing efforts to improve the documentation related to cases, we are also working to improve the case summary to fully state all activities conducted in the investigation of fraud, waste and abuse referrals.</p> <p><b>Future Actions/Plans</b>  In 1<sup>st</sup> Quarter 2012, Passport Health Plan ended its agreement with AMHP for program integrity services, and engaged the services of TC3 Health to conduct fraud, waste and abuse investigations and services.</p> <p>This new delegate was selected using the RFP process, and a Letter of Intent executed thereafter. The contract was presented to DMS, and received approval in April 2012. Passport Health Plan will also have staff locally to work closely with TC3 and monitor their performance.</p>
<p>Passport Health Plan should continue routine and as-needed member services training and education, including provision of examples of correct and incorrect case processing and documentation, to ensure</p>	<p><b>Initial Plan of Action</b>  Continue to review the complaint data that is manually placed in the grievance spreadsheet to ensure that all grievances are handled correctly. Promote collaboration between the Special Support Technicians to ensure that this is done correctly. The Member Services Auditor/Trainer will continue consistency reviews of the four technicians.</p>

IPRO Recommendation	Passport Health Plan Response
<p>appropriate investigation, follow-up and resolution of member grievances.</p>	<p>How was this accomplished?  This will be an on-going process, along with a new implementation of the Special Support Technicians reviewing each other's grievances on a weekly basis. This will allow consistency and ensure that they are all documenting and forwarding grievances to the correct place in a timely manner. After the IPRO audit, a review related to the correct handling of quality of care cases was conducted with the Special Support Technicians. The grievance policy was updated to include the Quality of Care Referral triggers and distributed to the Technicians.</p> <p>Outcome and Monitoring  Auditing and monitoring is an on-going process which will ensure that our policy is being followed. Any issues will be brought to the Manager's attention for review and corrective action if necessary.</p> <p>Future Actions/Plans  The Auditor/Trainer will continue to monitor the Technicians throughout 2012 to ensure that all grievances are handled and forwarded correctly. The grievance spreadsheet will also be reviewed by the Member Services Manager to ensure accuracy and that all grievances are being documented and coded correctly. Within the documentation, we will have the Grievances, Investigation, and Resolution.</p>
<p>Passport Health Plan should continue work on enhancing behavioral health and physical health coordination of care, including promoting awareness of the Behavioral Health Liaison.</p>	<p>Initial Plan of Action  Identified area for improvement and to enhance behavioral health and physical health coordination of care.</p> <p>How was this accomplished?  In the 2<sup>nd</sup> Quarter of 2011, the Plan initiated on-site assistance to one of the high-volume Seven County Services sites utilized by Passport Health Plan members to facilitate and coordinate the assessment and treatment for members with behavioral health needs. The Behavioral Health Liaison works to identify members in need of assistance in accessing physical and behavioral services, and involves the member in the selection of a provider for behavioral health services.</p> <p>The Behavioral Health Liaison:</p> <ul style="list-style-type: none"> <li>• Utilizes HIPAA protocols to maintain and protect member confidentiality by ensuring member completion of the Release of Information Form to allow the exchange of information between physical and behavioral health providers</li> <li>• Provides education regarding services covered under Passport Health Plan and services covered under Medicaid fee-for-service</li> <li>• Maintains information to help members access non-covered out-patient substance abuse services following discharge from inpatient medical detoxification</li> <li>• Partners on the members' behalf with such organizations as: <ul style="list-style-type: none"> <li>○ Community mental health agencies</li> <li>○ Housing Authorities such as shelters and personal care homes</li> <li>○ Transportation and care delivery systems</li> </ul> </li> </ul>

