

*Commonwealth of Kentucky  
Cabinet for Health and Family Services  
Department for Medicaid Services*



**KENTUCKY PARTNERSHIP PLAN 1115(A) WAIVER  
EVALUATION DESIGN FINAL REPORT**

Prepared: February 2014  
Demonstration Year: (Waiver Period: 11/1/2008–12/31/2012)



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## **Introduction**

As required in the Special Terms and Conditions (STCs) for the Kentucky Passport Health Plan (PHP) section 1115(a) Medicaid demonstration waiver for the period November 1, 2008 through October 31, 2011, a draft Evaluation Design was approved by the Centers for Medicare and Medicaid Services (CMS). The requirement mandated an interim report on the Evaluation Design due with the extension request for the third initial application of the demonstration, due October 31, 2010. The Interim Report was prepared by Kentucky's external quality review organization (EQRO) October 28, 2010 and a waiver extension was granted through December 31, 2012. This report, also prepared by Kentucky's EQRO, represents the Final Evaluation and assesses progress on the evaluation measures through 2012.

## **Brief History of the Demonstration**

In December 1995, the Commonwealth of Kentucky, Cabinet for Health and Family Services, Department for Medicaid Services (DMS) was granted approval for an amendment to its Section 1115 Waiver Demonstration Project (No. 11-W00000-5/4-01). The approved amendment permitted the Commonwealth to attempt a truly innovative approach to establishing a Managed Care Organization (MCO) in an urban area as well as in rural and medically underserved areas of the state.

The concept embodied in the Commonwealth's approved amendment was the establishment of healthcare partnerships. These partnerships were to be coalitions of medical providers in both the public and private sectors who would come together to provide comprehensive medical services through integrated service delivery networks to Medicaid beneficiaries living in a designated region of the Commonwealth. The healthcare partnerships were to participate in the Medicaid Program as comprehensive risk-based entities paid an actuarially sound capitation rate per member per month. The partnerships would serve as sole-source managed care providers in their respective regions and virtually all Medicaid beneficiaries in the region would be assigned to the plan. Each partnership would have significant beneficiary representation on its governing board, and providers and beneficiaries would decide together how best to manage both healthcare needs and costs.

The concept was particularly appealing in a state in which there was little commercial managed care and in which the medical community was enthusiastic about attempting such a bold experiment. Initially, two (2) such partnerships were developed and implemented in Region 3 (Jefferson and 15 surrounding counties) and Region 5 (Fayette and 20 surrounding counties). Combined, the regions served approximately 34% of the Kentucky Medicaid population. Additional partnerships in six other regions were to be developed in the second and third years of the waiver project.

In the first two years of the project, the partnerships in Regions 3 and 5 demonstrated the efficacy of the concept and medical outcomes began to improve even as costs were held somewhat below the actuarially determined upper payment limit. Furthermore, beneficiaries reported increased satisfaction with their medical care. However, concerns about the quality of

managed care resulted in provider resistance to aligning with a risk-based managed care product.

In 1999, the Region 5 partnership notified DMS that it could no longer sustain its provider network, primarily due to widespread dissatisfaction with federally mandated reporting requirements, and what was believed to be unacceptable profit margins. The Commonwealth used this opportunity to review the project's scope and conceptual base in light of provider concerns and the increased likelihood that no further regional partnerships were possible.

Before making a final decision about how best to proceed, the Commonwealth published a Request for Information (RFI) to probe for any interest in Medicaid managed care from national MCOs, some of which were offering Health Maintenance Organization (HMO) products in limited areas of Kentucky, followed by a Request for Proposal (RFP). There were no viable responses. After much discussion and debate, the Commonwealth decided to strengthen its primary care case management model (KenPAC), pursuant to new authority in the Balanced Budget Act of 1997, and to seek authority from CMS to continue to operate its one remaining partnership. In 1999 and 2000, the Commonwealth requested and CMS approved amendments of its waiver program. Since July 2000, the Commonwealth has been operating its Partnership Plan, known as University Health Care (UHC) doing business as (dba) Passport Health Plan (PHP), in Region 3 and the following waiver extensions have been granted approval by CMS:

- In October 2002, the Commonwealth was granted approval to extend the Medicaid section 1115 waiver for an additional three (3) years from November 1, 2002 through October 31, 2005.
- In October 2005, the Commonwealth was granted approval to extend the Medicaid section 1115 waiver for an additional three (3) years beginning November 1, 2005 through October 31, 2008.
- In October 2008, the Commonwealth was granted approval to extend the Medicaid section 1115 waiver for an additional three (3) years beginning November 1, 2008 through October 31, 2011.
- In October, 2010, the Commonwealth submitted a waiver application and supporting documentation to renew the 1115 waiver for an additional three (3) years beginning November 1, 2011.
- Approval was granted by CMS to extend the waiver beginning November 1, 2008 through December 31, 2012.

With increasing Medicaid healthcare expenditures and a growing eligible population, like many other states across the country, the state of Kentucky began to explore ways to more effectively manage healthcare costs while maintaining or improving access and quality. Kentucky once again looked to risk-based managed care as a solution and in 2011, initiated a procurement process to contract with managed care organizations (MCO) that could provide services statewide. By July 2011, three additional MCOs were awarded contracts – Coventry Health and Life Insurance Company (doing business as CoventryCares of Kentucky), Kentucky

Spirit Health Plan, Inc., and WellCare of Kentucky, Inc. On November 1, 2011, state wide risk-based managed care was implemented.

## Summary of Findings

This evaluation of the waiver period November 1, 2008 to December 31, 2012 was a comprehensive study of the Partnership's performance in quality of care – utilization and outcomes, access and satisfaction. Measures were selected as indicators based on the following criteria: 1) evidence-based, 2) potential for improvement, 3) prevalence or incidence, 4) substantial impact on health status and/or outcomes, and 5) adaptability across various practice settings to the extent possible. Recommendations from previous waiver periods were reviewed and considered in developing the goals for this waiver period.

