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

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

FINAL REPORT
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Introduction

The first comprehensive evaluation summary was completed in October 2013 and presented an in-depth review of the accountability strategy, monitoring mechanisms and compliance assessment system described in the Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services, approved by the Centers for Medicare and Medicaid Services (CMS) September 20, 2012.[1]

CMS oversees the development and administration of Medicaid managed care programs as described in the Social Security Act (Part 1915[2] and Part 1932(a))[3], the Balanced Budget Act of 1997 and Title 42[4], Part 438 of the Code of Federal Regulations (CFR)[5]. According to federal regulation (42 CFR§438.200 et seq.), all states that contract with a managed care organization (MCO) or prepaid inpatient health plan (PIHP) are required to have a written strategy for assessing and improving quality of managed care services provided to Medicaid enrollees.

Following CMS guidelines for strategy development and content, Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services (also referred to as Kentucky's Quality Strategy) includes the following:

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

The intent of the Year 2 version of the Comprehensive Evaluation Summary is to continue the evaluation of Kentucky's Quality Strategy using updated information, reports and interviews conducted during 2013 through mid-2014. As part of the introduction, recent developments in Kentucky's Medicaid Managed Care Program are discussed including changes in program monitoring responsibilities and a description of the evaluation methodology. Also, by way of a review, findings from the previous Comprehensive Evaluation Summary of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services, completed in 2013, are presented to provide a background for the current evaluation.

Medicaid Managed Care in Kentucky – Recent Progress

Since the beginning of the Kentucky Medicaid Managed Care Program in December 1995 with CMS' approval under Section 1115 waiver authority to establish a statewide Medicaid managed care program that, over time, would be phased into different regions of the state, to Kentucky's current Medicaid managed care presence, there have been numerous successes and setbacks. By July 2011, there were four Medicaid MCOs in Kentucky – University Health Care (doing business as (dba) Passport Health Plan); plus three newly contracted MCOs – Coventry Health and Life Insurance Company (dba CoventryCares of Kentucky), Kentucky Spirit Health Plan, Inc., and WellCare of Kentucky, Inc. A little more than a year after implementation, Kentucky Spirit Health Plan notified Kentucky's Department of Medicaid Services (KDMS) that they would stop providing managed care services to Medicaid beneficiaries as of July 5, 2013. The state successfully procured a new contract with Humana – CareSource and the transition of enrollees from Kentucky Spirit Health Plan was underway in the latter half of 2013.

With expansion of Medicaid eligibility made possible in 2014 under the Patient Protection and Affordable Care Act (ACA), Kentucky recently contracted with Anthem Blue Cross and 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. Over the last seven months, Kentucky Spirit Health Plan enrollment has been transitioned to the other Medicaid MCOs and overall Medicaid managed care enrollment has increased by 303,141 enrollees, for a 44 percent increase. Service areas covered and enrollment of each of the current Medicaid MCOs is displayed in table 1 below.

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

MCO	Enrollment 9/2013	Enrollment 4/2014	Service Area
Anthem Blue Cross Blue Shield	NA	31,361	Statewide expansion enrollment excluding Region 3
CoventryCares of Kentucky	262,836	319,189	Statewide
Humana CareSource	16,068	60,314	Statewide expansion enrollment and Region 3
Passport Health Plan	125,452	190,417	Statewide expansion enrollment and Region 3
WellCare of Kentucky	282,831	387,916	Statewide
Total	**687,187**	**989,197**	NA

NA: not applicable

Responsibility for Program Monitoring

KDMS oversees the Kentucky Medicaid Managed Care Program and is responsible for contracting with Medicaid MCOs, monitoring their provision of services according to federal and state regulations and overseeing the state's Quality Strategy as well as each MCO's quality program. KDMS contracts with an external quality review organization (EQRO) to assist the

state in conducting external reviews and evaluations of state and MCO quality performance and improvement.

In mid-2013, KDMS was in the process of internal re-organization to better address its responsibilities for monitoring and oversight of an expanding Medicaid managed care program. A new division within KDMS, the Division of Program Quality and Outcomes (DPQ&O), was created and consisted of two branches – Disease and Case Management Branch and Managed Care Oversight – Quality Branch. The Managed Care Oversight-Contract Management Branch was created within the Division of Policy and Operations, but effective July 1, 2014, this branch is under the Division of Program Quality and Outcomes. The Managed Care Oversight – Contract Management Branch monitors MCOs' contract compliance and performs audits of MCO system/processes to assess the accuracy of data in the MCO reports. The Managed Care Oversight – Quality Branch oversees the EQRO contract and works with the EQRO to develop better quality initiatives for the KDMS program.

New leadership positions were created and resulted in several new staff appointments which have now been completed and include:

- Director and Assistant Director for the Division of Program Quality and Outcomes;
- Branch Manager for Disease and Case Management;
- Branch Manager for Managed Care Oversight – Quality; and
- Branch Manager for Managed Care Oversight – Contract Management.

Several new staff positions were also created within the branches and KDMS is in the process of filling these positions as well. 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.

Evaluation Methodology

The methodology for this report includes a review of documents from external review activities and plan reporting, literature review and stakeholder interviews. Experience from other states' external quality review and quality improvement initiatives was also researched to provide valuable examples of promising practices.

This report includes an overview of Kentucky's Medicaid managed care data reporting systems obtained from MCO and EQRO reports. Other state Quality Strategies, obtained from state websites, provided information regarding their EQRO activities, Performance Improvement Projects and other quality improvement initiatives. Core program goals from Kentucky's Quality Strategy were quantified and statewide aggregate baseline data were obtained from HEDIS® 2013 results.

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

- Department for Medicaid Services FY 14 Monitoring Tool;
- 2012 MCO Compliance Report findings;
- External Quality Review Technical Report, August 2013;
- A Member's Guide to Choosing a Medicaid Health Plan, 2013;
- Kentucky MMIS Encounter Validation Report, February 2014;
- Proposed Encounter Data Completeness Studies, April 2014;
- Encounter Data Validation Project – 2013 Encounter Data Questionnaire, February 2013;
- Provider Access and Availability Questionnaire Responses, June 2013;
- Validation of Managed Care Provider Network Submissions: Audit Report, June 2013;
- Web-Based Provider Directory Validation Study 2013, completed January 2014;
- Validation of 2012 Healthy Kentuckians Performance Measures Reported by Passport Health Plan, April 2013;
- Kentucky Newborn Readmissions Focused Study, March 2014;
- Kentucky Postpartum Readmissions Focused Study, January 2014;
- 2014 Focused Study Proposal: Experience of Care for Children with a Behavioral Condition; and
- MCO Performance Improvement Project proposals and reviews, 2013 and 2014.