IPRO Recommendation	Passport Health Plan Response
	<ul style="list-style-type: none"> <li>○ Pharmacies</li> <li>○ Adult Day Cares</li> <li>○ Alcoholics Anonymous (AA)</li> <li>○ Narcotics Anonymous (NA)</li> </ul> <p><b>Outcome and Monitoring</b> A tracking tool and medical management documentation system is in place to track referral requests from PCP's, documentation of collaboration with the PCP and BH specialists, member/PCP assistance with access to BH services, member assistance with access to medical services, involvement of members in BH provider selection, member interface between BH Liaison and Passport Health Plan case management and/or targeted Case Management agencies to facilitate member access to needed services. Note templates have been updated to capture all member and provider interaction and activity.</p> <p><b>Future Actions/Plans</b> The Care Coordination Department has coordinated with Provider Relations and Public Affairs to educate providers and members regarding the Behavioral Health Liaison. An educational article was in the Member Newsletter distributed in 3<sup>rd</sup> Qtr. 2011. Provider communication to educate on the availability of the Behavioral Health Liaison's role and contact information was distributed to all participating providers via letter in 4<sup>th</sup> Quarter of 2011. Additions to the Provider Manual to explain role, availability and contact information for the Behavioral Health Liaison will be updated in 2012. A provider communication regarding Case/Disease Management, Behavioral Health Liaison, and Foster Care Liaison is planned for the 3<sup>rd</sup> Quarter of 2012. It is the Plan's intent, for 2012, to continue the Behavioral Health Liaison onsite at the Seven Counties location and expand services to a large PCP practice that manages many members with behavioral health needs to assist in coordination of care with behavioral and physical health.</p>
<p>Performance on child and adolescent BMI screening declined and represents an opportunity for improvement.</p>	<p><b>Initial Plan of Action</b> The Plan made the decision to mandate providers calculate and document in the members' chart the BMI value obtained during an EPSDT screening.</p> <p><b>How was this accomplished?</b> The plan of action is a requirement for a complete EPSDT screen reimbursement using appropriate CPT-2 code.</p> <p><b>Outcome and Monitoring</b> An EPSDT Claims Audit will be conducted on an annual basis in order to verify documentation of a complete age appropriate screen. Audit criteria for each age screen are based on the Plan's approved Periodicity schedule and the DMS EPSDT Screening Services and EPSDT Special Services Policies and Procedure Manual.</p>

IPRO Recommendation	Passport Health Plan Response
	<p>Future Actions/Plans</p> <p>The Plan will:</p> <ul style="list-style-type: none"> <li>• Conduct clinical staff education regarding EPSDT required elements</li> <li>• Conduct provider education regarding EPSDT required elements</li> <li>• Share best practices of required documentation</li> <li>• Share documentation checklist tool</li> </ul> <p>The provider will:</p> <ul style="list-style-type: none"> <li>• Utilize the birthday calculator to verify age-appropriate screen required to ensure specific elements are addressed</li> <li>• Utilize the documentation checklist tool</li> <li>• Contact the provider network account manager with questions</li> </ul>
<p>Results of the Study of Utilization and Quality of Care for Persistent Asthmatics suggest an opportunity for improvement in outpatient monitoring of members with persistent asthma, and possibly in identification and management of comorbidities.</p>	<p>Initial Plan of Action</p> <p>Passport Health Plan received the <i>PCP Management of Persistent Asthma Quality of Care Focus Study</i> from the Commonwealth of Kentucky Department for Medicaid Services Division of Medical Management dated November 2011. Passport Health Plan reviewed the study and sent a written response to the recommendations and findings December 2011, which was approved by DMS.</p> <p>How was this accomplished?</p> <p>The Passport Health Plan's Response to Recommendations and Findings to the <i>PCP Management of Persistent Asthma Quality of Care Focus Study</i> was taken to the Child and Adolescent Committee quarterly meeting and is scheduled for continued discussion at QMMC for provider discussion and feedback.</p> <p>Outcome and Monitoring</p> <p>The Passport Health Plan goal is to provide education to the providers and follow-up with an audit of documentation compliance in late 3<sup>rd</sup> and 4<sup>th</sup> Quarter 2012. Audits would have a compliant score of 80% with re-education and a written action plan required for any score less than 80% including a timeline for re-audit.</p> <p>Future Actions/Plans</p> <p>Develop provider education tools in conjunction with committees to educate providers regarding management of members with persistent asthma. The Plan will continue member education regarding asthma treatment, common triggers, action plans, smoking cessation, how to prevent exacerbations, flu vaccinations and how to take their medications. The ER Coordinator will initiate utilization of an auto-dialer program to assist in reaching more members to allow more interaction with members for education on provider follow up, medication compliance, provider appointment reminders, verification of kept appointments and assistance with transportation.</p>

