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Department for Medicaid Services
Division of Program Quality and Outcomes

Managed Care Program Progress Report
IPRO/DMS Contract Year 2
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Background and Introduction

The Commonwealth of Kentucky's report, Strategy for Assessing and Improving the Quality of Managed Care Services, outlines a strategy for quality oversight that is aligned with federal regulations and pursuant to the Social Security Act (Part 1915[1] and Part 1932(a)),[2] the Balanced Budget Act of 1997 and Title 42,[3] Part 438 of the Code of Federal Regulations (CFR).[4]

According to the Social Security Act (42 CFR Part 1932(a)) each state that contracts with Medicaid managed care organizations (MCOs) is required to provide for an external independent quality review. The Balanced Budget Act of 1997 further described mechanisms states should use in monitoring Medicaid MCO quality and in early 2003, the Centers for Medicare and Medicaid Services (CMS) issued a final rule defining the requirements for external quality review and state quality monitoring.[5]

The purpose of this report is to summarize information from the external quality review activities that describe the status and progress that has occurred in Kentucky's Medicaid Managed Care Program during the period of July 1, 2013 through June 30, 2014. Key reports referenced while preparing this Progress Report include the following:

- Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services, September 2012[6]
- The External Quality Review Technical Report for MCO contract year(s) 2011–2013[7]
- The Comprehensive Evaluation Summary, July 2014[8]
- 2013–2014 MCO Compliance Report findings
- A Member's Guide to Choosing a Medicaid Health Plan, 2014
- Kentucky Medicaid Management Information System (MMIS)Encounter Validation Report, July 2014
- Proposed Encounter Data Completeness Studies, April 2014
- EPSDT Screening Encounter Data Validation, Clinical Focused Study 2014, May 2014
- Proposal for Access and Availability Surveys for Behavioral Health Providers "Secret Shopper," April 2014
- Validation of Managed Care Provider Network Submissions: Audit Report, June 2013
- Web-Based Provider Directory Validation Study 2013, completed January 2014
- Kentucky Newborn Readmissions Focused Study, March 2014
- Kentucky Postpartum Readmissions Focused Study, January 2014
- Kentucky Behavioral Health Study, July 2014
- 2014 Focused Study Proposal: Experience of Care for Children with a Behavioral Condition

EQRO Activities Overview

Federal regulations list three mandatory and five optional external quality review activities for states that provide care to Medicaid enrollees.[9] Kentucky's Department of Medicaid Services (DMS) has a contract with Island Peer Review Organization (IPRO), an external quality review organization (EQRO), to conduct all of the three mandatory review activities as well as many of the optional activities. The Kentucky EQRO work plan includes the following activities:

- Validate performance improvement projects (PIPs)
- Validate plan performance measures
- Conduct review of MCO compliance with state and federal standards
- Validate encounter data
- Validate provider network submissions
- Develop MCO Quality Dashboard
- Develop annual health plan report card
- Conduct focused studies
- Prepare EQRO technical report

- Provide technical assistance and presentations as needed
- Conduct Access and Availability surveys as needed

Managed Care Organizations

As of July 2011, there were four Medicaid MCOs in Kentucky: University Health Care (doing business as (dba) Passport Health Plan) and three newly contracted MCOs, Coventry Health and Life Insurance Company (dba CoventryCares of Kentucky); Kentucky Spirit Health Plan, Inc.; and WellCare of Kentucky, Inc. On July 5, 2013, a little more than a year after implementation, Kentucky Spirit Health Plan notified DMS that they would stop providing managed care services to Medicaid beneficiaries. The state successfully procured a new contract with Humana-CareSource and the transition of enrollees from Kentucky Spirit Health Plan was underway during the latter half of 2013.

As a result of the Patient Protection and Affordable Care Act (ACA), Medicaid eligibility was expanded in Kentucky. Anthem Blue Cross Blue Shield was subsequently contracted to provide additional coverage to Medicaid expansion members, which included all regions of the state except Region 3 (Jefferson County and 15 surrounding counties) and contracted with Passport Health Plan to cover Medicaid expansion enrollees statewide and Region 3. Over the last seven months, Kentucky Spirit Health Plan enrollment has been successfully transitioned to the other Medicaid MCOs.

Enrollment/Regions

Enrollment in Kentucky's Medicaid Managed Care Program has been steadily increasing. As of December 30, 2011, 172,559 Medicaid beneficiaries were enrolled in one managed care plan, Passport Health Plan.[10] By August 2013, there were 698,377 enrolled in managed care and within another year, enrollment increased 48.2% to just over a million. Humana-CareSource showed the greatest percent increase in enrollment (+378.8%) over the last year, followed by Passport Health Plan (+60.8%), WellCare of Kentucky (+39.5%) and CoventryCares of Kentucky (+14.5%). Currently 89.5% of the Medicaid eligible population is enrolled in managed care (Table 1).

Table 1. Medicaid Enrollment between August 26, 2013 and August 25, 2014

MCO	Enrollment 8/26/2013	Enrollment 8/25/2014	Percent Change	Service Area
Anthem Blue Cross Blue Shield	NA	44,405	NA	Statewide except Region 3
CoventryCares Health Plan	269,260	308,345	+14.5%	Statewide
Humana-CareSource	16,599	79,481	+378.8%	Region 3
Passport Health Plan	127,347	204,746	+60.8%	Statewide
WellCare of Kentucky	285,171	397,899	+39.5%	Statewide
Managed Care Total	*698,377*	*1,034,876*	*+48.2%*	Statewide
Fee-for-Service	122,469	121,096	-1.1%	Statewide
Total Medicaid	*820,846*	*1,155,972*	*+40.8%*	Statewide

NA: not applicable, no enrollment in 2013

Responsibility for Program Monitoring

In mid-2013, DMS implemented an internal re-organization to better address its responsibilities for monitoring and oversight of an expanding Medicaid Managed Care Program. A new division within DMS, the Division of Program Quality and Outcomes (DPQ&O), was created and consisted of two branches: (1) Disease and Case Management Branch and (2) Managed Care Oversight – Quality Branch. The Managed Care Oversight – Quality Branch oversees the EQRO contract and works with the EQRO to develop better quality initiatives for the DMS program.

The Managed Care Oversight-Contract Management Branch was created within the Division of Policy and Operations to monitor MCO contract compliance and to perform audits of MCO system/processes to assess the accuracy of data in the MCO reports.

New leadership positions were created and several new staff appointments were recently completed. Overall, the state has vigorously applied new staff resources and expertise to the development of their expanding Medicaid Managed Care Program which will serve to provide direction and cohesiveness for the program moving forward.

Benefits

Kentucky's Medicaid Managed Care Program offers a comprehensive benefit plan for enrollees.[11] Enrollee benefit information is made available to new enrollees as they become eligible and to all enrollees during the open enrollment period. Information regarding benefits is provided on the DMS Medicaid website, Member Information page. The Kentucky Medicaid Member Handbook also provides an overview of the benefits members are entitled to receive through the Kentucky Medicaid Benefit Plan.

Beginning on January 1, 2014, all members were to be in the same benefit plan. The Benefit Plan covers basic medical services including acute inpatient hospital services; outpatient hospital/ambulatory surgical centers; laboratory, diagnostic and radiology services; physician office visits; preventive services; early and periodic screening, diagnosis and treatment (EPSDT); emergency ambulance and hospital emergency room services; occupational, physical and speech therapy; hospice, chiropractic, hearing and vision services; prosthetic devices; and durable medical equipment.

Also included in the benefit package are behavioral health services; dental services; maternity services; prescription drugs; home healthcare; substance abuse; family planning; podiatry; and end-stage renal disease and transplants. While a number of services require a small co-payment, some people covered by Medicaid are exempt, including non-KCHIP (children not in Kentucky's Child Health Plus Program), children under 19 years who are in foster care, pregnant women, as well as hospice care and home care patients. Also, while the Benefit Plan sets co-payments and limits for each benefit category, many of the Medicaid MCOs have opted to augment the benefits and/or services by removing co-payments and offering additional services such as member rewards and gift incentives, free mobile phone service, and 24-hour nurse advice lines, to name a few.[12]

Data Systems Validation

Kentucky Medicaid MCOs are required to maintain a Management Information System (MIS) to support all aspects of managed care operation including member enrollment, encounter data, provider network data, quality performance data, claims, and surveillance utilization review to identify fraud and/or abuse by providers and members. During the progress report period from July 1, 2013 to June 30, 2014, the EQRO validated encounter data submissions, EPSDT encounter data screening submissions, provider network submissions, and MCO web-based provider directories. Healthy Kentuckians data submissions were also audited based on validation protocols prepared by CMS.