A valuable component of this evaluation approach is the view of quality from the MCO's perspective which was obtained through conference call interviews with key quality staff in each of the Kentucky MCOs. Dialog with MCO staff allowed the reviewer to obtain insights and information not available in written reports and websites and to better understand the relationships between the MCOs, the state and the EQRO. Interviews were held with staff from Kentucky Department of Medicaid Services (KDMS), Anthem Health Plan, CoventryCares of Kentucky, Humana CareSource, Passport Health Plan, WellCare of Kentucky and the EQRO, Island Peer Review Organization (IPRO).

Summary of Previous Findings - Comprehensive Evaluation Summary, October 2013

The previous Comprehensive Evaluation Summary of the Commonwealth of Kentucky Strategy for Assessing and Improving the Quality of Managed Care Services, which was completed in October 2013, reviewed Kentucky's Medicaid Managed Care Program activities during 2012-2013 and identified program strengths and opportunities for improvement. These previous findings are presented here to provide a review of the first Evaluation Summary and to set the stage for identifying the progress that has been made by KDMS in response to the findings.

Strengths

Regulation/Contract

- The state's Quality Strategy is well written, follows the CMS outline, includes all required topics and adequately describes the Kentucky Medicaid Managed Care Program. The strategy is approved by CMS and all MCO contract provisions incorporate the standards of 42 CFR Part 438, subpart D.
- Core program goals were carefully selected to reflect Healthy Kentuckians goals and reflect the particular needs of the Medicaid population. Standardized benchmarks are used to measure improvement. MCOs are aware of the Quality Strategy goals and are setting their own performance goals to align with the state's goals.
- A contract with an external quality review organization is in place. The EQRO contract includes conducting all quality monitoring and improvement activities that are required by CMS as well as several optional activities. There is a good working relationship between the state and EQRO.
- Data collection systems are in place and include encounter data, provider network data and HEDIS® quality performance data.

Monitoring Systems

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

Coordination

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

Opportunities for Improvement

Regulation/Contract

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

Monitoring Systems and Quality Improvement

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

- KDMS monitoring of MCO quality activities requires MCOs to submit many written reports – some quarterly and/or annually. This reporting burden was commented on by all MCOs interviewed and further supports the need for KDMS to re-evaluate what is necessary to be reported periodically and what can be obtained through EQRO work plan requirements, Compliance Reviews and/or national accreditation reviews.

Coordination

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

Strategies from Other States

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

Core Program Goals and Results

As stated in Kentucky's Quality Strategy, approved in 2012, the primary goal of Kentucky's Medicaid Managed Care Program is to improve the health status of Medicaid enrollees and to lower morbidity among enrollees with serious mental illness. Statewide health care outcomes and quality indicators for the goals and objectives were designated by KDMS in collaboration with input from the Department of Public Health (DPH) and Behavioral Health, Developmental and Intellectual Disabilities (BHDID). The four goals listed in the Quality Strategy are:

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

For each goal, selected quality indicators from HEDIS® results will be tracked over time and compared to national benchmarks in order to measure program success. Benchmarks used to measure improvement are from NCQA's Quality Compass Medicaid[6] which includes HEDIS® data submitted to NCQA by Medicaid plans throughout the nation. Using these standardized measures as benchmarks allows states to make meaningful comparisons of their rates to rates for all reporting Medicaid managed care plans nationwide and thus allows state policy makers to better identify program strengths and weaknesses and target areas most in need of improvement. Improvement in the Kentucky strategy is measured by a comparison of the state's rate to the 50th or 75th percentile of the national benchmark or as an improvement of a ten percent difference between the state's baseline rate and the re-measurement rate. This use of national performance is a reasonable approach to setting benchmarks particularly since the Commonwealth modestly set the bar at the 50th percentile for the majority of the measures (colorectal cancer screening, breast cancer screening, cervical cancer screening, comprehensive diabetes care, cholesterol management, antidepressant medication management and outpatient visits).

At the writing of this second year evaluation summary report, only one year of HEDIS® data are available, namely HEDIS® 2013 (measurement year 2012), thus an analysis of improvement from baseline to re-measurement is not possible. Kentucky's HEDIS®2013 state aggregate baseline rates are shown below for the objectives listed in the Quality Strategy. The state aggregate rate for each objective was compared to the 2012 NCQA Quality Compass national Medicaid percentile rate for that measure. For example, Kentucky's aggregate statewide rate for Breast Cancer Screening was 51.67% which was above the national Medicaid 50th percentile rate of 50.47%, thus exceeding the objective for this measure. The tables below show that as many as eleven (11) measures already meet or exceed the benchmark and another eight (8) measures are within five percentage points of the targeted national benchmark. The tables below present Kentucky's baseline data for measures included in each of the four goals and indicate whether a measure's baseline rate has already met or exceeded the HEDIS®2012 national Medicaid benchmark[7].

Goal 1. Improve preventive care for adults

All measures meet/exceed 2012 Medicaid 50th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate

Objectives	HEDIS® 2013 Baseline Rate (%)	Met Objective (Yes/No)
HEDIS® Colorectal Cancer Screening	NR	NR
HEDIS® Breast Cancer Screening	51.67%	Yes
HEDIS® Cervical Cancer Screening	49.61%	No

NR: not reported

Goal 2. Improve care for chronic illness

All measures meet/exceed 2012 Medicaid 50th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate

Objectives	HEDIS® 2013 Baseline Rate (%)	Met Objective (Yes/No)
CDC:* Hemoglobin A1c testing	83.38%	Yes
CDC: HbA1c Poor Control (> 9.0%)**	47.42%	No
CDC: HbA1c Control (< 8.0%)	44.51%	No
CDC: HbA1c Control (< 7.0%)	35.00%	No
CDC: Eye Exam Performed	41.91%	No
CDC: LDL-C Screening	75.27%	No
CDC: LDL-C Control (< 100 mg/dL)	32.80%	No
CDC: Medical Attention for Nephropathy	76.67%	No
CDC: Blood Pressure Control (< 140/90 mmHg)	56.67%	No
HEDIS® Cholesterol Mgt – LDL-C Screening	79.91%	No
HEDIS® Cholesterol Mgt – LDL-C Control (< 100 mg/dL)	44.59%	Yes

* CDC: HEDIS® Comprehensive Diabetes Care measure

** For this measure, a lower rate is better.

Goal 3. Improve behavioral health care for adults and children

Measures meet/exceed 2012 Medicaid 50th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate

Objectives	HEDIS® 2013 Baseline Rate (%)	Met Objective (Yes/No)
HEDIS® Antidepressant Medication Management: Effective Acute Phase	58.36%	Yes
HEDIS® Antidepressant Medication Management: Effective Continuation Phase	42.98%	Yes