IPRO Recommendation	Passport Health Plan Response
<p>Adult CAHPS® rates reveal decline in five rates with three rates benchmarking at the 25<sup>th</sup> percentile or less.</p>	<p><b>Initial Plan of Action</b>  Identified areas for improvement noted from the 2010 CAHPS® Adult Survey with a rate decline and rates benchmarking at the 25<sup>th</sup> percentile or less were in the areas of the following individual survey items Health Care Overall (67%, in the 25<sup>th</sup> percentile) and Personal Doctor (73%, in the 25<sup>th</sup> percentile), and How Well Doctors Communicate (83%, in the &lt; 10<sup>th</sup> percentile) for the survey composite measures. Two additional measures noted a rate decline, one in the area of individual survey item Specialist Overall (78%, in the 50<sup>th</sup> percentile) and one in the area of survey composite measure item Customer Services (82%, in the 50<sup>th</sup> percentile).</p> <p>All five rates noted with a decrease in rate from the 2010 CAHPS® Adult Survey noted increases in the results from the 2011 CAHPS® Adult Survey. Health Care Overall noted a three percentage point increase, Personal Doctor noted a four percentage point increase, How Well Doctors Communicate noted a four percentage point increase, Specialist Overall noted a five percentage point increase, and Customer Services noted a three percentage point increase from the previously reported measurement year.</p> <p>How was this accomplished?  The Plan implemented interventions which included:</p> <p><u>Improve member satisfaction with their specialists through:</u></p> <ul style="list-style-type: none"> <li>• Monitor member complaints against specialists via semi-annual complaint reports and conducting outreach to those providers not meeting Plan standards</li> <li>• Continue to assess member satisfaction as a component of the Specialist Provider Recognition Program via telephonic member surveys</li> <li>• Distribute a training tool for practitioners and office staff on ways to improve patient satisfaction</li> <li>• Educate specialists regarding member satisfaction at every opportunity, including annual practice management seminar, provider workshops, roundtables, site visits and Plan web site</li> </ul> <p><u>Improve members' satisfaction with their personal doctor through:</u></p> <ul style="list-style-type: none"> <li>• Monitor member complaints against PCPs via semi-annual complaint reports and conducting outreach to those providers not meeting Plan standards</li> <li>• Continue to assess member satisfaction as a component of the PCP Provider Recognition Program and distribute results twice annually</li> <li>• Distribute a training tool for practitioners and office staff on ways to improve patient satisfaction</li> <li>• Educate PCPs and specialists regarding member satisfaction at every opportunity including, annual practice management seminar, provider workshops, roundtables, site visits and Plan web site</li> <li>• Continue to build upon provider awareness of the Plan's process for monitoring, trending and communicating members' complaint data via new provider orientations, site visits, provider workshops and roundtable meetings</li> </ul>