Encounters

Encounters are defined as professional face-to-face transactions between an enrollee and a provider (either a person or facility) that delivers service and includes all procedures and services rendered during the contact. MCOs are required to submit all Medicaid managed care encounters to DMS on at least a monthly basis.

May 2013 was the first month for submitting encounter data for the expansion MCOs. Passport Health Plan had previously submitted encounters for seven years prior to the expansion of managed Medicaid, but in June of 2012, Passport Health Plan's files submission to IPRO were temporarily suspended when the EQRO contract ended. Passport Health Plan continued to submit the files to DMS. Encounter file creation was resumed after all plans successfully submitted files in the 5010 format and the change order for the file layouts was completed by DMS. Humana-CareSource has been submitting encounters since mid-2013, while Anthem Health Plan recently began submissions in June 2014.

Each month, the EQRO receives a final extracted file from DMS, and creates a monthly data validation report summarizing the MCO submissions. The format of this report has two parts: a file validation report and an intake report. In both reports, data are presented for all MCOs and for each MCO separately. The validation report presents the number and percent of missing data and the number and percent of invalid data for each encounter variable. A separate validation table is created for encounter type, including inpatient, outpatient, professional, home health, long-term care, dental and pharmacy. The intake report presents the number of encounters submitted to Kentucky MMIS and includes encounter volume reports by place of service.

The Monthly Encounter Data Validation Report prepared in July 2014 reviewed encounters between August 1, 2013 and July 31, 2014. The total number of monthly encounters increased from 5.4 million in August 2013 to 6.2 million through July 2014, an increase of 14%. A review of missing data elements by place of service indicates a number of variables that consistently have a high percentage missing, including diagnoses codes 4 and above, performing provider key, inpatient procedure codes, procedure modifier codes, referring provider key, and inpatient and outpatient surgical ICD-9 codes. For the month of July 2014, provider-related information was missing several notable elements including National Provider Identification (PFI) number (55% of encounters), Provider License Number (46% of encounters) and Taxonomy (56% of encounters). DMS continues to work with the MCOs, the EQRO and appropriate divisions of DMS to review MCO progress in encounter data quality and

completeness, and to troubleshoot issues in need of improvement. Monthly meetings between DMS and the MCOs have greatly helped the plans in working out their shortcomings regarding missing and incomplete encounter data. DMS is hiring new staff to work with the monthly validation reports and address the issues identified.

The EQRO proposed an encounter data completeness study entitled "Encounter Data Validation and Data Benchmarking." The purpose of this study is to compare MCO-specific HEDIS®[13] (Healthcare Effectiveness Data and Information Set) rates submitted by the MCOs to NCQA with rates produced from the encounter data warehouse. A sample of this method was prepared by the EQRO and presented to DMS using the following measures: Breast Cancer Screening, Adult Access to Preventive/Ambulatory Health Services, Children's Access to Primary Care Practitioners, and Annual Dental Screening. The EQRO calculated measure rates from submitted encounter data and compared them using plan submitted HEDIS® data. A follow-up, Phase-2 study will use the HEDIS® 2014 submitted rates from the MCOs.

EPSDT Screening Encounter Data Validation

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

Developmental Screening in the First Three Years of Life is a measure in the Children's Health Insurance Program Reauthorization Act (CHIPRA) core measure set that examines the percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding their first, second or third birthday. This screening can be represented in encounter data by Current Procedural Terminology (CPT) code 96110, but the code has been shown to have questionable validity. To assess the validity in the use of code 96110 among providers in the Kentucky Medicaid Managed Care Program, two stratified random samples were selected from each of the four MCOs:

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

According to the final report, completed May 2014, the EQRO found that encounter codes evaluated in each cohort did not completely reflect the provision of a comprehensive well-child visit or developmental screening as described in standard clinical guidelines or EPSDT requirements.

Provider Network

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

The EQRO completed an audit of Kentucky's Provider Network Submissions in June 2013 and a validation of MCO web-based provider directories in January 2014. The 2013 Provider Network Validation used a sample of providers randomly selected from Kentucky's Managed Care Assignment Processing System (MCAPS). One hundred primary care providers (PCPs) and 100 specialists from each MCO received surveys. With an overall response rate of 63.7%, returned responses validated information that was correct in the MCAPS data system and reported revisions that should be made to incorrect data. A total of 252 providers (48.4%) who returned the survey noted at least one revision. Errors were most commonly found in telephone numbers, provider license numbers, and street addresses. The EQRO sent each MCO a report which included a list of provider-noted changes and a list of incorrect addresses, and requested that the MCOs update their provider directory file with this information. DMS found the results of the survey informative in addressing issues related to access to service, particularly for providing accurate provider information, such as addresses and phone numbers, which is important for enrollees.

A different track for validating MCO Provider Network data was taken with the 2014 Web-Based Provider Directory Study. Each MCO was asked to submit the file that they used to populate their MCO's web directory. The EQRO selected a random sample of 200 providers (100 PCPs and 100 specialists) from each MCO web directory file. The information on the web directory file for each of these providers was then compared to information submitted to the MCAPS for each provider and discrepancies were noted. WellCare of Kentucky had the lowest match rate for both PCPs and specialists resulting in a provider match rate of 88% and 85%, respectively. The percentage of providers in the web directory that had consistent data reported for all elements when compared to the MCAPS file ranged from 47% (Passport Health Plan) to 100% (Humana-CareSource) for PCPs and from 0% (Passport Health Plan and WellCare of Kentucky) to 100% (Humana-CareSource) for specialists. The DMS Managed Care Oversight – Quality Branch conducted meetings with each MCO to discuss the findings of the audit and is working with the MCOs to maintain an accurate provider database.

Quality Performance

Quality performance data is the framework upon which quality assurance and improvement activities are based. MCOs are responsible for contracting with a certified HEDIS®[14] auditor to conduct a National Committee for Quality Assurance (NCQA)-approved audit prior to submitting their HEDIS® and CAHPS® (Consumer Assessment of Healthcare Providers and Systems[15]) data to DMS. Healthy Kentuckians, HEDIS® and CAHPS® data were successfully submitted by CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky in June 2014 for services provided in the 2013 measurement year (MY). DMS elected not to rotate any of the HEDIS® measures selected for rotation by NCQA. DMS is reviewing the possibility of rotation of HEDIS® measures for future submissions.

The EQRO validated the Healthy Kentuckians data based on the CMS protocol: *Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities (updated 2012)*[16]. All audit findings were compiled as part of the EQRO's validation of quality performance data. Audit reports were prepared along with HEDIS® and Healthy Kentuckians measure results. The performance validation methodology includes an information systems capabilities assessment; denominator validation; data collection validation and numerator and rate validation.

MCO Performance Annual Health Plan Report Card

The EQRO summarized HEDIS®2013 quality performance data in Kentucky's first consumer-friendly document entitled "A Member's Guide to Choosing a Medicaid Health Plan." Copies of the guide were included in mailings during open enrollment and the guide was also available on the DMS Medicaid Managed Care webpage. A similar guide was developed with HEDIS® and CAHPS® 2014 data and is posted on the DMS website at: http://www.chfs.ky.gov/dms/member+information.htm#plans.

MCO Performance Dashboard

For DMS internal monitoring purposes, the EQRO designed an MCO Performance Dashboard to pictorially describe national, statewide and MCO-specific performance on selected quality measures using graphs and charts. The initial version of the MCO Performance Dashboard presented HEDIS® 2013 data and was posted on the EQRO's website. The EQRO and DMS are currently developing the format for presenting HEDIS® 2014 and Healthy Kentuckians data as well as other indicators of quality used by DMS for MCO monitoring. They are also considering a more public posting of each MCO's quality performance data information.

Compliance with State and Federal Standards

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 NCQA accreditation findings, where they are determined equivalent to regulatory requirements.

A full review of all requirements was conducted for the MCO new to Kentucky's Medicaid Managed Care Program (Humana-CareSource). All review domains were evaluated for compliance with contractual requirements and standards, as were any corresponding files. Passport Health Plan also received a full review, as this was the first year under new contract requirements. CoventryCares of Kentucky and WellCare of Kentucky underwent a partial review including: standards subject to annual review; initial review of applicable contract changes; and standards previously rated as less than fully compliant during the prior review.

The annual compliance review for the contract year January, 2013–December, 2013, conducted in March 2014, addressed contract requirements and regulations within the following domains:

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

Data is collected from the MCOs prior to the survey, during the onsite visit or in follow-up. All data submitted to the EQRO are considered in determining the extent to which the health plan is in compliance with the standards.

Reviewer findings on the review tools formed the basis for assigning preliminary and final designations. The standard designations used are listed in Table 2.