Overall, the Partnership/PHP performed above average for many of the evaluation measures when compared to national Medicaid benchmarks. Although above average compared to national norms, there remain opportunities for improvement in areas falling short of the outcome goals for the waiver. Overall there were forty-five (45) measures addressed in this evaluation; two measures did not have an outcome goal, 15 did not have a national Medicaid benchmark rate, and four were not trendable over time. Key summary findings for this Final Evaluation Report are as follows:

- 28 of 41 applicable total measures (68%) showed an improving trend over the waiver period;
- 28 of 30 applicable total measures (93%) had HEDIS®2013 rates that were better than the HEDIS®2012 National Medicaid average benchmark;
- 20 of 43 applicable total measures (47%) met or exceeded the outcome goal during the waiver period;
- Measures to evaluate compliance with Access Standards all achieved 100% compliance, thus meeting their outcome goals;
- Measures to evaluate Member Satisfaction all showed improved rates between 2008 and 2012 and all had HEDIS®2013 rates better than the HEDIS®2012 national Medicaid average. Three of the Member Satisfaction measures also exceeded their outcome goals.
- Opportunities for improvement are identified for measures that did not meet or exceed the outcome goal, were not better than the national Medicaid average benchmark and/or did not have an improving trend.

The Partnership/PHP quarterly reports provided documentation of comprehensive community outreach and collaboration, many active quality committees with active provider and member participation, and a wide variety of both provider and member focused system-level interventions for each of its quality initiatives. PHP conducted both targeted and pro-active efforts such as physician office academic detailing and performance feedback, risk stratification

and interventions for members with chronic diseases as well as broader-based activities such as educational mailings. The EQRO's review of PHP's Quality Assurance and Improvement program indicated that PHP has a very comprehensive, dynamic quality assessment and performance improvement program that integrates activities of multiple departments and includes many innovative interventions.

## **Waiver Evaluation Design**

The primary goal of the Kentucky Medicaid Managed Care Program is to improve the health status of Medicaid members. Objectives of the state Medicaid managed care program as detailed in the Section 1115 Waiver include: 1) improve access and co-ordination of care; 2) provide healthcare at the local level through the managed care system using public and private providers; 3) redirect the focus of healthcare toward primary care and prevention of illness; and 4) monitor and improve quality of healthcare. These goals and objectives are detailed in the CMS approved Commonwealth of Kentucky's *Strategy for Assessing and Improving the Quality of Managed Care Services*. The state developed the quality strategy document incorporating the requirements of both the June 14, 2002 Final Rule and the January 24, 2003 Final Rule.

Chosen performance measures are relevant to the program's target populations in Kentucky. The performance measures were identified as significant based on the following criteria: 1) evidenced based; 2) potential for improvement; 3) prevalence or incidence; 4) substantial impact on health status and/or health outcomes; and 5) to the extent possible, adaptability across various practice settings. Kentucky Medicaid uses the Healthcare Effectiveness Data and Information Set, HEDIS<sup>®1</sup> as a guideline for its methodology to develop, collect, and report data for most of these targeted performance measures. The results reported are indicators of members' use of services, rather than absolute rates for how successfully the managed care plan provides care. The measure performance trends have been used to guide the design of focused interventions for quality improvement throughout the waiver period.

Reported HEDIS<sup>®</sup> rates are benchmarked against the National Committee for Quality Assurance's (NCQA) Quality Compass<sup>®2</sup>, which includes Medicaid HEDIS<sup>®</sup> data reported by MCOs nationally. These measures are used to evaluate services of subpopulations, including those with chronic conditions and special healthcare needs. Access and utilization measures assess patterns of utilization for primary and specialty care, ambulatory, emergency department, and inpatient care utilization to evaluate if care is provided in the most appropriate, least restrictive setting.

Health plans and government administrators have an interest in quality of care data that can be used to initiate and guide improvement efforts. Another important source of information is the consumer's perspective on their direct experience with healthcare providers and services. The most widely used instrument for collecting reports and ratings of healthcare services from the

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

<sup>2</sup> Quality Compass<sup>®</sup> is a registered trademark of the NCQA.

member’s perspective is the Consumer Assessment of Healthcare Providers and Systems – (CAHPS<sup>®3</sup>) Health Plan Survey. Reported CAHPS<sup>®</sup> results can be benchmarked against the NCQA’s Quality Compass, which includes means and percentiles based on Medicaid CAHPS<sup>®</sup> data reported by MCOs nationally. CAHPS<sup>®</sup> survey data allows for the: 1) analysis of performance compared to benchmarks; 2) identification of changes or trends in performance; and/or 3) identification of indicators of performance other than MCO reported quality and utilization measures. Waiver Evaluation Measures

**Table 1. Waiver Evaluation Measures**

Domain	Measures	Data Source(s)
Quality of Care: Utilization	Childhood Immunizations	HEDIS <sup>®</sup>
	Breast Cancer Screening	HEDIS <sup>®</sup>
	Appropriate Medication for Asthma	HEDIS <sup>®</sup>
	Comprehensive Diabetes Care	HEDIS <sup>®</sup>
	Normal Body Weight for Height for Adults Height and Weight Documented	State-specific
	Normal Body Weight for Height for Children Height and Weight Documented	State-specific
	Lead Screening in Children	HEDIS <sup>®</sup>
	Persistence of Beta-Blocker Treatment After a Heart Attack	HEDIS <sup>®</sup>
Quality of Care: Outcomes	Adult Access to Preventive/Ambulatory Services	HEDIS <sup>®</sup>
	Children and Adolescents Access to Primary Care Providers	HEDIS <sup>®</sup>
	EPSDT	State-specific
	Dental Visits	HEDIS <sup>®</sup>
	Ambulatory Care	HEDIS <sup>®</sup>
Access	Access Standards: Provider and Practitioner Availability and Network Sufficiency	State-specific
	Access Standards: Practitioner Performance Against Access Standards	State-specific
	Out-of-Network	State-specific
Satisfaction	Number/Type of Provider Grievances	State-specific
	Number/Type of Member Grievances	State-specific
	Practitioner Satisfaction	State-specific
	Provider Satisfaction	State-specific
	Member Satisfaction	CAHPS <sup>®</sup>

<sup>3</sup> CAHPS<sup>®</sup> is a registered trademark of the federal Agency for Healthcare Quality and Research (AHRQ).