IPRO Recommendation	Passport Health Plan Response
	<p><u>Improve members' satisfaction with their health care through:</u></p> <ul style="list-style-type: none"> <li>• Random telephonic surveys to members who called the Plan's Member Services Department to better understand their feelings about their health care and their perceived barriers to care</li> <li>• Utilize the Rapid Response Outreach Team, consisting of Case Manager Technicians and case managers to discuss with members their urgent medical needs, help with scheduling appointments, and finding needed services for the member</li> <li>• Increase member awareness regarding the importance of selecting a PCP through distribution of member materials and phone contact by Member Services</li> </ul> <p><u>Improve members' experiences with the Plan's customer service area through:</u></p> <ul style="list-style-type: none"> <li>• Maintain department consistency review process to evaluate consistency among representatives, identify training opportunities, monitor for accuracy of information and coach as needed</li> <li>• Utilize the Rapid Response Outreach Team to assist members with urgent health issues and questions, assisting with removal of barriers and access to care issues by using inbound and outbound outreach</li> <li>• Random telephonic surveys to members who called the Plan's Member Services department assessing their satisfaction with the Plan's Member Services</li> <li>• Conduct ongoing training designed to develop and refine staff customer service skills and increase knowledge regarding Plan benefits and services</li> <li>• Conduct telephonic member outreach welcoming new members to the Plan. During calls, members are offered assistance with choosing a PCP, education regarding Plan benefits and completion of a Personal Information Form used to obtain demographic information and member's current health status</li> <li>• Collaborate with DMS Eligibility Department as well as the Plan's Enrollment Department to expedite updates</li> <li>• Collaborate with Department of Community Based Services (DCBS) to understand the members experience from both Passport Health Plan and DCBS</li> </ul> <p><u>Improve member satisfaction with how well doctors communicate through:</u></p> <ul style="list-style-type: none"> <li>• Monitor member complaints against PCPs and specialists via semi-annual complaint reports and conducting outreach to those providers not meeting Plan standards</li> <li>• Continue assessing member satisfaction with doctor communication as a component of the Specialist Provider Recognition Program via telephonic member surveys</li> <li>• Post a training tool on the Plan's website for practitioners and office staff on ways to improve patient satisfaction</li> <li>• Educate PCPs and specialists regarding member satisfaction at every opportunity, including annual practice management seminar, provider workshops, roundtables, site visits and Plan web site.</li> </ul>

IPRO Recommendation	Passport Health Plan Response
	<p><b>Outcome and Monitoring</b>  Each year the Plan contracts with an NCOA certified survey vendor to conduct a member satisfaction survey assessing members' satisfaction with the health plan as well as care and services provided by participating providers. Two surveys are conducted, one for the adult population and one for the child and adolescent population. Utilizing NCOA's nationally recognized survey allows for uniform measurement of members' health care experiences thus allowing for comparison of results across various health plans. NCOA only releases national comparisons benchmarks for the adult satisfaction survey and as such, no national comparisons are made for the results of the child and adolescent survey. Passport Health Plan uses these results to identify areas of strength and weakness in order to improve services to members.</p> <p>Ratings measure how members of the Plan feel about major areas of their health care. These areas include:</p> <ul style="list-style-type: none"> <li>• Health Plan</li> <li>• Specialist</li> <li>• Personal Doctor or Nurse</li> <li>• Health Care</li> </ul> <p>Composite scores measure how well the Plan meets members' satisfaction in key areas and include:</p> <ul style="list-style-type: none"> <li>• Getting Needed Care</li> <li>• Getting Care Quickly</li> <li>• How Well Doctors Communicate</li> </ul> <p><b>Future Actions/Plans</b>  Collaborate with the Plan's NCOA certified survey vendor to increase survey responses. Continue to monitor current interventions and implement new interventions as appropriate.</p>