Table 2. Standard Designations for Compliance Review

Standard Designations for Compliance		Points
Full Compliance	MCO has met or exceeded the standard.	3
Substantial Compliance	MCO has met most requirements of the standard, but may be deficient in a small number of areas.	2
Minimal Compliance	MCO has met some requirements of the standard, but has significant deficiencies requiring corrective action.	1
Non-Compliance	MCO has not met the standard and requires corrective action.	0
Not Applicable	The standard does not apply to the MCO.	N/A

Each element within a review category receives one of the determinations listen in Table 2 and a score for each determination (3 points for full compliance; 2 points for substantial compliance; 1 point for minimal compliance; and 0 points for non-compliance). The numerical score for each review category is then calculated by adding the points achieved for each element and dividing by the number of elements. Thus, an MCO may have some elements within a category deemed minimally compliant or non-compliant, but when averaged with other elements, the overall average for that category may still indicate substantial compliance. The overall compliance determination is assigned 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-Compliant: point average of 0–0.99, and
- Not Applicable

Table 3 summarizes each MCO's review findings for each category of review in 2014. Upon receipt of the final findings, the MCOs are instructed to prepare a response for all elements assigned Full Compliance with a recommendation and all elements designated with Substantial Compliance. A Corrective Action Plan (CAP) is required for all elements deemed minimal compliant or non-compliant.

Table 3. Overall Compliance Determinations by Review Category – 2014

Tool #/Review Area	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky
1. Quality Measurement and Improvement (QI/MI)	Substantial	Substantial	Substantial	Full
2. Grievance System	Substantial	Substantial	Substantial	Substantial
3. Health Risk Assessment	Minimal	Substantial	Substantial	Substantial
4. Credentialing and Recredentialing	Substantial	Substantial	Substantial	Substantial
5. Access	Substantial	Substantial	Substantial	Substantial
5a. Access - UM	Substantial	Substantial	Substantial	NA
6. Program Integrity	Minimal	Substantial	Full	Substantial
7. EPSDT	Substantial	Substantial	Substantial	Full
8. Delegation	Substantial	Full	Full	Substantial
9. Health Information Systems	Full	Full	Full	Full
10. Care Management	Substantial	Substantial	Substantial	Substantial

Tool #/Review Area	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky
12a. Enrollee Rights	Non-Compliant	Substantial	Full	Substantial
12b. Member Outreach	NA	Full	Full	Full
13. Medical Records	Substantial	Substantial	Substantial	Full
15. Behavioral Health Services	Substantial	Substantial	Substantial	Substantial
16. Pharmacy Benefit	NA	Substantial	Full	Full
Total (#)/% of Elements Requiring Corrective Action	(37/223)/17%	(34/803)/4%	(16/817)/2%	(5/252)/2%

Health Information Systems was the only review area to have full compliance for all four Kentucky MCOs. The evaluation in this area included, but was not limited to, a review of policies and procedures for claims processing; claims payment and encounter data reporting; timeliness and accuracy of encounter data; timeliness of claims payments; and methods for meeting Kentucky Health Information Exchange (KHIE) requirements.

Passport Health Plan and WellCare of Kentucky each had six areas with overall full compliance; Humana-CareSource had three areas with overall full compliance and CoventryCares of Kentucky had only one area (Health Information Systems) with full compliance.

The overwhelming majority of review areas for all plans (69%) exhibited substantial compliance, meaning that most requirements of the standards were met, but there were a small number of deficiencies identified. Many of the deficiencies noted were omissions or lack of clarity in MCO policies and procedures, Provider Manual, or Member Handbook.

CoventryCares of Kentucky received an overall minimal compliance determination for two review areas: Health Risk Assessment (HRA) and Program Integrity. For the HRA review, CoventryCares of Kentucky did not provide any of the 25 member files requested for review. It was also noted that the MCO did not demonstrate that all reasonable efforts were made to contact new members for completion of the health screening questionnaire. Minimal compliance for Program Integrity related to numerous omissions in the MCO's Program Integrity Plan and policies and procedures.

The review of Enrollee Rights for CoventryCares of Kentucky was the only review area to receive an overall non-compliant determination among all areas reviewed for all four MCOs. Evaluation of enrollee rights and responsibilities in the 2013–2014 Compliance Review included an assessment of policies and procedures for member rights and responsibilities, PCP changes and member services functions.

Provider Network Access

Kentucky Medicaid MCOs are required to maintain and monitor a network of appropriate providers and assure that there is adequate provider capacity that is sufficient in number, mix of specialty and geographic distribution. The MCOs are responsible for conducting ongoing reviews of provider credentials and assure that enrollees receive timely access to services within designated time and travel parameters.

Success in meeting these contract provisions is evident in HEDIS® Access and Availability measures, HEDIS® Use of Services, CAHPS® Consumer Satisfaction Survey results and Compliance Review findings.

Compliance with Access Standards

The EQRO's Compliance Review assessment of access included, but was not limited to a review of policies and procedures for direct access services, provider access requirements, program capacity reporting, evidence of monitoring program capacity and provider compliance with hours of operation and availability.

Findings from the 2013–2014 Compliance Review related to provider network access indicated that all Medicaid MCOs received an overall rating of substantial compliance. CoventryCares of Kentucky and WellCare of Kentucky had no elements requiring a corrective action plan, while Humana-CareSource and Passport Health Plan each had only one element that required corrective action.

Access and Availability Survey of Behavioral Health Providers

In 2013, the EQRO conducted a survey requesting each MCO to describe the method they used for surveying provider access and availability of appointments. The responses indicated that each MCO conducted this survey differently, with some, but not all, using a "secret shopper" methodology and some conducting phone calls or on-site visits to determine the next available appointment. Because these surveys use various methods for data gathering, it is difficult to summarize and aggregate results on a state-program level. Corrective actions for providers who fail to comply with the appointment standards are also not standardized and vary by MCO.

The EQRO recommended that the state consider developing one approved method of obtaining rates for provider appointment availability and either conduct a state-sponsored survey or instruct each of the MCOs to conduct the survey using a designated methodology and timeframes. To this end, the EQRO prepared a proposal to conduct access and availability surveys for behavioral health providers using the "secret shopper" methodology. The proposal, submitted to DMS in April 2014, used a random sample of 250 behavioral health providers from each MCO for a total of 1,000 providers. If an MCO had less than 250 providers, then the entire universe for that MCO would be selected. The EQRO used the MCAPS database to select the sample; phone calls to provider offices would occur over a six-month period allowing time for initial phone calls and recalls for providers after obtaining updated phone numbers. The methodology uses several different scenarios for requesting an appointment with the behavioral health provider depending on whether the call is to a psychiatrist (for an adult or child/adolescent member), a psychologist (for adult or child/adolescent member) or a social worker/counselor (for adult or child/adolescent member). The survey is currently on-going.

Board Certification

HEDIS® Board Certification rates illustrate the percentage of physicians in an MCO's provider network who were board certified as of the last day of the MY (December 31, 2013) in the specialties of family medicine, internal medicine, obstetrics/gynecology, pediatrics, geriatrics and other specialties.

Kentucky Board Certification rates for all MCOs for each of the specialty categories were below the 25th national Medicaid percentile, and represent an opportunity for improvement. Passport Health Plan met the 90th percentile for Geriatricians, performed better than the national average for Family Medicine Board Certifications and better than the 25th percentile for Internal Medicine and Pediatrics. CoventryCares of Kentucky had Board Certification rates above the 25th percentile for Internal Medicine, Pediatrics, and Other Physician Specialists. Board Certification rates for all specialties for Humana-CareSource and WellCare of Kentucky were below the 25th percentile.

Access and Use of Services – HEDIS® 2014

HEDIS® Access measures indicate the percentages of children and adults who access their PCP for preventive services, dental services and alcohol and other drug dependence (AOD) treatment. Access to prenatal and postpartum services for Medicaid managed care enrollees are also assessed. HEDIS® Use of Services includes four measures related to access.

Statewide, performance measures related to Access were an area of strength for all four MCOs. Measures for which Kentucky's weighted statewide average met or exceeded the HEDIS®2014 national Medicaid 50th percentile included the following:

- Adult Access to Preventive/Ambulatory Health Services for all age groups
- Children and Adolescents' Access to Primary Care Practitioners for all age groups
- Annual Dental Visit for all age groups
- Timeliness of Prenatal Care
- Call Answer Timeliness
- Frequency of Ongoing Prenatal Care: 81+%

Although strong performance was demonstrated by these Access rates, there remains opportunity for improvement. The HEDIS® 2014 weighted statewide rate for Postpartum Care Visits fell short of the national Medicaid 50th percentile as did Well-Child Visits in the First 15 Months of Life (6+ visits), Well-Child Visits in the Three to Six Years of Life, and Adolescent Well-Care Visits. The weighted statewide rate for Initiation of AOD Dependence Treatment: Total was lower than the national Medicaid 10th percentile, while the weighted statewide rate for Engagement of AOD Dependence Treatment: Total was just below the 25th percentile.