## Validity and Reliability of Measures

Medicaid managed care performance measure reporting and validation is required by federal Medicaid managed care regulations [42 CFR 438.358 (b) (2)]. The majority of the performance measures selected by the state are HEDIS® measures. HEDIS® is the most widely used set of performance measures in the managed care industry. Developed and maintained by the National Committee for Quality Assurance (NCQA), HEDIS® is a part of an integrated system to establish accountability in healthcare. HEDIS® measures have been adopted for use by public purchasers, regulators, and consumers. The Measurement Advisory Panel (MAP) provides the clinical and technical expert knowledge required to develop measures for particular clinical areas or specific populations. HEDIS® technical specifications are updated annually. Guidelines for calculating rates and specifications for sampling for selected measures follow the NCQA's *HEDIS® Technical Specifications* for each measurement year (MY). The data is audited and found reportable by an NCQA licensed HEDIS® audit organization.

State agencies, especially Medicaid programs, have been using the CAHPS® surveys since their inception in the mid-1990's. Utilizing the CAHPS® survey results allows the state to benchmark the indicators of member satisfaction against the performance of Medicaid MCOs nationally, using Quality Compass. Survey instruments, sampling and survey administration methodology and analysis methods are contained in each measurement year version of the *HEDIS®: Specifications for Survey Measures* or, are available on the AHRQ website at: [www.cahps.ahrq.gov/cahpskit/Healthplan/HPchooseQXZ.asp](http://www.cahps.ahrq.gov/cahpskit/Healthplan/HPchooseQXZ.asp). The CAHPS® survey(s) are conducted annually for PHP by an NCQA-certified CAHPS® vendor.

State specific measures were developed to reflect the *Healthy Kentuckians 2010* outcome objectives which were targeted and designated by DMS in collaboration with the Departments of Public Health (DPH) and Behavioral Health, Developmental and Intellectual Disabilities (BHDID). Healthy Kentuckians was the state's commitment to the national preventive initiative, Healthy People 2010, with the overarching goals to increase years of healthy life and eliminate health disparities and included objectives and targets set to meet the needs of Kentuckians by 2010. The EQRO validates the state specific performance measure rates reported by PHP using a methodology consistent with the CMS EQR protocol, *Validation of Performance Measures*. The EQRO evaluates the reliability of the PHP reported data, and assesses the degree to which PHP complied with the measure specifications defined by the state. Additionally, the EQRO has worked with DMS and PHP to refine the performance measure specifications and develop new state-specific performance measures to ensure that they are methodologically sound and clinically relevant.

## Management/Coordination of the Evaluation

The Waiver Evaluation Project is an on-going collaboration between Kentucky's Department of Medicaid Services (DMS), PHP and the External Quality Review Organization (EQRO). DMS has responsibility for coordinating all evaluation activities and maintains regular communication

with PHP for project control purposes. DMS also serves as the contract officer for the External Quality Review Organization (EQRO) contract and has responsibility for coordination of EQRO activities.

DMS contracts with an EQRO to conduct the federally required review of Managed Care Entity (MCE)'s as defined in 42 CFR 438 Subpart E. The Commonwealth's contracted EQRO, Island Peer Review Organization (IPRO), was awarded the EQRO contract renewal in July 2008 through the competitive procurement process. IPRO has been contracted to perform EQR activities for the state according to CMS protocols. Information obtained from these activities is included in the Waiver Evaluation Design analysis plan, where applicable and appropriate.

#### Kentucky Medicaid Managed Care EQR Activities:

- Prepare detailed technical report;
- Validate performance improvement projects;
- Validate MCO performance measurements reported;
- Review to determine MCO compliance with federal and state standards;
- Validate encounter data;
- Administer or validate consumer or provider surveys of quality of care;
- Calculate additional performance measures;
- Conduct additional quality improvement projects; and
- Conduct studies that focus on a particular aspect of clinical or non-clinical services at a point in time.

### **Final Evaluation: Data Sources and Methodology**

DMS developed the approved evaluation design plan for the Waiver Demonstration period 11/1/2008 through 12/31/2012 and conducted the required ongoing oversight, analysis and monitoring. The DMS was responsible for the quarterly and annual reporting requirements and contracted with an outside vendor, IPRO, for completion of the interim and final evaluations and reports.

In order to evaluate performance of the waiver demonstration program, and PHP specifically, IPRO reviewed pertinent information from a variety of data sources related to the measures delineated in the Evaluation Design, including:

- State managed care standards and contract requirements;
- PHP's HEDIS<sup>®</sup> Final Audit Reports (FARs) and Interactive Data Submission System reports for HEDIS<sup>®</sup> 2009, 2010, 2011, 2012 and 2013 (Measurement Years (MY)s 2008, 2009, 2010, 2011, 2012);
- PHP Healthy Kentuckians Clinical Outcomes Performance Measure data for reporting years (RY) 2009, 2010, 2011, 2012, 2013 (MYs 2008, 2009, 2010, 2011 and 2012);
- CMS-416 EPDST Screening and Participation rates reported by PHP in 2008, 2009, 2010, 2011 and 2012;

- Geo-Access reports prepared by PHP for 2008, 2009, 2010, 2011 and 2012;
- Data derived from the state-required quarterly statutory reports submitted by PHP in 2008, 2009, 2010, 2011 and 2012;
- PHP's Provider Satisfaction Survey results for 2008, 2009, 2010, 2011 and 2012;
- PHP's Adult and Child Medicaid CAHPS survey results for 2008, 2009, 2010, 2011 and 2012;
- PHP's Quality Improvement Work Plans for 2008, 2009, 2010, 2011 and 2012;
- The Commonwealth of Kentucky, Department of Medicaid Services' Evaluation Design, last revised on October 19, 2010 established baseline data from HEDIS®2007 and outcome goals for 2009 and sustained through 2010.