**Figure 13: DMS Response to Recommendations Issued in 2011 Technical Report**

IPRO Recommendation	KDMS Response
<p>§ DMS should continue collaborative efforts to assist Passport Health Plan in enhancing its policies and procedures, training, reporting, analysis and compliance with federal and state laws and regulations related to fraud and abuse in order to meet DMS expectations.</p>	<p>Initial Plan of Action</p> <ul style="list-style-type: none"> <li>• DMS/OIG will continue to provide training and workshops for both DMS/Passport Health Plan.</li> <li>• DMS will establish contact and meet with Passport Health Plan’s fraud and abuse coordinator to review compliance issues related to the Passport Health Plan’s contract.</li> <li>• DMS will review Passport Health Plan’s policies and procedures related to all aspects of member and provider fraud and abuse and provide input to further assist Passport Health Plan in their efforts to deter or identify these issues.</li> <li>• DMS will review and analyze reports submitted by Passport Health Plan to verify information is warranted and provide input and/or change report content.</li> <li>• DMS, if warranted will continue to amend the contract to set timeframes and clarify content regarding Passport Health Plan’s contract deliverables.</li> </ul> <p>How was this accomplished?</p> <ul style="list-style-type: none"> <li>• DMS continues to provide training to Passport Health Plan.</li> <li>• Contract amended regarding deliverables but not time constraints.</li> </ul> <p>Outcome and Monitoring</p> <ul style="list-style-type: none"> <li>• DMS has continued to monitor Passport Health Plan’s reporting for content and accuracy. Passport Health Plan needs to continue to improve reporting deliverables and provide feedback to Passport Health Plan as warranted.</li> </ul> <p>Future Actions/Plans</p> <ul style="list-style-type: none"> <li>• Continue to have workshops related to fraud and abuse. Provide updates to Passport Health Plan related to fraud and abuse issues on both the state and federal level.</li> <li>• Onsite review and monitoring of Passport Health Plan’s fraud and abuse day to day activities.</li> <li>• DMS Program Integrity staff will follow-up as needed with appropriate Passport Health Plan staff on issues, areas of concern and focus areas.</li> <li>• DMS will amend Passport Health Plan’s contract to meet the requirements of Program Integrity fraud and abuse section.</li> <li>• DMS will encourage Passport Health Plan to continue to evaluate potential racial and ethnic disparities.</li> </ul>
<p>§ Additional opportunities for DMS for collaborative improvement efforts with Passport Health Plan were identified in the annual review, including ongoing work on coordination of behavioral health and physical health, and the</p>	<p>Initial Plan of Action</p> <ul style="list-style-type: none"> <li>• Passport Health Plan assigned behavioral health liaison to interact with Passport Health Plan members at Seven Counties community mental health center.</li> </ul> <p>How was this accomplished?</p> <ul style="list-style-type: none"> <li>• Behavioral health liaison obtained release of information signatures from Passport Health Plan members while at Seven Counties site.</li> <li>• Behavioral health liaison also collected information regarding member’s race, ethnicity and language data,</li> </ul>

IPRO Recommendation	KDMS Response
<p>collection of race, ethnicity and language data to monitor for disparities.</p>	<p>current address and phone number.</p> <ul style="list-style-type: none"> <li>• Passport Health Plan's database was updated with current information.</li> <li>• Passport Health Plan provided information to DMS member service line.</li> </ul> <p>Outcome and Monitoring</p> <ul style="list-style-type: none"> <li>• Member information updated</li> <li>• Passport Health Plan case managers provided information to both physical and behavioral health providers regarding member's return on investment (ROI) status.</li> <li>• DMS will review a monthly report of Passport Health Plan's activities at Seven Counties and other community mental health centers.</li> </ul> <p>Future Actions/Plans</p> <ul style="list-style-type: none"> <li>• DMS will encourage Passport Health Plan to have a behavioral health liaison outreach to more than one community mental health center.</li> </ul>
<p>§ Encounter data validation and benchmarking studies revealed opportunity for further work with Passport Health Plan to explore the impact of factors such as retroactive enrollment, denials and notification dates to ensure consistency of data systems.</p>	<p>Initial Plan of Action</p> <ul style="list-style-type: none"> <li>• DMS will monitor Passport Health Plan's encounter data for accuracy and completeness.</li> </ul> <p>How was this accomplished?</p> <ul style="list-style-type: none"> <li>• EQRO submits a monthly encounter data validation report to DMS.</li> <li>• DMS reviews report for accuracy, missing required data and number of encounters.</li> </ul> <p>Outcome and Monitoring</p> <ul style="list-style-type: none"> <li>• Pharmacy NPI numbers and dental claims seem to be a primary issue.</li> <li>• DMS will continue to monitor to resolve issues.</li> </ul> <p>Future Actions/Plans</p> <ul style="list-style-type: none"> <li>• DMS MMIS staff will monitor encounter data on a monthly basis.</li> </ul>

## APPENDIX A – Medicaid Managed Care Compliance Monitoring

### Objectives

Each annual detailed technical report must contain data collected from all mandatory EQR activities. Federal regulations at 42 CFR 438.358, delineate that a review of an MCO's compliance with standards established by the State to comply with the requirements of § 438.204(g) is a mandatory EQR activity. Further, for plans that were in operation prior to the current review, the evaluation must be conducted within the previous three-year period, by the State, its agent or the EQRO.