Goal 3. Improve behavioral health care for adults and children

Measures meet/exceed 2012 Medicaid 75th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate

Objectives	HEDIS® 2013 Baseline Rate (%)	Met Objective (Yes/No)
HEDIS® Follow-up After Hospitalization for Mental Illness within 30 days of discharge	62.55%	No
HEDIS® Follow-up After Hospitalization for Mental Illness within 7 days of discharge	36.60%	No

Goal 4. Improve Access to a Medical Home

All measures meet/exceed 2012 Medicaid 75th Percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate

Objectives	HEDIS® 2013 Baseline Rate (%)	Met Objective (Yes/No)
HEDIS® Adult Access to Preventive/Ambulatory Health Services		
Ages 20–44	86.22%	Yes
Ages 45–64	91.32%	Yes
Ages 65+	91.31%	Yes
Total	88.75%	Yes
HEDIS® Children and Adolescents Access to Primary Care		
12–24 Months	97.65%	No
25 Months–6 Years	92.07%	Yes
7–11 Years	91.95%	No
12–19 Years	91.64%	Yes

Goal 4. Improve Access to a Medical Home

Outpatient visits meet/exceed 2012 Medicaid 50th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate

Emergency Department (ED) visits decrease rate of utilization by 10% between the baseline rate and the re-measurement rate

Objectives	HEDIS® 2013 Baseline Rate	Met Objective (Yes/No)
Outpatient visits for all age groups	645.76	No
ED Visits for all age groups	84.45	NA

NA: not applicable

In assessing the program's success in meeting their goals and objectives, it should be noted that the benchmark targets were determined at a point in time when Kentucky's experience was with only one Medicaid managed care plan, in one region of the state. Thus the targets were selected for the Quality Strategy objectives without knowing what the baseline rates would be

for the state's current, expanded Medicaid Managed Care Program. With HEDIS®2014 rates soon to be available, if a measure's performance continues to meet the benchmark objective for a second year, KDMS may want to consider raising some of the benchmark targets in an update of the strategy. Also, as noted in the previous review of the Quality Strategy goals and objectives, the state could consider expanding the goals to address the large enrollment of women and children in the Medicaid Managed Care Program by including goals and objectives for prenatal/postpartum care and preventive measures addressing childhood obesity, counseling for nutrition and physical activity and adolescent risk screening.

While the number of baseline measures that already meet or exceed the 2012 national benchmark is commendable, there are several measures that are worth identifying as opportunities for improvement based on a substantial difference between the Kentucky statewide aggregate HEDIS® 2013 rate and the 2012 national Medicaid benchmark, and these are:

- Cervical Cancer Screening;
- Comprehensive Diabetes Care: Eye Exam Performed;
- Follow-up After Hospitalization for Mental Illness within 30 days and within 7 days of discharge; and
- Outpatient Visits/1,000 Members for All Age Groups.

Quality Monitoring and Assessment

Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services outlines a strategy for quality oversight that is aligned with federal regulations. The Social Security Act (Part 1932(a))[8] requires states that contract with Medicaid MCOs to provide for an external independent review. The Balanced Budget Act of 1997 further described mechanisms states should use in monitoring Medicaid MCO quality 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.[9] This two-part section describes and assesses the activities of Kentucky's EQRO and the review and monitoring activities of the Kentucky Department of Medicaid Services (KDMS).

EQRO Activities Overview

Federal regulations outlining the activities for quality review and monitoring, list three mandatory activities and five optional activities for states that provide care to Medicaid enrollees through managed care organizations. KDMS has a contract with an EQRO to conduct all of the three mandatory review activities as well as many of the optional activities. The Kentucky EQRO work plan includes the following activities:

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

Data Reporting Systems Review

Medicaid MCOs in Kentucky are required to maintain a Management Information System (MIS) to support all aspects of managed care operation including member enrollment, encounter data, provider network data, quality performance data, claims and surveillance utilization review to identify fraud and/or abuse by providers and members. The MCO is responsible for verifying, through edits and audits that the information contained in their databases is accurate and timely. They are expected to screen for data completeness, logic and consistency. The data must be consistent with procedure codes, diagnoses codes and other codes as defined by KDMS and in the case of HEDIS® data, as defined by NCQA.

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

Encounter Data

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

May, 2013 was the first month that CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky submitted encounters to KDMS. For seven years prior to the MCO expansion, only Passport Health Plan submitted encounters to KDMS for validation by the EQRO. The Passport Health Plan encounter submissions were suspended in June 2012 due to the end of the EQRO contract. Encounter file creation was then resumed after all MCOs successfully submitted files in the 5010 format and the change order for the file layouts was completed by KDMS. Humana CareSource has been submitting encounters since mid-2013 and Anthem Health Plan has been conducting test submissions for several months now.

In early 2013, the EQRO conducted a review of the state's encounter data systems and processes that are used to load MCO encounter files. This review covered state requirements for collection and submission; confirmation of the data submission format; description of the information flow from the MCO to the state; list of edit checks built into the state's system; process for voids and adjustments; error reports; state uses of loaded data; process for quality checks to ensure that all data from the MCO's system and from vendors are loaded completely and accurately into the data warehouse; and key reasons for encounter record rejections. There was also a section on claims processing.

The EQRO receives a final extracted file from KDMS each month for further processing and prepares a monthly data validation report summarizing the MCOs 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 most recent validation report reviewed for this evaluation is the Monthly Encounter Data Validation Report, February 28, 2014 for encounters loaded in the system through March 3, 2014. A review of missing data elements by place of service, indicates a number of variables that consistently have a high percent missing including diagnoses codes 4 and above,

performing provider key, inpatient and outpatient procedure codes, procedure modifier codes, referring provider key, inpatient and outpatient surgical ICD-9 codes.

During the interview portion of this evaluation, MCOs commented that their communications with KDMS regarding encounter data submissions is positive, there is good response provided to MCO questions and issues which has resulted in a lot of progress toward rectifying submission and coding issues. As reported in the previous evaluation summary report, MCOs are still struggling with coding issues, taxonomy and provider matching with the state Medicaid roster. All MCOs are aware of potential capitation rate withholds if they do not maintain a minimum encounter acceptance rate of 95%. This service level agreement can be an impetus for MCOs to improve their encounter record rejection rates, but how it is implemented is a concern. MCOs commented that there are some rejections that can never be corrected, that the turn-around time for resubmitting rejected records is not long enough and that the majority of errors are related to poor quality/completeness of provider data which requires training and re-training of physician staff which also will take time. KDMS has started having conference calls with the EQRO to discuss the monthly encounter data validation reports and they are forming a workgroup to address the issues identified.