The evaluation methodology is based on the CMS-approved Evaluation Design. For each domain the goal/objective and hypothesis is stated; the data sources are listed; the analysis plan is described; and a summary of the results is provided. For each measure within the domains the following are provided: measure description; relevant specification changes during the measurement years; the data source(s); the measure-specific quantitative goal(s) and results; and a summary of PHP initiatives and interventions aimed at achieving improvement. Finally, recommendations regarding next steps related to the measurement methodology, goals, and achieving improvement are offered.

As stated in the Evaluation Design, methods used to analyze each measure include:

- Assessment of achievement of the improvement goal(s) stated in the Evaluation Design;
- Trending of data over time to assess for improvement and/or decline in performance;
- Comparison of the HEDIS® measure rates against Quality Compass 2012<sup>4</sup> Medicaid average rate and percentiles (for HEDIS® and CAHPS® measures); and
- Analyses of measure performance and comparisons (as applicable and appropriate).

For ease of interpretation, in addition to the narrative, measure rates and data are displayed in graphs and tables; and relevant benchmarks, such as the Evaluation Design goal(s) and Quality Compass benchmarks are included for reference.

It is important to note that this evaluation does not consider cost and financial information related to the delivery of care. While cost is a critical factor in the delivery of Medicaid services, this report focuses exclusively on processes, outcomes, and satisfaction related to the care and services provided to Medicaid managed care members.

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<sup>4</sup> Since many of the measures reported are derived from HEDIS® and CAHPS®, for comparisons to national Medicaid benchmarks the most recent and relevant benchmarks are utilized. These originate from the NCQA's Quality Compass 2012 and represent the performance of all Medicaid managed care plans that reported HEDIS® and CAHPS data to NCQA for measurement year 2012.

## **I. Domain – Quality of Care – Utilization**

### **Goal/Objective**

The demonstration project, through the healthcare Partnership, will measurably affect the quality of care delivery and improve the health of Partnership members.

### **Hypothesis**

Will the healthcare Partnership cause an improvement in member health status outcomes measures as a result of the demonstration project?

### **Data Sources**

HEDIS® results (using administrative and medical records as required), Healthy Kentuckians Clinical Outcomes Performance Measures (using administrative and medical record data as required), and statutory reports of utilization.

### **Analysis Plan**

- Comparison of HEDIS® baseline rates (HEDIS®2007) and annually (from MYs 2008–2012) for selected measures. Subsequent to the MCO's annual HEDIS® Compliance Audit, PHP is required to submit the Final Audit Report (FAR) which lists the auditor's determination regarding which measure rates are reportable (i.e., were calculated in accordance with HEDIS Technical Specifications), and if not-reportable, the reason. The rates are compared for each submission period against the baseline.
- HEDIS® rates of performance are compared with national benchmarks, using NCQA's *Quality Compass* to assess performance levels against Medicaid means.

## Childhood Immunizations

### Background and Specifications

Data for this measure is derived from PHP's reported rates for HEDIS® 2009–2013 (MYs 2008, 2009, 2010, 2011 and 2012). Benchmarks are derived from NCQA's Quality Compass 2012. This measure is based on the HEDIS® Effectiveness of Care measure: Childhood Immunization Status: Combo 2 and Combo 3. This hybrid measure calculates a rate for each vaccine and two separate combination rates:

- Combination 2 (Combo 2)- The percentage of children who have been appropriately immunized for all of the following vaccines: 4 Diphtheria/Tetanus/Pertussis, 3 Polio, 1 Measles/Mumps/Rubella, 3 H Influenza type B, 3 Hepatitis B and 1 Varicella on or before the child's second birthday;
- Combination 3 (Combo 3) – The percentage of children who have been appropriately immunized for all of the following vaccines: 4 Diphtheria/Tetanus/Pertussis, 3 Polio, 1 Measles/Mumps/Rubella, 3 H Influenza type B, 3 Hepatitis B, 1 Varicella, and 4 pneumococcal conjugate on or before the child's second birthday.

The data is derived from HEDIS® rates reported by PHP and audited and found reportable by an NCQA licensed HEDIS® audit organization.

### Outcome Goals

**Increase the rate of children who receive all American Academy of Pediatrics (AAP) recommended immunizations including chicken pox vaccine (varicella) and pneumococcal conjugate to 92% (Combo 2) and to 85% (Combo 3) by 2009 with sustained improvement 2010.**

### Results

Figure 1 below presents the trend in rates of immunizations for children up to two years of age enrolled in PHP. Rates for Combo 2 increased from a baseline of 79.91% in HEDIS®2007 to 87.17% in 2012 (an improvement of 7.26 percentage points) and rates for Combo 3 increased from 69.09% in the baseline year to 82.74% in 2012. The MY 2012 rate for both Combo 2 and Combo 3 surpassed the Quality Compass 2012 national average rates of 74.48% for Combo 2 and 70.64% for Combo 3.