DMS annually evaluates the MCOs' performance against contract requirements and state and federal regulatory standards through its EQRO contractor. In an effort to prevent duplicative review, federal regulations allow for use of the accreditation findings, where determined equivalent to regulatory requirements. For purposes of the review of the Kentucky MCOs, no requirements were deemed via accreditation.

A full review of all requirements was conducted for the MCOs new to Kentucky's Medicaid Managed Care program. All domains listed were evaluated for compliance to contractual requirements and standards, as were any corresponding files. Passport Health Plan received a partial review including: standards subject to annual review; initial review of applicable contract changes; standards previously rated as less than fully compliant; and standards due for review (previously reviewed more than 3 years ago).

The annual compliance review for the contract year November 2011 - December 2012, conducted in March 2013, addressed contract requirements and regulations within the following domains:

- § Behavioral Health Services
- § Case Management/Care Coordination
- § Continuity and Coordination of Care: Behavioral and Physical Health Care
- § Enrollee Rights and Protections: Enrollee Rights
- § Enrollee Rights and Protections: Member Education and Outreach
- § EPSDT
- § Grievance System
- § Health Risk Assessment
- § Medical Records
- § Pharmacy Benefits
- § Program Integrity
- § QAPI: Access
- § QAPI: Access - Utilization Management
- § QAPI: Measurement and Improvement
- § QAPI: Measurement and Improvement – Health Information Systems
- § QAPI: Structure and Operations - Credentialing
- § QAPI: Structure and Operations - Delegated Services

Data collected from the MCOs, either submitted pre-onsite, during the onsite visit or in follow-up, was considered in determining the extent to which the health plan was in compliance with the standards. Further descriptive information regarding the specific types of data and documentation reviewed is

provided in the section “Description of Data Obtained” listed below and in this report under subpart, “Compliance Monitoring.”

#### Technical Methods of Data Collection

In developing its review protocols, IPRO followed a detailed and defined process, consistent with the CMS EQRO protocols for monitoring regulatory compliance of MCOs. For each set of standards reviewed, IPRO prepared standard-specific tools with standard-specific elements (i.e., sub-standards). The tools include the following:

- § Statement of state and MCO contract requirements and applicable state regulations
- § Suggested evidence
- § Prior results
- § Reviewer compliance determination
- § Descriptive reviewer findings and recommendations related to the findings
- § Review determinations

In addition, where applicable (e.g., member grievances), file review worksheets were created to facilitate complete and consistent file review.

Reviewer findings on the tools formed the basis for assigning preliminary and final designations. The standard designations used were as follows:

Standard Designations	
Full Compliance	MCO has met or exceeded the standard
Substantial Compliance	MCO has met most requirements of the standard, but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements of the standard, but has significant deficiencies requiring corrective action
Non-Compliance	MCO has not met the standard and requires corrective action
Not Applicable	The standard does not apply to the MCO

Pre-Onsite Activities – Prior to the onsite visit, the review was initiated with an introduction letter, documentation request, and request for eligible populations for all file reviews.

The documentation request is a listing of pertinent documents for the period of review, such as policies and procedures, sample contracts, program descriptions, work plans and various program reports.

The eligible population request is a request for case listings for file reviews. For example, for member grievances, a listing of grievances for a selected quarter of the year; or, for care coordination, a listing of members enrolled in care management during a selected quarter of the year. From these listings, IPRO selected a random sample of files for review onsite.

Additionally, IPRO began its “desk review”, or offsite review, when the pre-onsite documentation was received from the plan.

Prior to the review, a notice was sent to the MCOs including a confirmation of the onsite dates, an introduction to the review team members and the onsite review agenda.