Consumer Satisfaction with Access – CAHPS® 2014

The adult member satisfaction survey was sent to a random sample of members ages 18 years and older as of December 31, 2013, and continuously enrolled for at least five of the last six months of 2013. The child and adolescent member satisfaction survey was sent to the parent/guardian of randomly sampled members ages 17 years and younger as of December 31, 2013, and continuously enrolled for at least five of the last six months of 2013.

Overall, the CAHPS® adult and child surveys showed strong consumer satisfaction with access to care under the Kentucky Managed Care Program (Table 4). The reported child survey rates for Getting Care Quickly were above the national Medicaid average for all four MCOs. For the adults, the Kentucky statewide average was above the national Medicaid average and three of the four MCO

rates were above the national average (CoventryCares of Kentucky, Passport Health Plan and WellCare of Kentucky).

The child survey statewide average for Satisfaction with Customer Service was above the national Medicaid average. While the statewide rate for Adult Satisfaction with Customer Service was slightly below the national Medicaid average, Passport Health Plan and WellCare of Kentucky each exceeded the national average for adult satisfaction with customer service (Table 4).

Table 4. CAHPS® 5.0 Survey Access Measures – Measurement Year 2013

Measure[1]	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	Statewide Average
Adult Survey					
Getting Care Quickly[1]	84.99%	76.00%	85.37%	86.70%	83.85% «
Customer Service[1]	79.53%	84.11%	90.48%	87.03%	85.56%
Child Survey					
Getting Care Quickly[1]	94.03%	89.55%	92.21%	93.02%	92.44% «
Customer Service[1]	87.90%	84.73%	90.13%	88.55%	88.21% «

[1] These indicators are composite measures.

« Weighted statewide average met or exceeded HEDIS® 2014 National Quality Compass average.

Quality Assessment and Performance Improvement

Quality Assessment and Performance Improvement (QAPI) is part of the EQRO's annual compliance review and includes, but is not limited to, a process review of each MCO's Health Information Systems, Credentialing and Delegation Procedures, Utilization Management, Quality Improvement (QI) Program, Annual QI Evaluation, QI Work Plan and QI Committee Structure and Function. In addition to procedure and process measures, the EQRO also reviews MCO performance including a compilation and analysis of quality performance and satisfaction data submitted by Kentucky Medicaid MCOs. In terms of improvement, the EQRO validated MCO performance improvement projects (PIPs) and completed two focused clinical studies during the contract period. This section of the Progress Report outlines and discusses the various quality assessment and improvement activities undertaken as part of Kentucky's Medicaid Managed Care Program.

Health Information Systems:
The compliance review evaluation of MCO Health Information Systems 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. All four MCOs reviewed for compliance with federal and state standards for Health Information Systems received overall full compliance determinations in 2014.

Credentialing:
Kentucky Medicaid MCOs are responsible for ongoing review of provider performance and credentials. As part of the 2013–2014 Compliance Review, the EQRO assessed MCO written policies and procedures regarding the selection and retention of providers in their network. Providers, including individuals and facilities, must be validly licensed and/or certified to provide services in the state, and may also be accountable to a governing body for review of credentials for physicians, dentists, advanced registered nurse practitioners and vision care providers.

Findings from the 2013–2014 Compliance Review indicated that all four MCOs reviewed for Credentialing/Recredentialing received overall substantial compliance ratings. Humana-CareSource and Passport Health Plan were each required to submit two CAPs: Humana-CareSource for omissions in MCO policies and procedures; and Passport Health Plan for lack of evidence of compliance regarding procedures for enrolling providers not participating in the Kentucky Medicaid Program or for offering participation agreements with current Medicaid providers who have received electronic health record incentive funds.

Delegation:
With the approval of DMS, MCOs are allowed to enter into subcontracts for the performance of administrative functions or the provision of services to members. Kentucky MCOs used subcontractors for a variety of purposes such as HEDIS® data collection and record review, claims processing, call centers, behavioral, dental and vision providers, to name a few. MCOs are required to notify DMS in writing, regarding all subcontracts on a quarterly basis and of the termination of a subcontract within ten days of termination.

The 2013–2014 Compliance Review evaluation in this area included, but was not limited to, a review of subcontractor contracts and subcontractor oversight, including subcontractor reporting

requirements and conduct of pre-delegation evaluations and annual, formal evaluations. Humana-CareSource and Passport Health Plan received overall full compliance ratings for their Delegation services and CoventryCares of Kentucky and WellCare of Kentucky each received overall substantial compliance for Delegation. No CAPs were required for any of the four MCOs reviewed.

Utilization Management:
A comprehensive Utilization Management (UM) program reviews services for medical necessity and monitors and evaluates the appropriateness of care and services on a regular basis. Each MCO's UM program is required to have mechanisms in place to check for consistency in the application of clinical review criteria and protocols. The EQRO's Compliance Review included an evaluation of UM policies and procedures, UM committee meeting minutes and a review of a sample of UM cases for CoventryCares of Kentucky, Humana-CareSource and Passport Health Plan. WellCare of Kentucky received a full compliance determination for UM in their previous compliance review and thus this element was not reviewed in 2014.

All three MCOs reviewed for UM in 2014 received overall substantial compliance determinations. Passport Health Plan had two elements that required a CAP and Humana-CareSource had nine non-compliant elements in the review of policies and procedures that required CAPs. CoventryCares of Kentucky did not have any elements requiring a CAP.

Quality Measurement and Improvement:
Findings from the 2013–2014 Compliance Review indicated that WellCare of Kentucky was overall in full compliance for Quality Measurement and Improvement standards while CoventryCares of Kentucky, Humana-CareSource and Passport Health Plan each had overall substantial compliance ratings. Three CAPs were required from Humana-CareSource for minimally compliant elements and two were required from Passport Health Plan. No CAPs were required for CoventryCares of Kentucky.

Performance Measurement

Quality performance data are the framework upon which quality assurance and improvement activities are based. MCOs are responsible for contracting with a certified HEDIS® auditor to conduct an NCQA-approved audit prior to submitting their HEDIS® and CAHPS®[17] data to DMS. For HEDIS® 2014, all effectiveness of care, access and availability, access dental and utilization measures were required to be submitted. DMS elected not to rotate any of the measures selected for rotation by NCQA. The state is reviewing the possibility of rotation of HEDIS® measures for future submissions.

The Healthy Kentuckians data, submitted annually to DMS, was validated by the EQRO according to CMS protocol. All audit findings were compiled and audit reports were prepared. The performance validation methodology includes an information system capabilities assessment; denominator validation; data collection validation; and numerator validation.

Healthy Kentuckians Performance – Reporting Year 2013

Each MCO is required to report annual performance measures based upon the Healthy Kentuckians (HK) 2020 goals. HK 2020 is Kentucky's commitment to the national prevention initiative Healthy People 2020. HK 2020 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 healthcare delivery and outcomes. The HK measure set is composed of HEDIS® adolescent screening numerators/denominators for preventive and access measures and HK numerators/denominators for measures including prenatal and postpartum risk assessment,

preventive screening, counseling, access to care and preventive care for individuals with special healthcare needs. Each measure's statewide rate was calculated by adding the MCO numerators and denominators and then dividing the resulting numerator by the denominator. IPRO reviewed all data and documentation used to calculate the performance measures to ensure the validity and reliability of the reported measures.

Three MCOs reported performance measures for reporting year 2013: CoventryCares of Kentucky, Passport Health Plan, and WellCare of Kentucky. Humana-CareSource began enrolling members in January 2013, and therefore, was not required to report HK performance measures for reporting year 2013. The HK measure rates were presented in the External Quality Review Technical Report, dated September 2014, and noted that the MCOs' performance should not be compared to each other due to variation in service area characteristics and duration of MCO experience in Kentucky. Passport Health Plan had a limited and more urban/suburban service area and had been in operation for over ten years, while the other two MCOs served the Kentucky Medicaid population for less than two years (as of June 2013) and had a larger service area with more rural areas.