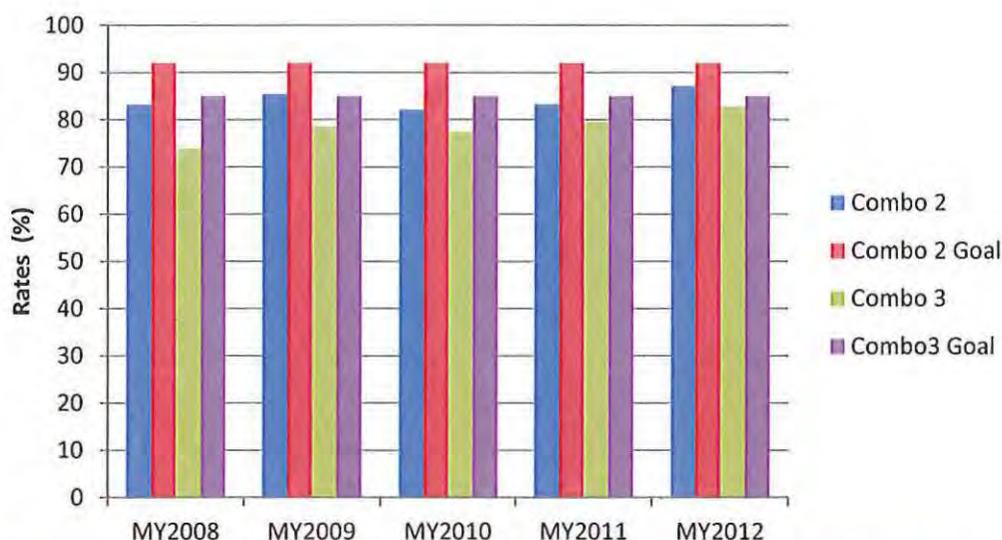
While PHP's childhood immunization rates notably improved over the waiver period, they continue to fall short of the 2009 Outcome Goals of 92% for Combo 2 and 85% for Combo 3. The goal was not achieved for either Combo 2 or Combo 3; however, both rates exceeded the Medicaid mean thus representing good performance as compared to other Medicaid MCOs in the nation.

**Table 2. Childhood Immunizations Rates (%)**

Measures	2007 Baseline	HEDIS® 2009 MY 2008	HEDIS® 2010 MY 2009	HEDIS® 2011 MY 2010	HEDIS® 2012 MY 2011	HEDIS® 2013 MY 2012	Percent- age Point Change	HEDIS® 2012 Nat'l Ave.
Childhood Immunizations – Combo 2	★79.91	★83.19	★85.40	★82.08	★83.22	★87.17	+7.26	74.48
Childhood Immunizations – Combo 3	69.09	★73.89	★78.54	★77.43	★79.47	★82.74	+13.65	70.64

A shaded cell, if any, indicates that a measure rate met or exceeded the outcome goal.

A star (★) indicates that a HEDIS® measure rate is better than the national average benchmark.



**Figure 1. Comparison of Childhood Immunization Rates to Outcome Goals.** Reported rates (%) of childhood immunizations Combination 2 and 3 by PHP compared to the outcome goals for these immunizations for HEDIS® 2009–2013 (MY 2008–2012).

Interventions and initiatives taken to improve the level of childhood immunizations included the following activities:

- Updated PHP’s National clinical practice guideline for Preventive Health with the 2012 Adult and Child immunization schedule. The guideline was communicated to providers via the provider alerts system, in Pharmacy News and placed on PHP’s website and updated in the Provider Manual;
- Identified members in Head Start program and outreached to their parents to encourage EPSDT visits and immunizations;
- Monitored monthly administrative data;
- Members identified as being overdue for childhood immunizations were sent reminder postcards;

- Telephonic outreach to members was conducted;
- Parents/guardians of newborns were educated on the importance of preventive care and EPSDT screenings;
- EPSDT outreach home visits were conducted for members who could not be reached any other way;
- EPSDT immunization mailings were sent to providers and members;
- Provider site visits were conducted to provide education;
- Providers were given lists of members on their panels in need of immunizations;
- Reminder postcards were distributed to newborn parents regarding selecting a PCP and scheduling an EPSDT visit;
- Reminder postcards to members are distributed when immunizations are due;
- Participated in community events and distributed EPSDT / immunization informational material;
- Used on-hold messages to remind members to get immunizations;
- Member newsletter articles on immunizations.

## Breast Cancer Screening

### Background and Specifications

Data for this measure is derived from PHP's reported HEDIS® rates for MYs 2008 -2012. Benchmarks are derived from NCQA's Quality Compass 2012. This measure is based on the HEDIS Effectiveness of Care measure: Breast Cancer Screening. The measure uses administrative data to calculate the proportion of women 40–69 years of age who received a mammogram to screen for breast cancer during the measurement year or the year prior. Members must be continuously enrolled during the measurement year and the year prior to the measurement year with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment.

It is important to note that between the baseline and HEDIS® 2009, the age criteria for this measure was changed from age 50 -69 years to age 40–69 years. This change to the measure specification, which was based on American College of Obstetrics and Gynecology (ACOG) recommendations, will make comparisons with the baseline rate somewhat unreliable.

The data is derived from HEDIS® rates reported by PHP and audited and found reportable by an NCQA licensed HEDIS® audit organization.

### Outcome Goals

**Increase the rate of mammograms to 57% by 2009 with sustained results in 2010.**

### Results

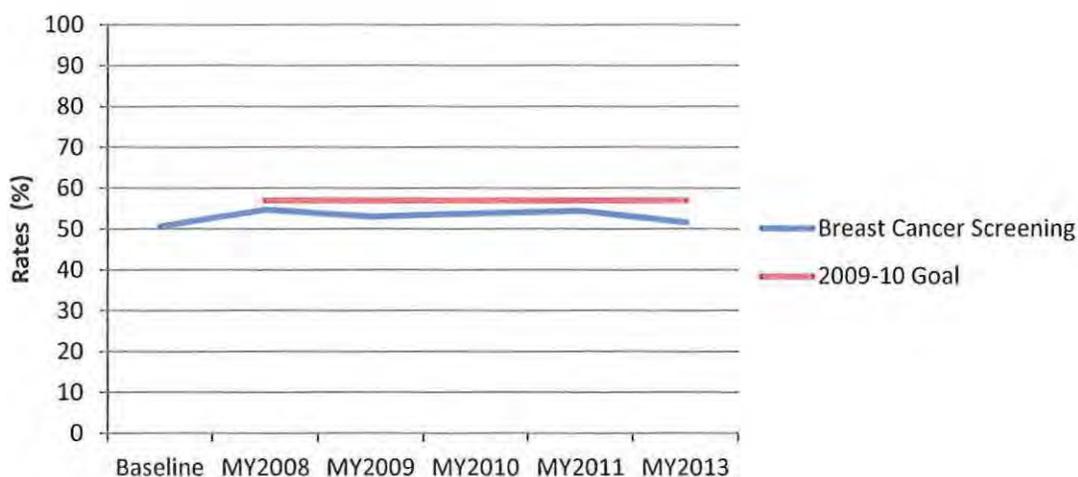
During the entire waiver period, the rate did not meet the goal of 57% set for 2009, and while there was some improvement in the rate overall when we compare the HEDIS®2007 baseline rate of 50.76% and the HEDIS®2013 rate of 51.67%, breast cancer screening rates during the waiver period showed increases and decreases in the rate throughout. This being said, it remains notable that PHP's HEDIS®2013 rate of 51.67% was above the average performance among Medicaid MCOs in the nation.