Onsite Activities – The onsite review commenced with an opening conference where staff was introduced, and an overview of the purpose and process for the review and onsite agenda were provided. Following this, IPRO conducted a review of the additional documentation provided onsite, as well as the file reviews. Staff interviews were conducted to clarify and confirm findings. When appropriate, walkthroughs or demonstrations of work processes were conducted. The onsite review concluded with a closing conference, during which IPRO provided feedback regarding the preliminary findings, follow-up items needed and the next steps in the review process.

#### Description of Data Obtained

As noted in the Pre-Onsite Activities, in advance of the review, IPRO requested documents relevant to each standard under review, to support the health plan's compliance with federal and state regulations and contract requirements. This included items such as: policies and procedures; sample contracts; annual QI Program Description, Work Plan, and Annual Evaluation; Member and Provider Handbooks; access reports; committee descriptions and minutes; case files; program monitoring reports; and evidence of monitoring, evaluation, analysis and follow-up. Additionally, as reported above under Onsite Activities, staff interviews, demonstrations, and walkthroughs were conducted during the onsite visit. Supplemental documentation was also requested for areas where IPRO deemed it necessary to support compliance. Further detail regarding specific documentation reviewed for each standard for the 2012 review is contained in the Compliance Monitoring section of this report.

#### Data Aggregation and Analysis

Post-Onsite Activities – As noted earlier, each standard reviewed was assigned a level of compliance ranging from Full Compliance to Non-Compliance. The review determination was based on IPRO's assessment and analyses of the evidence presented by the health plan. For standards where the plan was less than fully compliant, IPRO provided a narrative description of the evidence reviewed in the review tool, and reason for non-compliance. The plan was provided with the preliminary findings with the opportunity to submit a response and additional information for consideration. In accordance with the DMS/MCO contract, the MCO is required to submit a written corrective action plan to address any findings rated as "Minimal" or "Non-Compliant". At this time, IPRO is in the process of reviewing any responses submitted by the plan and will make final review determinations in the coming months.

## APPENDIX B – Validation of Medicaid Managed Care Performance Improvement Projects

### Objectives

Medicaid Managed Care Organizations (MCOs) implement Performance Improvement Projects (PIPs) to assess and improve processes of care and, as a result, improve outcomes of care. The goal of the PIP is to achieve significant and sustainable improvement in clinical and nonclinical areas. A mandatory activity of the External Quality Review Organization (EQRO) under the BBA is to review the PIP for methodological soundness of design, conduct and report to ensure real improvement in care and confidence in the reported improvements.

The Performance Improvement Projects (PIPs) were reviewed according to the Centers for Medicare and Medicaid (CMS) protocol described in the document “Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities”. The first process outlined in this protocol is assessing the methodology for conducting the PIP. This process involves the following ten elements:

- § Review of the selected study topic(s) for relevance of focus and for relevance to the MCO’s enrollment.
- § Review of the study question(s) for clarity of statement.
- § Review of selected study indicator(s), which should be objective, clear and unambiguous and meaningful to the focus of the PIP.
- § Review of the identified study population to ensure it is representative of the MCO enrollment and generalizable to the plan’s total population.
- § Review of sampling methods (if sampling was used) for validity and proper technique.
- § Review of the data collection procedures to ensure complete and accurate data was collected.
- § Assessment of the improvement strategies for appropriateness.
- § Review of the data analysis and interpretation of study results.
- § Assessment of the likelihood that reported improvement is “real” improvement.
- § Assessment of whether the MCO achieved sustained improvement.

Following the review of the listed elements, the review findings are considered to determine whether or not the PIP findings should be accepted as valid and reliable. In addition to validating and scoring the PIPs, IPRO provided ongoing technical assistance to the MCOs as part of its EQR tasks.