KDMS continues to work with the MCOs, the EQRO and other divisions of KDMS to correct errors in encounter submissions and to more closely align the edits used by KDMS with those used by the MCOs. The monthly meetings between KDMS and the MCOs have greatly helped the plans in working out their problems. The state is hiring new staff that will be working with the monthly validation reports and addressing the issues identified. A closer examination of missing data by place of service and how each MCO compares to statewide rates and how they compare to other MCO rates for missing data might be the place to begin. Another validation method to consider for validating missing data would be a medical record review where a sample of encounters are selected and the medical records for those encounters are reviewed to see if the missing data were recorded in the record but were not recorded in the encounter submission. A similar study was conducted by the EQRO in New York State and resulted in useful information regarding MCO encounter coding practices.

The EQRO has also proposed an encounter data completeness study entitled Encounter Data Validation and Data Benchmarking. The purpose of this study is to compare MCO specific HEDIS® rates with rates produced from the encounter data warehouse. A sample of this method was prepared by the EQRO and presented to KDMS 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 will calculate measure rates from submitted encounter data and compare them using plan submitted HEDIS® data. A follow-up, Phase 2 study will be conducted later in 2014 using the HEDIS®2014 submitted rates from the MCOs. This study method is a cost-effective validation, compared to medical record review studies, and has been successfully used by the EQRO in other states.

As the state's encounter data system continues to develop with the expansion of Medicaid MCOs, KDMS is focusing on building staff expertise to better use encounter data for evaluating

quality, utilization, network adequacy and access and in calculating risk-based capitation rates. In the interim, KDMS uses a multitude of reports required to be submitted by the MCOs quarterly, many of which are derived from the plan's encounter data system:

- For access they routinely monitor Provider Network File layout, Geo-Access Reports and Maps, Access and Delivery Network Narrative reports and Utilization of Subpopulations and Individuals with Special Healthcare Needs report;
- MCO reports focusing on quality of care include Summary of Quality Improvement Activities, Quality Assessment and Performance Improvement Work Plans, Monitoring Indicators, Benchmarks and Outcomes, Performance Improvement Projects, Satisfaction Surveys, Evidence-Based Guidelines for Practitioners, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, Grievances and Appeals;
- The following MCO submitted reports help KDMS monitor utilization: Utilization of Ambulatory Care by Age, Utilization of Emergency and Ambulatory Care Resulting in Hospital Admission, Emergency Care by ICD-9 Diagnosis, Home Health Utilization, Utilization of Ambulatory Care by Provider Type and Category of Aid, EPSDT Special Services, Provider and Member Fraud, Waste and Abuse Reports, Monthly Formulary Management, Top 50 Drugs by various categories and Top 50 Prescribers by various categories.

Florida's Medicaid Revised Comprehensive Quality Strategy, 2013-2014 Update[10] provides a good example of how that state uses and intends to use Medicaid encounter data. Florida uses encounter data to evaluate MCO performance measures, and they have also developed a method for analyzing access to specialists using encounter data. Risk adjustment using encounter data was phased in over a three-year period as a component of the rate setting process for capitated payments to MCOs. To determine completeness, the state developed a methodology for forecasting the volume of encounter submissions to expect from a plan based on plan member demographics, types of plan services, health status and the case mix of each plan. The Florida Agency for Health Care Administration is actively working toward using encounter data to assess quality and appropriateness of care using a statistical analysis to monitor the association between medical services and pharmacological treatments within clinical practice guidelines. They are also exploring the feasibility of assessing network adequacy using the provider information submitted in an encounter.

Provider Network Data

Each of the Kentucky MCOs maintains a Provider Network database that is continually updated and submitted to KDMS 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 state.

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 the state's Managed Care

Assignment Processing System (MCAPS) and sent surveys to 100 primary care providers and 100 specialists from each MCO. 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 (48.4%) providers who returned the survey noted at least one revision. Errors were most commonly found in telephone number, provider license number and street address. The EQRO sent plan specific reports including a list of changes and a list of incorrect addresses to the MCOs and requested that the MCOs update their provider directory file with this information. KDMS found the results of the survey informative in addressing issues related to access to service and particularly the importance of providing accurate provider information, such as addresses and phone numbers, to enrollees.

Actions taken by the MCOs to correct their files for the sampled providers is a place to start, but the results of this survey gave MCOs an indication that further validation on their part is needed. The MCOs are aware that their provider data are only as accurate as what is submitted by the provider and changes such as office relocation need to be reported by the provider. The state and the MCOs need to continually remind providers that any change regarding their practice needs to be submitted to their participating plans and to the state.

A different tract for validating MCO Provider Network data was taken with the 2014 Web-Based Provider Directory Study. Each MCO was requested to submit to the EQRO the file that they used to populate their MCO's web directory. A random sample of 200 providers (100 PCPs and 100 specialists) was selected 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. An overall match rate for each MCO for primary care providers and specialists was calculated. There were several limitations noted by the EQRO in evaluating results by MCO and by provider type. A major limitation of the study was the fact that the sample data were being compared to a file that, given the results of the previously described validation of MCAPS records, had some degree of undetermined accuracy. Another limitation to this study was that it did not take into consideration the fact that providers often have multiple office sites. The KDMS 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 a correct database.

A different approach for validating web-based provider network data was recommended as a result of this study. The EQRO proposed using a sample of the provider validated file information from the Provider Network Submissions audit and comparing this information to what is posted on the MCO's web directory. This approach seems more direct and will insure that information recently reviewed and submitted by the provider, and thus more likely to be accurate, is compared to the web directory that members access online.

Quality Performance Data

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® (Consumer

Assessment of Healthcare Providers and Systems[11]) data to KDMS. The Healthy Kentuckians data, submitted annually to KDMS, is validated by the EQRO based on the CMS protocol: *Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities (updated 2012)*[12]. All audit findings are compiled as part of the EQRO's validation of quality performance data and audit reports are 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 validation. For HEDIS®2013, all effectiveness of care, access and availability, access dental and utilization measures were required to be submitted. KDMS 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.

Quality performance data results were presented in the following EQRO activities:

- A Member's Guide to Choosing a Medicaid Health Plan, 2013 (also referred to as the Annual Health Plan Report Card);
- MCO Quality Performance Dashboard; and
- The External Quality Review Technical Report.

Annual Health Plan Report Card

An Annual Health Plan Report Card was developed by the EQRO in collaboration with KDMS to provide quality performance information to be used as a guide for individuals choosing a Medicaid managed care health plan. Entitled "A Member's Guide to Choosing a Medicaid Health Plan", the first edition was published in 2013 and was distributed in written format to Kentucky enrollees during the open enrollment period. The document was also posted on the Advisory Council for Medical Assistance (MAC) webpage, but it is unclear how Medicaid managed care enrollees would know to look for this document on this webpage.