**Table 3. Breast Cancer Screening Rates (%)**

Measure	2007	HEDIS®	HEDIS®	HEDIS®	HEDIS®	HEDIS®	Percent- age Point Change	HEDIS®
	Baseline	2009	2010	2011	2012	2013 <sup>1</sup>		2012 Nat'l Ave.
		MY 2008	MY 2009	MY 2010	MY 2011	MY 2012		
Breast Cancer Screening	★50.76	★54.76	★53.02	★53.84	★54.43	★51.67	+0.91	50.43

A shaded cell, if any, indicates that a measure rate met or exceeded the outcome goal.

A star (★) indicates that a HEDIS® measure rate is better than the national average benchmark.



**Figure 2. Comparison of Breast Cancer Screening Rates to Outcome Goals.** Reported rates (%) for breast cancer screening by PHP compared to outcome goals for this measure for HEDIS® 2009–2013 (MY 2008–2012).

Interventions and initiatives taken to improve the level of breast cancer screening included the following activities:

- Conducted individual level member education via mailings, on-hold SoundCare messages, mailed postcard reminders, and conducted telephonic outreach;
- Posted Member Center mammogram information under the Health & Wellness section on the plan website. This information includes health recommendations for mammography screening, a listing by county of facilities that provide mammogram screenings to members, and the James Graham Brown Cancer Center mobile van schedule;
- Conducted individual level provider education via newsletter, and targeted listings of members in need of PAP or mammography were distributed to Primary Care Physicians (PCPs);
- PHP published articles in the Provider Newsletter to encourage practitioners to perform an annual mammogram on women ages 40 and older. The articles also informed providers that breast cancer screening is a component of the Provider Recognition Program (incentive program);
- PHP collaborated with the Provider Relations Department to distribute information regarding the importance of breast cancer screenings during provider outreach/education visits, conducted outreach, site visits, education, posted medical information for Breast Cancer Screenings and the provider incentive program on the website in the Provider section;
- Group level interventions included community outreach and education activities, community initiatives, distribution of mammogram information, collaboration with a Family Health Center to host a mobile mammography screening day for PHP members; and
- Monitored monthly administrative data.

## Appropriate Medication for Asthma

### Background and Specifications

Data for this measure is derived from PHP's reported HEDIS® rates for MYs 2008–2012. Benchmarks are derived from NCQA's Quality Compass 2012. This measure is based on the HEDIS Effectiveness of Care measure: Appropriate Medication for People with Asthma. The measure uses administrative data to calculate the percentage of members 5–56 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed controller medication during the measurement year. The member must be enrolled during the measurement year and the year prior to the measurement year with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment. Members with persistent asthma are identified by claims and/or pharmacy data. The methodology for identifying eligible members for this measure is through administrative data.

The data is derived from HEDIS® rates reported by PHP and audited and found reportable by an NCQA licensed HEDIS® audit organization.

### Outcome Goals

**Increase the rate of members who receive appropriate medications to 98% by 2009 with sustained results in 2010.**

### Results

The reported rates for this measure steadily increased between MYs 2008, 2009 and 2010 and then declined for 2011 and 2012. This may have been the result of the sampling methodology change but also may have been related to changes in Kentucky's Medicaid encounter data submissions that took place between 2011 and 2012. This measure did not meet the outcome goal of 98%.

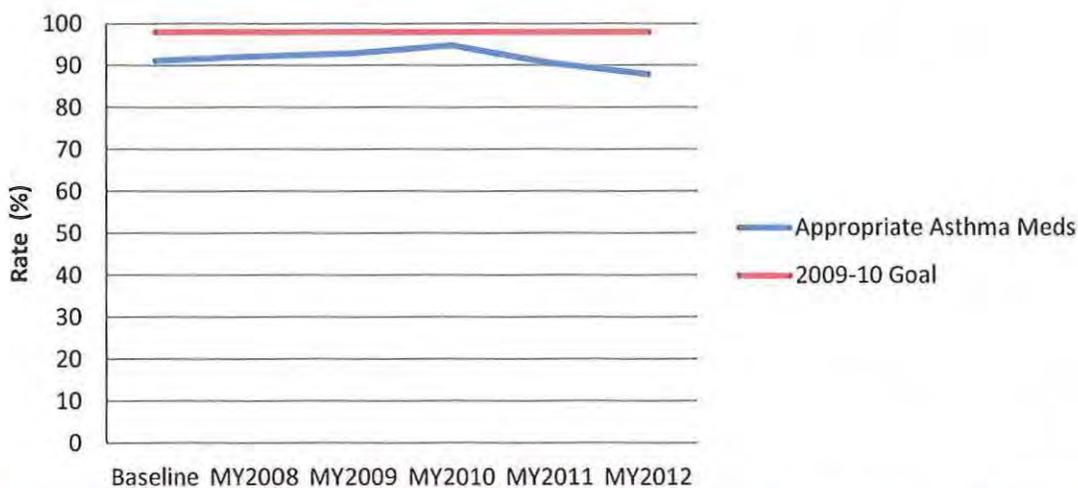
While the trend in PHP's rates has not steadily increased over the entire waiver period, the HEDIS®2013 rate of 87.88% is close to 3 percentage points higher than the HEDIS®2012 Medicaid national average, thus indicating above average performance compared to other Medicaid MCOs across the nation.