The majority of the HK statewide rates (excluding the HEDIS® measures in the HK dataset) for the reporting year 2013 were below 50%, but there were eight measures that exhibited above state wide average performance:

- Children with Special Health Care Needs (CSHCN):
  - 12–24 months who had a visit with a PCP during the MY (97.33%)
  - 25 months–6 years who had a visit with a PCP during the MY (93.93%)
  - 3–6 years who had one or more visits with a PCP during the MY (66.55%)
  - 2–21 years who had at least one annual dental visit (58.58%)
- Adult Cholesterol Screening (76.94%)
- Child and Adolescent Height and Weight Documented (75.63%)
- Adult Height and Weight Documented (68.63%)
- Adolescent Screening/Counseling for Tobacco Use (52.35%)

For reporting year 2013, seven statewide HK measure rates could not be calculated since at least one MCO failed the medical record review validation for each of these measures:

- Adolescent Screening/Counseling for Depression
- Prenatal Screening Positive for Tobacco Use
- Prenatal Screening/Counseling Intervention for Tobacco Use
- Prenatal Screening Positive for Alcohol Use
- Prenatal Screening/Counseling Intervention for Alcohol Use
- Prenatal Screening Positive for Substance/Drug Use
- Prenatal Screening/Counseling Intervention for Substance/Drug Use

These non-reportable topics are critical components of adolescent and prenatal preventive care and should be considered opportunities for improvement in future HK data reporting. Since they rely heavily on well documented medical records and/or screening checklists to provide evidence of having occurred, MCOs should consider interventions for improvement including physician education, and development and distribution of screening/counseling checklists.

Quality Performance – HEDIS® 2014

Annual submission of HEDIS® data is a contract requirement for Kentucky's Medicaid MCOs. The HEDIS® measures required for reporting included the following domains: Board Certification, Effectiveness of Care, Access/Availability of Care and Use of Services. All four MCOs (CoventryCares of

Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky) successfully submitted audited HEDIS® data in June 2014 for services provided in MY 2013.

Summary data results from this most recent HEDIS® submission were prepared by the EQRO and published in a one-page document entitled "A Member's Guide to Choosing a Medicaid Health Plan." Copies of the guide were included in open enrollment mailings by DMS to eligible enrollees for their recent open enrollment period. An MCO Performance Dashboard format is currently being prepared by the EQRO using selected measures for DMS monitoring.

HEDIS® 2014 results for Board Certification, Access and Use of Services were summarized in the Provider Network Access section above. Effectiveness of Care results are summarized below.

HEDIS® 2014 Effectiveness of Care measures evaluate how well a health plan provided preventive screenings and care for members with acute and chronic illnesses, including: respiratory illnesses, cardiovascular illnesses, diabetes, behavioral health and musculoskeletal conditions. In addition, medication management measures were also included.

A review of HEDIS® Effectiveness of Care results for the four MCOs reporting in 2014 indicated that close to half (47%) of the weighted statewide rates compared favorably with Medicaid National Quality Compass results at the 50th percentile including the following:

- Adult BMI Assessment
- Childhood Immunizations for Varicella and Pneumococcal Conjugate
- Immunizations for Adolescents, including Meningococcal, Tdap/Td (Tetanus, Diphtheria, Pertussis/Tetanus, Diphtheria) and Combination #1
- Breast Cancer Screening
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Use of Appropriate Medications for People with Asthma (Ages 5–11 Years, 12–18 Years, and Total)
- Comprehensive Diabetes Care:
    - HbA1c Testing
    - HbA1c Poor Control (> 9.0%)
    - HbA1c Control (< 8.0% and < 7.0%)
    - LDL-C Screening and LDL-C Level (< 100 mg/dL)
    - Medical Attention for Nephropathy
    - Blood Pressure Control (< 140/90 mmHg)
- Follow-up Care for Children Prescribed ADHD Medication (Initiation and Continuation/Maintenance Phases)
- Annual Monitoring for Patients on Persistent Medications (All Medications: ACE Inhibitors, Digoxin, Diuretics, Anticonvulsants, Total)
- Medication Management for People with Asthma (75% All Age Groups and Total)

Opportunities exist for MCOs to focus on improvement of measures with weighted statewide averages below the national 10th percentile benchmark including:

- Appropriate Treatment for Children with Upper Respiratory Infection
- Pharmacotherapy Management of COPD Exacerbation (Systemic Corticosteroid and Bronchodilator)
- Comprehensive Diabetes Care: Blood Pressure Control (< 140/80 mmHg)
- Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis
- Use of Imaging Studies for Low Back Pain

Consumer Satisfaction – CAHPS® 2014

DMS requires all MCOs to conduct annual assessments of member satisfaction with quality of care and access to services using the CAHPS® survey tool. All four Kentucky Medicaid MCOs contracted with NCQA-certified CAHPS® survey vendors to conduct their member satisfaction survey for both

adult and child member populations. The adult member survey was sent to a random sample of members ages 18 years and older as of December 31, 2013, and the child and adolescent member survey was sent to parents/guardians of randomly selected members ages 17 years and younger as of December 31, 2013. The MCOs submitted their CAHPS® survey results to DMS in June 2014 along with their HEDIS® results.

Statewide, 74.67% of adults were overall satisfied with their healthcare under managed care, which was the same as the national Medicaid average for overall satisfaction with healthcare. For the child survey, 83.23% of those surveyed were satisfied overall with their healthcare, falling just short of the CAHPS® 2014 national Medicaid average.

Quality Improvement

Performance Improvement Projects (PIPs)

A protocol for conducting PIPs was developed by CMS to assist MCOs in the design and implementation of their performance improvement efforts. Federal regulations require that all PIPs be validated according to guidelines specified by CMS. In Kentucky, two new PIP topics are proposed each year and are generally completed in two to three years; thus, an MCO is likely to have two to four PIPs at various stages of activity: initiation, baseline measurement, implementation, and up to two years of re-measurement. Each state determines the number of PIPs required to be conducted, and a review of other state quality strategies indicates that most require one or two PIPs annually.

Initially, the MCO selected the PIP topics based on HEDIS® results, but currently, DMS has designated two topic categories: physical health and behavioral health; and each MCO is able to determine a specific PIP project within each category. Table 5 presents a list of Kentucky MCOs' active PIP topics.

Table 5. PIP Project Status 2013–2014

Plan	PIP Topic	Proposal Submitted	PIP Period
CoventryCares of Kentucky	Major Depression: Antidepressant Medication Management and Compliance	2012	2012–2014
	Decreasing Non-Emergent Inappropriate Emergency Department Utilization	2012	2012–2014
	Secondary Prevention by Supporting Families of Children with ADHD	2013	2013–2015
	Decreasing Avoidable Hospital Readmissions	2013	2013–2015
Humana-CareSource	Untreated Depression	2013	2013–2015
	Emergency Department Use Management	2013	2013–2015
Passport Health Plan	Dental Care in Children with Special Health Care Needs	2010	2010-2013
	Reduction of Emergency Room Care Rates	2011	2011–2014
	Reduction of Inappropriately Prescribed Antibiotics in Pharyngitis and Upper Respiratory Infections (URI)	2011	2011–2014
	You Can Control Your Asthma! Development and Implementation of an Asthma Action Plan	2013	2013–2015
	Psychotropic Drug Intervention Program	2013	2013–2015
WellCare of Kentucky	Utilization of Behavioral Health Medication in Children	2012	2012–2014
	Decreasing Inappropriate Emergency Department Utilization	2012	2012–2014
	Follow-up after Hospitalization for Mental Illness	2013	2013–2015

Plan	PIP Topic	Proposal Submitted	PIP Period
	Management of Chronic Obstructive Pulmonary Disease (COPD)	2013	2013–2015

The state's EQRO was responsible for validating MCO PIPs, which begins with DMS approval of the PIP topic. Using a team of reviewers, the EQRO reviewed all PIP proposals including topic selection rationale, methodology, planned interventions and study indicators. The EQRO follows each PIP through completion with periodic conference calls with each MCO to discuss progress and problems. In addition, the EQRO also conducted training for MCOs on PIP development and implementation.

The EQRO's review of PIPs included a description of PIP strengths and opportunities for improvement. Several recurring strengths were noted in the PIP review summaries including:

- Strong project rationale using multiple literature citations and/or statewide and plan-specific data
- Strong evidence of topic relevance to the plan or a public health issue
- Use of external collaborators
- Use of a multi-disciplinary team for project implementation
- Interventions addressed barriers
- Multi-dimensional interventions targeted providers, members and health plan staff

Throughout the process, the EQRO's role in validating the PIP also involved identification of opportunities for improvement, such as the following recurring comments from active PIP reviews:

- Project descriptions often lack specifics regarding the interventions, such as timeframes and logistics on how the interventions will be implemented.
- Measures are not clearly defined or are not clearly linked to the proposed interventions.
- Some proposals lack process measures.
- Use of primarily passive interventions, such as newsletter articles, mailings and/or website postings, need to be combined with active interventions for better outcomes.
- Use of only existing programs as interventions is not acceptable.