Kentucky DMS intends to update the quality performance and consumer satisfaction information in this report each year after new HEDIS® and CAHPS® data are submitted and ready for publication. They intend to place the 2014 report card on the KDMS website this fall, 2014 for open enrollment. The format for 2014 will be a tri-fold brochure with an MCO comparison of performance in the center and questions members should ask their MCO on the back. This tool is a consumer friendly document that describes managed care, shows MCO service areas and provides MCO contact information. The report will show each plan's actual performance percentage rates compared to the state's percentages. An enrollee can easily look at areas of preventive care, access and satisfaction and see how each plan compares with the others. While the 2013 version of this report was primarily available in a written format, the distribution of future reports could be more far reaching if they are posted on the Kentucky Medicaid Managed Care webpage in addition to being included in the open enrollment packet sent to enrollees. No matter where the document is posted on the website, there should be links to the document on pages most likely to be viewed by members and it is also important to

include appropriate keywords in the posting so that the document will appear in website searches.

Two of the five MCOs interviewed had seen the 2013 Member's Guide and they both commented that MCO's should be given an opportunity to review the guide and confirm and/or validate information presented about their plan before the report is finalized. This procedure is followed in New York State for both their HEDIS®/CAHPS® published data reports and their Consumer Guides to help in choosing a plan.

MCO Quality Performance Dashboard

The EQRO, in collaboration with KDMS, developed an MCO Dashboard. Designed in a similar fashion to gauges on a vehicle's dashboard, this monitoring tool is intended to pictorially describe national, statewide and MCO-specific performance on selected quality measures. A 2013 version of the MCO Dashboard was posted on the EQRO's website for KDMS internal monitoring purposes only.

Major content topics include Overall Performance, Poor Performances; Review Plan; and Measures. Data for measures includes all HEDIS®2013 measures and satisfaction metrics. For each measure there is a bar chart plan comparison and a line chart trend over time (currently showing only one year's data). The content of the 2013 MCO Dashboard is comprehensive and clearly displayed. It is easy to navigate the site to quickly obtain information. KDMS has been reviewing reports and data currently received from the MCOs to identify additional information from these reports that could be included on the dashboard. They will be meeting with the EQRO to discuss the current content and what the 2014 version should include.

While the original intent of the dashboard concept was to be an internal KDMS monitoring tool that would be updated as data became available, the comprehensiveness of the data presented and the ease of navigating the site should make this a useful tool not only for KDMS staff, but for the Kentucky MCOs, as well as Medicaid managed care enrollees, other states and the general public. To that end, KDMS staff members report that they are working on building the quality portion of the Medicaid managed care website and would like to eventually make the EQRO's MCO Dashboard public. This tool is a perfect example of data transparency and sharing it more broadly should be pursued.

Technical Report

Based on guidelines in the Balanced Budget Act and final regulations, the EQRO prepared a Technical Report in August 2013. The report provides a quantitative analysis evaluating access, timeliness and quality of care provided by Kentucky's four Medicaid MCOs – CoventryCares of Kentucky, Kentucky Spirit Health Plan, Passport Health Plan and WellCare of Kentucky. The report included quality performance data, CAHPS® satisfaction data, results of compliance reviews, validation results of performance measures and validation of performance

improvement projects. MCO strengths and opportunities for improvement were outlined for each MCO. The MCO is required to respond to the EQRO and KDMS for each opportunity for improvement. The MCO's response is then published in the next annual Technical Report. While the federal regulations require an annual review of access, timeliness and quality of care, a full review is only necessary every three years.

Since the Technical Report is a requirement for all states with a Medicaid managed care program, the state should take this opportunity to prepare a report that will have usefulness beyond the fact that it is required to be submitted to CMS. For example, in New York State, Health Department staff uses the Technical Report when preparing interview questions for the quality portion of MCO on-site compliance reviews. This report is also a vital reference anytime state quality staff meets face to face with an MCO, as it covers many topics likely to be discussed regarding quality.

Compliance Reviews

Federal regulations require that every state with a Medicaid managed care program conduct a full review of MCO compliance with state and federal regulations at least once every three years. The reviews can be done by the state or the EQRO. In Kentucky, the EQRO is contracted to annually evaluate each MCO's performance against contract requirements and state and federal regulatory standards. In 2013, a full review of all requirements was conducted for the MCOs new to Kentucky's Medicaid Managed Care Program – CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky. Based on previous compliance review findings with Passport Health Plan, several elements with previous full compliance were not reviewed in 2013. At this time, KDMS is committed to conducting compliance reviews on an annual basis.

According to 42 CFR§ 438.360, states can use information obtained from a national accrediting organization review for the mandatory external quality review activities conducted by either the state or its EQRO. With this authority, states can deem NCQA standards as equivalent to state requirements or use the information obtained through accreditation surveys to streamline their oversight process.[13] NCQA annually publishes a crosswalk to assist states in determining which of their state requirements would qualify for deeming and thus reduce duplicative reviews. Using this crosswalk, in 2013, the EQRO prepared a Proposal for the Implementation of Deeming Option where federal requirements for compliance were compared to NCQA and URAC[14] (formerly known as the Utilization Review Accreditation Commission) accreditation standards. KDMS, in collaboration with the EQRO, agreed upon a list of deemed elements for Compliance Review. Currently, only Passport Health Plan is NCQA accredited. Anthem and Humana-CareSource anticipate submitting applications in 2015, CoventryCares of Kentucky and WellCare of Kentucky have their NCQA on-site reviews scheduled for July, 2014.

In 2014, a full review of all requirements was conducted for the expansion MCOs including the addition of Humana-CareSource. Passport Health Plan again had a partial review. The 2014 Compliance Review findings are currently being drafted for KDMS review. Prior to this year, KDMS staff participated in the on-site portion of the Compliance Review, but this year state staff participated via conference call.

KDMS is in the process of reviewing the review tools, particularly offsite reviews for pharmacy, health information systems and annual disclosure, to look for ways to streamline the annual review requirements. They are discussing with the EQRO the possibility of reviewing select elements throughout the year. KDMS is also considering having a face-to-face meeting with the EQRO staff while they are on-site for reviews in Louisville. Further, the state is adding language to the results of the reviews to clarify that if the MCO does not correct issues found two years in a row, then their score for the review will be non-compliant and Corrective Action Plans will be assessed.