**Table 4. Appropriate Medication for Asthma Rates (%)**

Measure	2007 Baseline	HEDIS® 2009 MY 2008	HEDIS® 2010 MY 2009	HEDIS® 2011 MY 2010	HEDIS® 2012 MY 2011	HEDIS® 2013 MY 2012	Percent- age Point Change	HEDIS® 2012 Nat'l Ave.
Appropriate Medication for Asthma	★91.15	★92.13	★92.92	★94.84	★90.63	★87.88	-3.27	84.99

A shaded cell, if any, indicates that a measure rate met or exceeded the outcome goal.

A star (★) indicates that a HEDIS® measure rate is better than the national average benchmark.



**Figure 3. Comparison of Appropriate Medication for Asthma Rates to Outcome Goals.** Reported rates (%) for appropriate medication for asthma by PHP compared to outcome goals for this measure for HEDIS® 2009–2013 (MY 2008–2012).

Interventions and initiatives taken to improve the level of appropriate medication for enrollees with persistent asthma included the following activities:

- A 2009–2010 Study of Utilization and Quality of Care for Persistent Asthmatics using Managed Care Organization Reported Encounter Data was conducted by the EQRO. PHP was provided results and provided written feedback, including an action plan based on study findings and recommendations;
- A 2010–2011 Quality of Care Focused Study of PCP Management of Asthma was developed and conducted collaboratively by DMS, PHP the EQRO. This study compared PHP asthma care to national guidelines and care provided to high risk subpopulations among PHP members with asthma;
- PHP has a dedicated Asthma Disease Care Manager who continues to work with those members who have asthma and the practitioners who treat these members. This program focuses on population-based asthma education, practitioner education, individual care management for asthmatics with an ICU admission for asthma, and

- special interventions for members with multiple asthma related hospital and/or Emergency Room visits;
- Monitored monthly administrative data;
  - Mailed postcard notification of the updates of the Asthma Clinical Practice Guideline to providers;
  - Distributed letters to members seen in the ER to educate them regarding controller medications and the importance of PCP follow up;
  - Sent notification letters to PCPs whose panel members were seen in the ER for asthma;
  - Distributed educational information and asthma action plans to members identified as having persistent asthma;
  - Conducted outreach and education visits to PCPs regarding asthma standards of care;
  - Conducted assessments of members newly identified as having asthma for case management/disease management;
  - Sent educational mailings to members identified as not using controller medications;
  - Published educational articles in member and provider newsletters;
  - Posted Asthma Program information on PHP website – Members page;
  - Participated in the Healthy Hoops Kentucky asthma initiative;
  - Continued to enroll members in the Asthma Disease Management Program;
  - Participated in the “Yes, You Can!” Smoking Cessation Program. Education was provided to those asthmatic members who were also enrolled in the smoking cessation program regarding the associated risk factors of smoking in prevention and management of asthma;
  - Collaborated with respiratory specialist at the Kentucky Chronic Disease Prevention Branch in a state-wide initiative to improve asthma awareness and treatment;
  - Collaborated with the American Lung Association (ALA) to plan the Asthma Educator Institute;
  - Collaborated with Kosair Children's Hospital to prepare clinical guidelines for the ARK (Asthma Research Kosair) project;
  - Collaborated with Pediatric Pulmonologists to provide asthma education to child care givers employed by the YMCA. YMCA requested Healthy Hoops train their after school, summer camp, and daycare staff in the management of a child with asthma;
  - Collaborated with the Louisville Metro Department of Public Health and Wellness to plan and conduct Regional Asthma Forum in Louisville;
  - Collaborated with Public Affairs to develop web based asthma information for children regarding actions to take during air quality alert days;
  - Collaborated with a pharmaceutical company to determine if their Asthma Navigator program might be incorporated into the Passport Asthma Disease Management Program member and provider initiatives;
  - High Risk Letter mailed to high risk asthma program members and their primary care provider. Member letter advised follow-up with the primary care provider and instructions on the importance of daily use of prescribed controller medicines.

## Comprehensive Diabetes Care

### Background and Specifications

Data for this measure is derived from PHP's reported HEDIS® rates for MYs 2008–2012. Benchmarks are derived from NCQA's 2012 Quality Compass. This measure is based on the HEDIS® Effectiveness of Care measure: Comprehensive Diabetes Care. This measure uses hybrid (both administrative and medical record) data to calculate the percentage of members 18 -75 years of age with diabetes (Type 1 and Type 2) who meet the criteria for the following numerators: Hemoglobin A1c (HbA1c) testing; HbA1c poor control (>9.0%)<sup>5</sup>; HbA1c control (<8.0%); HbA1c control (< 7.0%); eye exam (retinal) performed; LDL-C screening; LDL-C controlled (<100 mg/dL); medical attention for nephropathy; blood pressure control (< 130/80 mmHg); and blood pressure control (< 140/90 mmHg). The member must be continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days during the measurement year. Members are identified as having diabetes via claims (visits with a diagnosis of diabetes) and/or pharmacy data.

The data is derived from HEDIS® rates reported by PHP and audited and found reportable by an NCQA licensed HEDIS® audit organization.

### Outcome Goals

Increase each of the Comprehensive Diabetes Care measures below by 5%. Table 5 shows a breakdown of individual data elements with the goal rate for this measure.