For all of the completed or interim PIPs reviewed during the contract year, the EQRO determined that the validation findings generally indicated that the credibility of the PIP results was not at risk after the revisions suggested by the EQRO were completed.

In July 2014, after a preliminary analysis of Medicaid claims data and discussions with MCO Medical Directors and the University of Louisville, Department of Pediatrics, a multi-disciplinary research team was created to further explore the potential for a statewide collaborative PIP topic. In a presentation to the Advisory Council for Medical Assistance (MAC), it was recommended that the MAC adopt and implement a collaborative PIP focused on psychotropic medications in children. The study design for the collaborative PIP, entitled "HEDIS® Safe and Judicious Anti-Psychotic Use in Children and Adolescents" is currently in process. The EQRO is assisting DMS in the development of this collaborative PIP for implementation in 2015.

Focused Clinical Studies

A focused clinical study examines a particular aspect of clinical or non-clinical service at a point in time and is listed in federal regulation as an optional quality review activity that the Commonwealth of Kentucky has chosen to include in its Quality Strategy.

The EQRO recently completed two related focused studies: (1) Kentucky Postpartum Readmissions Focused Study, January 2014; and (2) Kentucky Newborn Readmissions Focused Study, March 2014. A third focused study, completed in July 2014, focused on behavioral health encounters.

The Postpartum and Newborn Readmission studies aimed to expand the scope of an original study from analyzing readmissions within 14 days of birth hospitalization using administrative data to analyzing 30-day readmission rates through administrative data plus medical record reviews in order to better identify risk factors for readmission. Both studies had a two-part approach:

1) Retrospective cohort study using an administrative data set that included members with and without readmissions to evaluate risk factors for readmissions, and
2) Retrospective medical record review restricted to enrollees with readmissions to profile member characteristics and care received in order to identify potentially actionable areas that might be addressed for quality improvement. From the administrative data set, this part of each of the studies reviewed a random sample of 100 records with a readmission per MCO.

Kentucky Postpartum Readmissions Study

This focused study identified a postpartum readmission rate of 1.5% (310 of 20,374 members who delivered a live baby). Hypertension, cesarean or obstetric wound problem, and infection were the three highest volume reasons for readmission. Risk factors for postpartum readmissions included a delivery stay diagnosis of hypertension, drug abuse, asthma, sepsis, overweight or obesity, cesarean delivery, and absence of postpartum follow-up. A significant finding indicated that the majority of women with postpartum readmissions did not have any record of case management services submitted by the MCOs, and furthermore, the vast majority of women in the medical record review study had no risk assessment conducted by managed care services at any time during the perinatal period. The study concluded that there is a potential to improve postpartum outcomes by better facilitating care transitions for women at risk.

Kentucky Newborn Readmissions Study

The Newborn Readmissions Study identified a newborn readmission rate of 1.92% (416 of 21,686 live-born babies). Highest volume reasons for newborn readmissions included respiratory syncytial virus, jaundice and other respiratory conditions. Risk factors for all-cause newborn readmissions included prematurity, any birth-stay diagnosis of respiratory distress, sepsis, congenital anomalies or other birth complications, and mechanical ventilation or other intubation during the birth stay. Male sex, 'other' race/ethnicity and lack of outpatient follow-up were also found to be risk factors. Evidence from this study suggests an opportunity to reduce newborn readmissions by improving case management interventions, particularly by facilitating outpatient follow-up visits for high-risk infants.

These two reports were sent to each MCO and the EQRO presented the findings at a Medical Directors' meeting. In a letter from the Commissioner, the MCOs were urged to act on the findings. All MCOs responded with a description of the actions they are taking to address the problems identified in the studies.

Kentucky Behavioral Health Study

This study used DMS electronic encounter files to identify the eligible population and create the study dataset. The report provides a profile of behavioral health disorder prevalence and service utilization in Kentucky's Medicaid Managed Care population during 2013. Chronic physical condition prevalence and service utilization patterns are quantified in order to identify susceptible subpopulations for targeted case management, care coordination and other quality improvement interventions. A third

aim of the study was to identify demographic and clinical risk factors for outcomes of all-cause hospitalization, behavioral health hospitalization and all-cause and psychiatric Emergency Department (ED) re-visits within 30 days of behavioral health hospital discharge.

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

Recommendations proposed for Kentucky Medicaid Managed Care plans included targeting care management to susceptible subpopulations based on risk; identifying and sharing best practices among providers; evaluating access to follow-up visits; offering continuing education to providers on clinical guidelines; collaborating with providers to screen for substance abuse and depression; considering new quality performance measures for 2015 and implementing evidence-based interventions in PIPs that target identified behavioral health problem areas. DMS was encouraged to provide guidance to the MCOs and collaborate with DCBS in addressing the issues identified in the report.

Experience of Care for Children with a Behavioral Condition

The EQRO further collaborated with DMS to implement an experience of care focused study for 2014 entitled "Experience of Care for Children with a Behavioral Condition." The study aim is to identify pediatric experience of care problems and opportunities for improvement in physical healthcare, behavioral healthcare and coordination of care. This study was conducted via a mail-in survey to a random sample of parents of children identified as having behavioral health problems. Study findings should be completed for fiscal year (FY) 2014.

In addition, two focused clinical study topics considered for FY 2015 are: 1) Medically Fragile Children in Foster Care, and 2) Child Obesity.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally required Medicaid program for children that has two major components: EPSDT Screenings and EPSDT Special Services. The Screening Program provides well-child check-ups and screening tests for Medicaid-eligible children in specified age groups. EPSDT Special Services are only provided when medically necessary, if they are not covered in another Medicaid program, or are medically indicated and needed in excess of a program limit. MCOs are required to submit quarterly EPSDT reports (quarterly and annual 416 reports) and an annual report of EPSDT activities, utilization and services including compliance and screening rates by age group and a description of member-level, provider-level and group/community-level interventions.

During this contract period, the EQRO also conducted an EPSDT Screening Encounter Data Validation Study. As a result of this validation, the EQRO concluded that encounter codes evaluated in each of the two cohorts did not completely reflect the provision of a comprehensive well-child visit or developmental screening as described in standard clinical guidelines or EPSDT requirements. MCOs were encouraged to collaborate with providers to encourage the use of screening tools through interventions for provider education, toolkits and pocket guides that reinforce elements of a well-child visit and EPSDT screening services. MCO auditing of EPSDT visits through periodic medical record reviews was also recommended. As part of the 2013–2014 Compliance Review, the EQRO conducted a review of adherence to EPSDT protocol using MCO EPSDT data reports and a review of a sample of files related to complaints, grievances, denials, and care management. Overall ratings for EPSDT compliance were high with WellCare of Kentucky in full compliance, and the other three MCOs receiving overall substantial compliance ratings. None of the MCOs were required to submit CAPs for EPSDT compliance.

Program Integrity

Maintaining program integrity includes guarding against fraud, abuse and deliberate misuse of Medicaid program benefits; ensuring that Medicaid enrollees receive necessary quality medical services; and ensuring that providers and recipients are in compliance with federal and state Medicaid regulations. In determining MCO compliance with federal and state regulations for program integrity, the EQRO's evaluation for the 2013–2014 Compliance Review, included, but was not limited to, a review of MCO policies and procedures, training programs, compliance with Annual Disclosure of Ownership (ADO) and financial interest provisions and a file review of program integrity cases.

Overall compliance determinations regarding Program Integrity for Kentucky Medicaid MCOs varied from full compliance for Passport Health Plan, substantial compliance for Humana-CareSource and WellCare of Kentucky, to minimal compliance for CoventryCares of Kentucky. WellCare of Kentucky was required to prepare one CAP; Humana-CareSource and Passport Health did not have to prepare any CAPs. CoventryCares of Kentucky had nine non-compliant elements out of 20 reviewed (45%) that required corrective action for omissions or failure to address required standards in the MCO's policies and procedures for Program Integrity.

Care Management/Coordination

Care coordination is a key component of managed care and is based on the assurance that all enrollees have an ongoing source of primary care 24 hours a day, 7 days a week. The MCO plays a unique role in being able to identify persons with special healthcare needs (including chronic physical, developmental, behavioral, neurological or emotional conditions) and offer care coordination through case management. MCOs identify enrollees in need of care coordination from Health Risk Assessments (HRAs) completed for new enrollees and by tracking other indicators of need such as encounter data algorithms to identify high risk diagnosis codes, high utilization, and repeated use of emergency rooms, frequent inpatient stays and hospital readmissions.