State Review Activities Overview

As described earlier, The Division of Program Quality and Outcomes, now including the Managed Care Oversight – Contract Management Branch has oversight responsibilities for Kentucky's Medicaid Managed Care Program. Managed Care Oversight – Contract Management staff members function as liaisons between the MCO and state regarding contract compliance and management. Branch staff members serve as plan managers and participate in compliance review activities for the MCOs, they review and analyze monthly encounter data reports from the EQRO and quarterly reports submitted directly to DMS from the MCOs. Included in these regularly submitted reports are access and availability reports, program integrity, grievances and appeals and EPSDT compliance. The Division of Program Quality and Outcomes, Disease and Case Management Branch has oversight responsibility for Medicaid enrollee care coordination including MCO case management programs as well as MCO coordination with other state agencies such as Kentucky's Department of Community Based Services (DCBS) and the Department for Aging and Independent Living (DAIL). The Managed Care Oversight - Quality Branch oversees the EQRO contract, reviews the compliance review findings, and works with the EQRO to develop quality measures and activities to improve Kentucky's healthcare quality and outcomes.

Monitoring Access to Care

Geo-access reports are a key part of the state's monitoring requirement to assure access to providers. The average distance (in miles) to a choice of providers for all members is presented, and the average distance to one provider for key geographic areas is also provided. Providers include primary care, primary care centers, dental, specialty, non-physician, hospital, urgent care center, local health department, federally qualified health centers, pharmacy, significant traditional provider, maternity care, vision care and family planning clinics. MCOs also monitor

access to high volume specialists such as cardiology, obstetrics/gynecology and surgery. All analyses are provided for enrollees in urban areas and for rural enrollees.

In addition to geographic access and validation of provider network submissions, each MCO also conducts surveys to determine appointment availability for urgent or non-urgent care in accordance with contract availability standards. The EQRO conducted a survey in 2013 requesting each MCO to describe the method they used for surveying provider access and availability of appointments. The responses indicated that each MCO conducts 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.

In last year's evaluation summary report, it was 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 the designated methodology and time frames. 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 was approved by KDMS in April 2014 and will be fielded in mid-2014. The survey methodology uses a random sample of 250 behavioral health providers from each MCO for a total of 1,000 providers. If an MCO has less than 250 providers, then the entire universe for that MCO would be selected. The EQRO will use the MCAPS to select the sample and phone calls to provider offices will 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). Surveying behavioral health providers rather than primary care providers or primary care centers is an ambitious way to try out the "secret shopper" survey method, but hopefully lessons learned in this initiative will provide useful information for future surveys in Kentucky and for other states considering the use of secret shopper methodologies.

One MCO reported that they have received feedback from their provider community opposing the use of secret shopper calls as they take office staff time away from real member calls to schedule appointments for fictitious members. It was also noted by one of the MCOs that some behavioral health providers in community mental health clinics may not be seeing patients on an outpatient basis. If possible, the state's sample selection should take this into account.

Care Coordination

Provisions of the Affordable Care Act (ACA) strongly support the role of care coordination in providing care to individuals with special health care needs. MCOs have traditionally embraced this concept and many have developed sophisticated systems to identify enrollees at risk, provide disease and case management services and monitor and track outcomes. Identifying new enrollees with care coordination needs can start with the completion of a Health Risk Assessment (HRA). MCOs are required to request that all members complete an initial HRA. Through the HRA, MCOs collect patient information regarding demographics, socioeconomic status, current health status, patient prescription drug use and behavioral risks. When enrollees' needs are known, disease management, case management and other member education programs can be targeted to appropriate persons. The response rate of completed HRAs continues to be low for Kentucky MCOs. MCOs can also identify enrollees in need of care coordination who don't have an HRA, by using encounter data algorithms or predictive modeling to track high risk diagnosis codes, high utilization, repeat use of emergency rooms, frequent in-patient stays and hospital readmissions as markers. This use of encounter data highlights another reason why it is important for MCOs to have accurate and complete encounter data.

In 2013 and continuing with Compliance Reviews conducted in 2014, coordination challenges between the MCOs and Kentucky's DCBS and 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 access to needed services. DCBS/DAIL service plans are the key source of this baseline information and ongoing communication with DCBS/DAIL staff is essential to coordinate the most appropriate services needed by individual members. DCBS/DAIL staff members should be working with the MCOs to identify individual needs, assess the effectiveness of interventions taken, and modify care plans accordingly. In the 2013 Compliance Reviews it was strongly recommended that all relevant entities (DCBS, DAIL, DMS, and MCOs) establish mutually-agreeable communication and information-sharing protocols to remedy this situation in order to comply with federal and state requirements, and most importantly, permit active, effective care coordination for these members.

KDMS, 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 was also noted that KDMS has revamped the care plan form, which was helpful.

Program Integrity

KDMS actively monitors MCO program integrity through quarterly reporting requirements that include utilization management, utilization of subpopulations, member satisfaction, provider

satisfaction, credentialing and re-credentialing activities, member and provider grievances, appeals, grievances and appeals trends/problems and fraud, waste and abuse reports. MCO administrative changes and other organizational changes are also monitored. KDMS monitors Member Services activities through review of quarterly MCO reports and call center reports. Results of the CAHPS® member satisfaction surveys are also be monitored for questions related to customer service. As part of the EQRO Compliance Review, assessments of plan operational policies and procedures and interviews with MCO staff are conducted regarding member grievances, prior authorization, cultural and linguistic services, marketing and program integrity.

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. The four Kentucky MCOs that use a centralized call center require vendor oversight and extensive reporting to monitor activity and track trends.

EPSDT Compliance

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 EPSDT 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 the annual Compliance Review, the EQRO conducts a separate review of adherence to EPSDT protocol using MCO EPSDT data reports and a review of a sample of files related to complaints, grievances, denials and care management. A separate EPSDT Report is prepared by the EQRO summarizing the findings of the EPSDT Compliance Review.

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.[15] 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. The

EQRO study also conducted validity assessment 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. The administrative data review and the medical chart review have been completed and a draft report has been submitted.

Strategies and Interventions to Promote Quality Improvement

Kentucky's Quality Strategy includes several activities focused on quality improvement including Performance Improvement Projects (PIPs), focused clinical studies, surveys and state-MCO-EQRO communications. This section discusses the current projects completed or on-going by the MCOs, KDMS and the EQRO. Experience from other states and innovative improvement initiatives are also presented for consideration.

Performance Improvement Projects (PIPs)

Conducting a Performance Improvement Project (PIP) is an ideal way for an MCO to try out an improvement initiative and create performance indicators to measure progress and effectiveness. Based on a problem solving approach to achieve improvement known as a PDSA cycle (Plan-Do-Study-Act), an MCO can revise the initiative along the way as they test and measure results. A protocol for conducting PIPs was developed by CMS to assist MCOs in the design and implementation of a PIP. Federal regulations require that all PIPs be validated according to guidelines 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 Medicaid managed care program determines the number of PIPs required to be conducted each year, 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, KDMS 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 2 is a list of Kentucky MCOs' active PIP topics.