**Table 5. Outcome Goals for Comprehensive Diabetes Care**

Measure Data Elements	Percentage (%)	Percentage Goal (+ 5%)
HbA1c Testing	84.36	88.58
HbA1c Poor Control	34.52	32.79
HbA1c Control (<7.0%)	37.59	39.47
Eye Exam	52.96	55.61
LDL-C Screening	79.67	83.65
LDL-C Level Control (<100 mg/dL)	38.53	40.46
Medical Attention for Nephropathy	77.07	80.92
Blood Pressure Controlled <130/80 mm Hg	31.44	33.01
Blood Pressure Controlled <140/90 mm Hg	65.01	68.26

<sup>5</sup> Note that for the measure HbA1c Poor Control, > 9.0%, a lower rate represents better performance.

## Results

Nine of the ten Comprehensive Diabetes Care measures had MY 2012 rates above the Medicaid MCO national average. Between baseline and MY 2012, four of the ten Comprehensive Diabetes Care measures showed increased rates of performance – HbA1c Control (<7.0%) +4.26 percentage points; LDL-C Control (<100mg/dL) +4.01 percentage points; Medical Attention to Nephropathy +2.41 percentage points and Blood Pressure Control (<130/80 mm Hg) +10.60 percentage points.

During the waiver period, several Comprehensive Diabetes Care measures exceeded the outcome goal set for that measure, and three measures sustained that level into the 2012 MY:

- HbA1c Control (<7.0%) was above the outcome goal of 39.47% for all of the years;
- HbA1c Poor Control (>9.0%) was below the outcome goal of 32.79% for MY 2008 only;
- LDL-C Control (<100mg/dL) was above the outcome goal of 40.46% for all of the years;
- Medical Attention to Nephropathy exceeded the goal of 80.92% in MY 2009 and MY 2011;
- Blood Pressure Controlled <130/80 mm Hg, exceeded the goal of 33.01% in all of the years.

**Table 6. Comprehensive Diabetes Care Rates (%)**

Measures	2007 Baseline	HEDIS® 2009 MY 2008	HEDIS® 2010 MY 2009	HEDIS® 2011 MY 2010	HEDIS® 2012 MY 2011	HEDIS® 2013 MY 2012	Percent- age Point Change	HEDIS® 2012 Nat'l Ave.
Hemoglobin A1c (HbA1c) Testing	★84.36	★87.30	★87.83	★86.49	81.95	★84.08	-0.28	82.53
HbA1c Poor Control (>9.0%)	★34.52	★31.35	★35.93	★35.33	★34.76	★35.57	+1.05 <sup>6</sup>	43.04
HbA1c Control (<8.0%)	NR	★59.92	★57.79	★55.79	★55.48	★55.97	-3.95	48.08
HbA1c Control (<7.0%)	★37.59	★56.95	★82.25	★50.00	★42.18	★41.85	+4.26	35.42
Eye Exam (Retinal) Performed	52.96	47.62	52.09	43.82	★54.28	52.74	-0.22	53.35
LDL-C Screening Performed	★79.67	★78.17	★78.14	★76.06	★76.34	★76.99	-2.68	75.00
LDL-C Control (<100mg/dL)	★38.53	★45.24	★47.91	★40.73	★41.04	★42.54	+4.01	35.23
Medical Attention to Nephropathy	77.07	★78.77	★86.50	77.41	★81.15	★79.48	+2.41	77.84
Blood Pressure Control (<130/80 mm Hg)	31.44	33.33	34.41	★41.51	★41.58	★42.04	+10.60	39.41
Blood Pressure Control (<140/90 mm Hg)	★65.01	★63.10	★66.16	★62.16	★63.64	★64.68	-0.33	60.95

A shaded cell, if any, indicates that a measure rate met or exceeded the outcome goal.

A star (★) indicates that a HEDIS® measure rate is better than the national average benchmark.

Interventions and initiatives taken to improve the level of comprehensive diabetes care included the following activities:

- PHP uses a dedicated Diabetes Disease Care Manager to coordinate care with members with diabetes and their providers;
- Diabetes Care Management program offers population-based diabetes education, practitioner education, education for newly diagnosed diabetics and individual case management for diabetics with multiple hospital admissions;

<sup>6</sup> Note that for the measure HbA1c Poor Control > 9.0%, a lower rate represents better performance.

- Identified and assessed newly identified members with diabetes;
- Conducted telephonic outreach to educate members regarding diabetes;
- Conducted mail outreach to members not reached via telephone;
- Sent members reminder cards regarding diabetes preventive care services;
- Distributed lists of members in need of diabetes screenings to PCPs;
- Used on-hold telephone message regarding preventive care for diabetes;
- Conducted targeted outreach to members in need of diabetic retinal eye exams;
- Posted Diabetes program information on PHP website – Members page;
- Monitored monthly administrative data;
- Collaborated with Block Vision, the Plan’s vision subcontractor, to conduct a barrier analysis regarding eye exams;
- Collaborated with Lincoln Trail Health Department in an initiative to improve all diabetic screening measures;
- Outreached to Prevent Blindness KY regarding the process to assist members in obtaining eyeglass hardware;
- Collaborated with high volume lab providers to receive HbA1c and LDL results and conduct member outreach as appropriate;
- Distributed eye care form to participating eye care providers and maintain the Kentucky Diabetes Network provider tool links on the Plan’s web site;
- Conducted routine internal workgroup meetings to review current interventions and identify opportunities to increase the percentage of members who receive appropriate diabetes related testing and control;
- Increased provider awareness of the appropriate treatment for diabetes by distributing the Plan’s current Diabetes Clinical Practice Guidelines through the Plan’s web, and by providing education on-line;
- Increase member awareness regarding the appropriate treatment and appropriate self-management skills for persons with diabetes through:
  - Reminder postcards biannually to those members identified as needing diabetic screenings;
  - Automated reminder calls to members who are late refilling their medications for diabetes;
  - Face-to-face outreach, telephonic outreach, member newsletters, on-hold messages, the Plan’s web site, member educational material, and education via a local television station;
- Distributed the comprehensive diabetes care booklet to newly diagnosed diabetic members and to members needing additional education;
- Increased community awareness regarding the appropriate treatment and appropriate self-management skills for persons with diabetes by distributing educational materials at health fairs and events;
- Utilized 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.