In 2013, and continuing with compliance reviews conducted in 2014, coordination challenges between the MCOs and Kentucky's Department of Community Based Services (DCBS) and the Department of Aging and Independent Living (DAIL) continue to persist. It is critical that the MCOs have access to baseline information about individuals identified by DCBS and DAIL to enable timely

and appropriate referrals and for MCO case managers to assure enrollee access to needed services. DCBS/DAIL service plans are the key source of this baseline information and ongoing communication with DCBS/DAIL staff is essential to coordinate the most appropriate services needed by individual members. DMS, through the new Branch of Disease and Case Management in the Division of Program Quality and Outcomes, has established a system of communication between the state agencies and the MCOs that has resulted in a more collaborative environment according to several Kentucky MCOs. Meetings are held more frequently and are less likely to be canceled. It should also be noted that DMS has revamped the care plan form, which has been helpful.

Overall compliance determinations in 2014 for Care Management resulted in substantial compliance ratings for all four MCOs; however, CAPs were required for all MCOs (one each for CoventryCares of Kentucky and WellCare of Kentucky; and five each for Humana-CareSource and Passport Health Plan). CoventryCares of Kentucky, Humana-CareSource and WellCare of Kentucky were required to develop and implement policies and procedures to ensure access to care coordination for all DCBS clients. Each MCO was instructed to track, analyze, report, and when indicated, develop CAPs on indicators that measure utilization, access, complaints and grievances, and satisfaction with care and services specific to the DCBS population. Policies and procedures for coordination of care for children receiving school-based services, early intervention and the First Steps program were required for Humana-CareSource and Passport Health Plan.

Enrollee Rights and Responsibilities

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

Evaluation of Enrollee Rights and Responsibilities in the 2013–2014 Compliance Review included an assessment of policies and procedures for member rights and responsibilities, PCP changes and Member Services functions. Overall compliance review determinations for Enrollee Rights varied from full compliance for Passport Health Plan, substantial for Humana-CareSource and WellCare of Kentucky to non-compliance for CoventryCares of Kentucky. The EQRO determined that CoventryCares of Kentucky did not address Member Services functions in their policies and procedures which resulted in a total of 22 elements being designated non-compliant. Humana-CareSource, Passport Health Plan and WellCare of Kentucky received overall full compliance for Member Outreach, while this category was determined to be not applicable for CoventryCares of Kentucky.

Strengths and Opportunities for Improvement

This report described the status and progress of the Kentucky Medicaid Managed Care Program's external quality review activities that have occurred over the past twelve-month contract period of July 1, 2013 through June 30, 2014. During the contract period, numerous strengths as well as opportunities for improvement have been identified and are highlighted below.

Strengths

Program Administration

- Kentucky's Medicaid Managed Care Program offers a comprehensive benefit plan for enrollees.
- Kentucky's Medicaid Managed Care Program is composed of five MCOs with capacity to serve Medicaid enrollment statewide. The total enrolled population has increased by 48.2% to just over a million enrollees in the twelve-month period of August 26, 2013 through August 25, 2014.
- The state successfully procured a new contract with Humana-CareSource and the transition of enrollees from Kentucky Spirit Health Plan occurred in the latter half of 2013.
- Kentucky recently contracted with Anthem Blue Cross Blue Shield to provide coverage to Medicaid expansion members in all regions of the state excluding Region 3 (Jefferson County and 15 surrounding counties) and with Passport Health Plan to cover Medicaid expansion enrollees statewide and Region 3.
- With support from the legislature and Commissioner, DMS has re-organized staff functions and responsibilities and has vigorously applied new staff resources and expertise to better address the needs of the expanding Medicaid Managed Care Program. New leadership positions and additional staff positions have been created.
- Kentucky has a contract in place for external quality review, including work plan activities for the annual technical report, the three mandatory quality review activities, and several additional activities including focused clinical studies, validation of encounter and provider network data, validation of Healthy Kentuckians data, development of a quality performance annual report card and a quality monitoring dashboard tool.
- There are excellent lines of communication between the state, the MCOs and the EQRO.

Data Systems

- All required data collection systems are in place including encounter data, provider network data, HEDIS® and Healthy Kentuckians quality performance data. All MCOs submitted data to DMS according to established timeframes.
- Each month the EQRO received a final extracted encounter file from DMS and created monthly data validation reports summarizing the MCO submissions.
- The EQRO completed an EPSDT Screening Encounter Data Validation Study.
- The EQRO successfully completed two data validation reviews of the Kentucky Medicaid Managed Care Program Provider Network, including an audit of Kentucky's Provider Network Submissions in June 2013 and a validation of MCO web-based provider directories in January 2014.
- Healthy Kentuckians, HEDIS® and CAHPS® data were successfully submitted by all MCOs in June 2014 for services provided in the 2013 measurement year.
- The EQRO validated the Healthy Kentuckians data for the 2012 and 2013 measurement years. All audit findings were compiled as part of the EQRO's validation of quality performance data.
- The EQRO summarized HEDIS® 2014 quality performance data in Kentucky's consumer-friendly document entitled "A Members Guide to Choosing a Medicaid Health Plan." A copy of the guide is posted on the DMS website.
- The EQRO developed an internal dashboard monitoring tool for DMS using HEDIS® 2013 data which was posted on the EQRO's website.

Compliance with State and Federal Standards

- An annual compliance review was successfully completed by the EQRO for the contract year January 2013–December 2013 for all four MCOs. Humana-CareSource and Passport Health Plan received full reviews, while CoventryCares of Kentucky and WellCare of Kentucky underwent partial reviews.
- The overwhelming majority of review areas for all plans (69%) exhibited overall substantial compliance.
- All four MCOs received overall full compliance determinations for the Health Information Systems review area.
- Overall full compliance was also received in the following review areas: Quality Measurement and Improvement (WellCare of Kentucky); Program Integrity (Passport Health Plan); EPSDT (WellCare of Kentucky); Delegation (Humana-CareSource and Passport Health Plan); Enrollee Rights (Passport Health Plan); Member Outreach (Humana-CareSource, Passport Health Plan and WellCare of Kentucky); Medical Records (WellCare of Kentucky); and Pharmacy Benefit (Passport Health Plan and WellCare of Kentucky).
- Of all elements reviewed for all four MCOs, only 4.4% received minimal or non-compliant ratings requiring a corrective action plan.

Provider Network Access

- Using the results of a survey conducted by the EQRO, DMS collaborated with the EQRO to design and implement a state-sponsored survey of provider appointment availability for behavioral health providers using the "secret shopper" methodology.
- HEDIS® 2014 statewide performance measures related to Access were an area of strength for all four MCOs.
- Measures for which Kentucky's weighted statewide average met or exceeded the HEDIS® 2014 national Medicaid 50th percentile included: Adult Access to Preventive/Ambulatory Health Services (all ages); Children and Adolescents' Access to Primary Care Practitioners (all age groups); Annual Dental Visit (all ages); Timeliness of Prenatal Care; Call Answer Timeliness; and Frequency of Ongoing Prenatal Care: 81+%.
- Overall, the adult and child CAHPS® 2014 survey results showed strong consumer satisfaction with access to care under the Kentucky Medicaid Managed Care Program, including composite ratings for Getting Care Quickly and Customer Service.

Quality Assessment and Performance Improvement

- Three MCOs (CoventryCares of Kentucky, Passport Health Plan and WellCare of Kentucky) reported Healthy Kentuckians performance measures for 2013.
- All four MCOs (CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan and WellCare of Kentucky) successfully submitted audited HEDIS® data in June 2014 for services provided in the 2013 measurement year.
- Summary data results from the most recent HEDIS® 2014 submission were prepared by the EQRO and published in a one-page document entitled "A Member's Guide to Choosing a Medicaid Health Plan." Copies of the guide were included in open enrollment mailings by DMS and posted on the DMS webpage. A quality performance monitoring dashboard tool is currently being prepared by the EQRO.
- A review of HEDIS® Effectiveness of Care results for the four MCOs reporting in 2014 indicated that close to half (47%) of the weighted statewide rates compared favorably with Medicaid National Quality Compass rates at the 50th percentile and included as many as 15 measure areas.
- Statewide results of adult CAHPS® survey indicated that 74.67% of adults were satisfied overall with their healthcare under managed care, which was the same as the national Medicaid average for overall satisfaction with healthcare. For the child survey, 83.23% of those surveyed were satisfied overall with their healthcare, falling just short of the CAHPS® 2014 national Medicaid average.