Table 2. PIP Project Status 2013–2014

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

The state's EQRO is responsible for validating MCO PIPs, which begins with KDMS approval of the PIP topic. Using a team of two to three reviewers, the EQRO reviews the PIP proposal, topic selection rationale, methodology, planned interventions and study indicators. The EQRO follows each PIP through completion with 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 validation team approach is an invaluable tool in validating the PIP results, but more importantly, it is helpful to the MCOs in refining the measurement indicators and study methodology prior to implementation. The MCOs benefit from a shared perspective of more than one reviewer. Periodic calls to discuss ongoing activities can help identify problems early and suggest possible revisions. The MCOs interviewed commented on the value of the periodic QI calls to discuss PIP progress, but several MCOs felt that the one on one calls between the EQRO and each MCO were preferable to conference calls with all MCOs. It was also noted that the turn-around time for proposal review and feedback to the MCOs was not always timely and caused some delay for the MCO in getting their PIP interventions started. More than one MCO commented on the quantity of PIPs that are on-going at any one time (as many as four to six),

which places a burden on MCO resources and may result in fewer or less aggressive interventions.

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

Kentucky's Quality Strategy supports MCO collaboration in conducting PIPs, but to date, this has not occurred. KDMS reports that they are working with the Advisory Council for Medical Assistance (MAC) and the MCO Medical Directors to develop a collaborative PIP to begin September 2014. The EQRO has provided several good suggestions for collaborative PIP topics.

Unsure of how collaboration among competitive MCOs could occur, New York State first ventured into a collaborative PIP by offering MCOs the option of joining the collaborative or conducting their own topic project. With positive feedback after several voluntary collaboratives, the state opted to conduct a mandatory collaborative PIP to reduce childhood obesity. MCOs were only allowed to opt out if they could demonstrate significant experience with previous PIPs on the topic, which did apply to one of the state's Medicaid MCOs. The remaining nineteen MCOs participated in the collaborative and each designed interventions for members, providers and community to achieve their specific goals.[16] Conference calls were held regularly throughout the PIP and included invited experts from New York State Department of Health, Division of Chronic Disease Prevention and New York City (NYC) Department of Health. Informational materials prepared by the state and NYC were also made available to MCOs. A conference was conducted at the end of the PIP collaborative to share results and discuss other opportunities for improvement for the state and MCOs. While none of the Kentucky MCOs have collaborated on any of their PIPs so far, there was interest in doing so in the future.

Focused Clinical Studies

A focused clinical study examines a particular aspect of clinical or nonclinical 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 initiates new topic selection by developing several proposals that are reviewed and discussed. KDMS makes the final choice of topics. While topics selected by the state have often been utilization-based, asthma and ADHD focused studies have also been conducted.

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. Both of these studies were aimed at expanding 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 per MCO with a readmission.

The Postpartum Readmissions 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 further, the vast majority of all 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 concludes that there is a potential to improve postpartum outcomes by better facilitating care transitions for women at risk.

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, 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 reports were sent to each MCO and the findings were also presented and discussed at a Medical Directors' meeting. Further, the MCOs were urged to address these issues in a letter from the Commissioner. They have all responded with a description of the actions they are taking to address the problems identified in the study.

Surveys

Kentucky MCOs are required to conduct member and provider satisfaction surveys annually. The member satisfaction survey results are submitted to KDMS with each MCO's HEDIS® submission. Results of each MCO's provider satisfaction survey are submitted to KDMS

annually. While these are the only required surveys to be conducted by Kentucky Medicaid MCOs, the state's EQRO often uses the survey approach to obtain MCO input and information.

Completed in February 2013, the EQRO conducted a survey to gather information regarding encounter data validation. As described earlier, this survey was sent to each MCO to obtain information on each MCO's encounter data system and processes that are used to load/submit encounter files to KDMS. Findings from this survey were used to develop an encounter data validation proposal using data benchmarking.

During the last 12 months, the EQRO surveyed MCOs regarding their use of the secret shopper methodology to assess provider appointment access and availability. Based on MCO responses, KDMS and the EQRO discussed possible ways of implementing a consistent and valid method for determining if provider practices were in compliance with appointment availability guidelines. It was decided that a secret shopper methodology survey should be fielded with behavioral health providers in Kentucky's Medicaid Managed Care Program. The EQRO is in the process of developing the sampling methodology and survey question scenarios.

In an effort to ensure that the MCO Dashboard project and the Annual Health Plan Report Card provide meaningful and useful information, the EQRO requested that each MCO provide input on the metrics or information to be presented; if appropriate for Dashboard or Report Card or both; what data source should be used and when the data would be available for incorporating. Based on responses, KDMS and the EQRO discussed possible approaches and created proposed versions of both for more discussion and input before each was finalized. Since they are both dependent on information available, their content and presentation format will be revised at least annually; however, it is intended that the MCO Dashboard will be revised more frequently than yearly.

Kentucky Medicaid MCOs all expressed an interest in providing feedback to the state, whether through surveys or in one on one discussions.

State-MCO-EQRO Communication

Communication and collaboration go hand in hand to foster quality monitoring and improvement. On a regular basis and sometimes ad hoc, communication between the state, the MCOs and the EQRO has occurred in various ways. Over the past year, KDMS has made considerable effort to improve communications, including the following:

- The state and the EQRO have a written contract which includes a work plan, project descriptions and timelines. Many projects begin with proposals from the EQRO which are discussed and input from both the state, and sometimes the MCOs, are considered prior to project initiation;
- The state also has written contracts with each MCO. While the purpose of this contract is to outline MCO requirements under the Kentucky Medicaid Managed Care Program, it

also provides a framework for communication in terms of quarterly and annual reports, compliance reviews and quality improvement.