### Technical Methods of Data Collection

Methodology for validation of the PIPs was based on CMS’ “Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities.” Each PIP submitted by the MCOs was reviewed using this methodology, and each of the ten protocol elements was considered. A reporting template was designed by IPRO in order to collect the information and data necessary to review the projects. IPRO provided a narrative summary review, detailing project strengths and opportunities for improvement at the proposal and interim report phases and a scored review at the demonstrable and sustained improvement phases. An assessment of each project in progress was conducted using tools developed by IPRO, approved by DMS, and consistent with the CMS EQR protocol for performance improvement project validation.

### Description of Data Obtained

Each PIP was validated using the MCOs' PIP project reports. Technical assistance was provided during conference calls and interviews of MCO staff during the onsite compliance reviews in March 2013.

### Data Aggregation and Analysis

At the proposal and interim report phases, a narrative summary review was produced, detailing project strengths and opportunities for improvement for each element applicable to the project at the time of the review. Overall credibility of results was assessed at the interim report phase. At the demonstrable and sustained improvement phases of the project, a scored review and validation was conducted to assess overall credibility of results. Review elements were assessed using a scale of Met, Partially Met, and Not Met. Each element was weighted and assigned a point value, adding to a total of 80 points for the demonstrable improvement phase and 100 points for the sustained improvement phase. Additional state-specific review elements to address contract requirements, such as methods to maintain member confidentiality; member involvement in the project; assessment of overall return on investment; and dissemination of findings were included in the review tool.

A report of the findings, strengths of each PIP and opportunities for improvement for each protocol element necessary for a valid PIP are documented in the Technical Report.

## APPENDIX C – Validation of Performance Measures

### Objectives

Medicaid Managed Care Organizations (MCOs) calculate performance measures to monitor and improve processes of care. As per the CMS Regulations, validation of performance measures is one of the mandatory EQR activities. The methodology for validation of performance measures was based on CMS *Validating Performance Measures: A protocol for use in Conducting Medicaid External Quality Review Activities* (updated 2012). This protocol was derived from protocols and tools commonly used in the public and private sectors for auditing performance measures, including those used by NCOA, IPRO and MEDSTAT.

The primary objectives of the performance measure validation process are to assess the:

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

### Technical Methods of Data Collection

IPRO requested and received from Passport Health Plan the following documentation related to the *Healthy Kentuckians* outcome measure creation:

- § Data and field definitions;
- § Documentation of the steps taken to:
  - Integrate the data into the health outcome measure data set.
  - Query the data to identify denominators, generate samples, and apply the proper algorithms to the data in order to produce valid and reliable performance measures.
  - Conduct statistical testing of results.
- § Procedures used to determine the measure denominators from the HEDIS<sup>®</sup> denominator base, and how the additional criterion of a PCP visit was applied (where applicable).
- § Medical record abstraction staff qualifications, training, and inter-rater reliability testing;
- § All data abstraction tools and associated materials.
- § Data entry and data verification processes.
- § List of members identified to have numerator positive findings (for sample selection for MRR and administrative where applicable).
- § HEDIS<sup>®</sup> 2012 *Interactive Data Submission System (IDSS)* report for the Medicaid product line.
- § HEDIS<sup>®</sup> 2012 *Final Audit Report, for the Medicaid Product Line*.
- § Table of measures including measure/numerator name, denominator value, numerator value and rate.

IPRO reviewed the documentation and verified that prior recommendations were implemented, and that other processes remained consistent with the previous reporting period.

## Performance Validation Review Methodology

IPRO auditors followed methodology consisting of:

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

Note that several of the measures are derived directly from HEDIS<sup>®</sup>, including: Adult BMI Assessment, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Controlling High Blood Pressure, Annual Dental Visit, Lead Screening for Children, Well-Child Visits in the First 15 months of Life, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Adolescent Well-Care Visits, and Children's' and Adolescents' Access to PCPs. These measures were independently audited by an NCOA licensed audit organization as part of Passport Health Plan's annual HEDIS<sup>®</sup> Compliance Audit<sup>™</sup>. Therefore, in accordance with the CMS EQRO provisions for non-duplication of activities, IPRO did not address those measures in its validation process. Rather, the focus was validating the State-specific measures.