Performance Improvement

- The EQRO reviewed all PIP proposals submitted by Kentucky Medicaid MCOs for 2014 and continues to validate all PIPs in progress though periodic conference calls with the MCOs. The EQRO also conducted training for MCOs on PIP development and implementation.
- Validation findings for all completed or interim reviews indicated that the credibility of the PIP results is not at risk after the revisions suggested by the EQRO were addressed.
- In response to recommendations that DMS consider conducting a statewide PIP topic, a proposal was developed and presented to the Advisory Council for Medical Assistance in July 2014 recommending that the MAC adopt and implement a collaborative PIP focused on Psychotropic Medications in Children. The EQRO is currently assisting DMS in the development of this collaborative PIP proposal for 2015.

- The EQRO completed two related focused studies: (1) Postpartum Readmissions Focused Study, January 2014; and (2) Newborn Readmissions Focused Study, March 2014. The two study reports were sent to each MCO and the EQRO presented the findings at a Medical Directors' meeting. All MCOs responded to a letter from the Commissioner and submitted a description of the actions they are taking to address the problems identified in the studies.
- The EQRO completed a Behavioral Health Study in July 2014 using an administrative dataset derived from encounter data for the 2013 study period.
- A focused survey, entitled Experience of Care for Children with a Behavioral Condition was conducted among children with behavioral problems to identify pediatric experience of care problems and opportunities for improvement in physical and behavioral health care and coordination of care. A final report is currently being prepared.

Care Management/Coordination

- DMS, through the new Branch of Disease and Case Management in the Division of Program Quality and Outcomes, has established a system of communication between the state agencies (DCBS and DAIL) and the MCOs that has resulted in a more collaborative environment according to several Kentucky MCOs.

Opportunities for Improvement

Data Systems

- A monthly validation review of encounter data submissions indicated a number of variables that consistently have a high percent of missing data elements including diagnoses codes 4 and above, performing provider key, inpatient procedure codes, procedure modifier codes, referring provider key, and inpatient and outpatient surgical ICD-9 codes. DMS needs to continue to work with the MCOs, the EQRO and appropriate divisions of DMS to review MCO progress in encounter data quality and completeness and to troubleshoot issues in need of improvement.
- In the EPSDT Screening Encounter Data Validation Study, the EQRO found that encounter codes evaluated in each study cohort do not completely reflect the provision of a comprehensive well-child visit or developmental screening as described in standard clinical guidelines or EPSDT requirements.
- The audit of MCO web-based directories indicated numerous variations in data consistency between the MCO web-based directory and the MCAPS database. The DMS Managed Care Oversight – Quality Branch should continue to work with the MCOs to improve the consistency of data for Medicaid network providers.
- DMS elected not to rotate any of the HEDIS® measures selected for rotation by NCQA. The state should continue to consider the possibility of rotation of HEDIS® measures for future submissions.
- DMS should consider expanding the use of the Quality Performance Dashboard to a more public posting of the MCO Dashboard information.

Compliance with State and Federal Standards

- CoventryCares of Kentucky was required to submit 37 Corrective Action Plans for Minimal or Non-Compliant elements, or 17% of total elements reviewed, while Humana-CareSource had 4% of elements requiring corrective action and Passport Health Plan and WellCare of Kentucky were required to submit Corrective Action Plans for 2% of elements reviewed respectively.

Provider Network Access

- As a measure of provider access, HEDIS® 2014 statewide rates for Board Certification for each of the physician specialty categories (family medicine, internal medicine, obstetrics/gynecology, pediatrics, geriatrics and other) were found to be below the 25th national Medicaid percentile.
- The following HEDIS® 2014 statewide rate, fell below the national Medicaid 50th percentile rate: Postpartum Care; Well-Child Visits in the First 15 Months of Life (6+ visits); Well-Child Visits in the Three to Six Years of Life; Adolescent Well-Care; Initiation of AOD Dependence Treatment: Total, and Engagement of AOD Dependence Treatment: Total.

Quality Assessment and Performance Improvement

- The majority of the Healthy Kentuckians statewide rates for the 2013 reporting year were below 50%. Seven statewide measure rates were deemed not reportable.
- HEDIS® 2014 measures with weighted statewide averages below the national 10th percentile present opportunities for improvement, including Appropriate Treatment for Children with Upper Respiratory Infection; Pharmacotherapy Management of COPD Exacerbation; Diabetes Blood Pressure Control (< 140/80 mmHg); Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis, and Use of Imaging Studies for Low Back Pain.
- Recommendations from the Postpartum and Newborn Readmissions studies offer numerous recommendations for improvement as did the Kentucky Behavioral Health Study.

Care Management/Coordination

- Overall compliance determinations for Care Management resulted in substantial compliance ratings for all four MCOs with corrective action plans required for all MCOs particularly as it related to developing and implementing policies and procedures to ensure access to care coordination for all DCBS clients. Each MCO was instructed to track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and satisfaction with care and services specific to the DCBS population. Policies and procedures for coordination of care for children receiving school-based services, early intervention and the First Steps program were required for Humana-CareSource and Passport Health Plan.
- Coordination challenges between the MCOs and DCBS and DAIL continue to persist.

Enrollee Rights and Responsibilities

- Evaluation of enrollee rights and responsibilities in the 2013–2014 Compliance Review resulted in an overall determination of non-compliance for CoventryCares of Kentucky. The EQRO determined that CoventryCares of Kentucky did not address Member Services functions in their policies and procedures which resulted in a total of 22 elements being designated non-compliant.

Recommendations

Focusing on the strengths and opportunities for improvement identified for the Kentucky Medicaid Managed Care Program between July 1, 2013 and June 30, 2014, the following key performance area recommendations are presented for DMS' consideration.

Data Systems

The quality of data collected and maintained by the MCOs is of critical importance in measuring program progress and achievements and for targeting improvement efforts. Missing codes in encounter data submissions and inaccurate provider information in MCO or DMS Medicaid provider directories impact the usefulness of the data. The EQRO and DMS should continue to work with the MCOs to improve the data quality by conducting ongoing audits of encounter and provider network submissions and providing training for MCO staff. Recommendations from the EPSDT Screening Encounter Data Validation Study should be implemented. The monthly meetings between DMS and the MCOs have greatly helped the plans in working out encounter data submission problems and should be continued.

MCOs are required to submit quality performance data in Healthy Kentuckians, HEDIS® and CAHPS® submissions annually. They also submit periodic data reports such as EPSDT and geo-access reports for provider access. DMS elected not to rotate any of the HEDIS® measures selected for rotation by NCQA. Recognizing the reporting burden on MCOs in Kentucky, the state should continue to evaluate the advantages of rotation of HEDIS® measures for future submissions.

DMS and the EQRO have presented quality performance data in a member's guide and in an internal dashboard monitoring tool. DMS should consider expanding their use of the internet to provide more public access to quality performance data and other quality related improvement efforts.

Provider Network Access

HEDIS® performance measures and CAHPS® satisfaction measures related to access were an area of strength for all four MCOs reviewed in this progress report; however, opportunities for improvement in the following HEDIS® rates should be addressed:

- Board Certification for all provider specialties
- Postpartum Care Visit
- Well-Child Visits in the First 15 Months of Life (6+ visits)
- Well-Child Visits in the Three to Six Years of Life
- Adolescent Well-Care Visits
- Initiation and Engagement of AOD Dependence Treatment: Total

Quality Assessment and Performance Improvement

Using the national Medicaid Quality Compass as a benchmark, opportunities for improvement should be considered in the following measure areas which fell below the national Medicaid 10th percentile:

- Appropriate Treatment for Children with Upper Respiratory Infection
- Pharmacotherapy Management of COPD Exacerbation
- Diabetes Blood Pressure Control (< 140/80 mmHg)

- Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis
- Use of Imaging Studies for Low Back Pain

Efforts to develop and implement a statewide collaborative PIP should be continued. Input from the MCOs during the development phase of the collaboration is important and should be a continuous part of the planning process.

Care Management

While compliance review findings are specific to each individual MCO and must be addressed by that MCO, there was one area of similarity in the findings that should continue to be targeted for overall improvement:

- Overall compliance determinations for Care Management resulted in substantial compliance ratings for all four MCOs with corrective action plans required for all MCOs, particularly as it related to developing and implementing policies and procedures to ensure access to care coordination for all DCBS clients.
- While there has been some improvement over the past year, DMS needs to continue to coordinate and improve communications between the MCOs, DCBS and DAIL.

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[13] HEDIS® (The Healthcare Effectiveness Data and Information Set) is a registered trademark of the National Committee for Quality Assurance.
[14] HEDIS® (The Healthcare Effectiveness Data and Information Set) is a registered trademark of the National Committee for Quality Assurance.
[15] CAHPS® (Consumer Assessment of Healthcare Providers and Systems) is a registered trademark for the Agency for Healthcare Research and Quality; http://cahps.ahrq.gov/about.htm.
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