- Data sharing between the state, the EQRO and the MCOs is made possible through the EQRO's FTP portal which is used to share reports. The MCO Dashboard is currently hosted on the EQRO website.
- KDMS holds monthly MCO Medical Directors Meetings led by Dr. John Langefeld, KDMS Medical Director. Topics include program updates and results of EQRO projects;
- KDMS has started Quarterly Quality meetings and Quarterly EPSDT meetings to enhance communication with the MCOs. Monthly Operational meetings are also held with each MCO;
- Conference calls and meetings between the DCBS, DAIL, KDMS and/or the MCOs are taking place to share information regarding foster children and aged adults in managed care;
- During the PIP validation process, the EQRO schedules periodic conference calls with each MCO to discuss PIP progress and problems. The EQRO provides technical assistance to MCOs both by phone and in scheduled training sessions;
- QI Calls were scheduled quarterly and included staff from KDMS, MCOs and the EQRO. The purpose of these calls was to share information related to quality. The MCOs were encouraged to contribute topics for the agenda and to actively participate on the calls, but the MCOs have been reluctant to contribute to the discussion and/or share quality strategy with other MCOs. KDMS and the EQRO discussed ways of improving MCO participation and decided to change from quarterly QI Calls to individual MCO quarterly quality meetings that will include the MCO, IPRO and KDMS. The first of these was held in July 2014;
- Many of the MCOs conduct provider training/education sessions throughout the year. Last year, Governor Steve Beshear directed the Cabinet for Health and Family Services (CHFS) to initiate enhanced educational efforts to improve the continued implementation of Medicaid managed care. Due to the success of last year's forums, the Cabinet for Health and Family Services in partnership with the Managed Care Organizations are sponsoring forums across Kentucky in August and September 2014. These forums are designed to allow any and all health care providers (including behavioral health and substance use providers) who have contracts with MCOs and serve Medicaid consumers to meet face-to-face and discuss concerns about proper billing, prior authorizations, prompt pay, appeals processes or any other specific issues related to the continued implementation of managed care. In attendance will be senior level staff from each Managed Care Organization, senior staff from the Department of Insurance (DOI), Office of Inspector General, Department for Medicaid Services, Department for Public Health, Department for Behavioral Health, Developmental and Intellectual Disabilities, and the Office of the Secretary.

There is a good working relationship between the state, the MCOs and the EQRO. Input and feedback are sought and respected. Efforts are made to keep all parties informed and to offer outreach when needed.

Several MCOs interviewed voiced particular concern regarding the volume and frequency of state monitoring/reporting requirements in two ways: 1) the quantity of monthly and quarterly reports required and 2) the timing of routine annual activities when it involves requesting information from providers and members to complete surveys or supply medical records. For the monthly/quarterly reports, it was suggested that the state identify the most useful and meaningful reports and continue these, and re-evaluate the need for the others or investigate the feasibility of using other data sources for some of the data reported, such as encounter data and provider network data. For reported data used for comparison between plans, it was noted that KDMS should ensure that all MCOs are interpreting the report specifications the same way. The state is aware of this concern and is currently reviewing all of the reports and activities required of the MCOs in terms of content and frequency to determine if there are other, more efficient ways of obtaining the information.

KDMS started a review of all the required MCO reports in 2014. MCOs were asked for their input to be submitted no later than May 2014. KDMS is analyzing the responses and scheduling meetings with the MCOs to discuss ways to modify, combine, reduce or eliminate some of the required reports in order to reduce the burden and increase the quality of information. These meetings should start in the fall 2014.

In regard to the timing of data requests, two MCOs proposed that KDMS provide a year's timeline of expected data requests including HEDIS® and CAHPS®, provider network audit surveys, experience of care surveys to members and medical record requests for focused clinical studies. Knowing the timing of these requests ahead of time will help the MCOs better plan their staff resource requirements.

Enhancing State Quality Improvement Initiatives

A review of other state's Quality Strategies provides an opportunity to examine a range of different approaches to monitoring Medicaid managed care quality and conducting quality improvement. The previous year's evaluation highlighted activities from states currently contracting with IPRO as their EQRO and five other state Medicaid programs representing a variety of small and large Medicaid programs, different geographic regions and a span of experience over twenty years. With the preparation of the previous evaluation not more than seven months ago, many of the strategies that were referenced in that report are still in effect. This year's evaluation again included two prominent leaders in Medicaid managed care – California[17] and New York State,[18] and added to their experience, several other states including Florida,[19] Illinois,[20] Kansas,[21] Massachusetts,[22] New Mexico,[23] and North Dakota.[24] Quality Strategies from these states were all obtained from state websites and are summarized in Attachment Table A.

All of the states reviewed use their EQRO to prepare the annual Technical Report and conduct the three mandatory activities – validate performance measures, validate PIPs and review compliance with state and federal regulations. It is also common for the EQRO to validate encounter data, but conducting focused clinical studies is less common. It is evident from many state Quality Strategies that the state and EQRO share not only monitoring responsibilities but also provide technical assistance to MCOs through their validation of performance measures, encounter data and PIPs, as well as providing training and conducting conferences to share information on quality improvement with the MCOs. This is particularly true in New York State and in Kentucky.

In addition to monitoring, the state and EQRO can both play an important role in developing and promoting quality performance improvement. To that end, there is a growing trend for states to work with their MCOs to:

- Become certified by a national organization such as NCQA or URAC;
- Promote collaboration between MCOs, the state, local community and the EQRO;
- Promote data transparency through public reporting; and
- Offer incentives for meeting performance goals or impose sanctions when goals are not met.

National Accreditation

Numerous independent national organizations, such as NCQA and URAC promote quality improvement through rigorous accreditation processes and many states have bought into this approach to compliment, but not duplicate, the state's efforts in quality monitoring and improvement. According to the 2012 NCQA Medicaid Managed Care Toolkit[25] there are 29 states that require their Medicaid MCOs to attain NCQA accreditation or recognize NCQA accreditation standards. Kentucky Medicaid MCOs are required to obtain NCQA accreditation

within two to four years of contracting with the state. Of the states reviewed in this report, accreditation is also required in California, Florida, Illinois and Kansas.

Collaboration

While multiple ways are available for states to collaborate with their MCOs, collaboration between MCOs, the state and the EQRO are most evident in states that conduct collaborative PIPs. There is a growing trend among states to conduct at least one mandatory statewide collaborative PIP during the year. The Illinois Quality Assessment and Performance Improvement Strategy 2012-2013 included a summary of findings from two of their recent collaborative PIPs, namely, Early Periodic Screening, Diagnosis and Treatment (EPSDT) Screening PIP and Perinatal Care and Depression Screening PIP. Another interesting on-going collaborative PIP is Illinois' Community Based Care Coordination PIP, which is being conducted by the state's Integrated Care Program MCOs (ICPs). This PIP focuses on medically high-risk members with a recent hospital discharge who are actively receiving care coordination. Reducing emergency room use and hospital readmissions were also popular topics selected for collaborative PIPs in other states.

Regular meetings with MCOs, such as Kentucky's quarterly MCO calls and meetings with MCO Medical Directors and Quality Directors that are held in many states foster sharing of information as well as providing a sounding board for new ideas.

Public Reporting

Public reporting of quality performance measures and improvement results creates an atmosphere of data transparency and promotes informed dialogue among stakeholders. Providing members with information on how the state's health plans perform is a useful tool in selecting a plan. California and New York State provide full disclosure of Medicaid managed care information including HEDIS® and consumer satisfaction rates, focused study reports, annual Technical Reports, other external quality review reports and PIP summaries.

The Kentucky Medicaid managed care program has used their website (http://medicaidmc.ky.gov/Pages/about.aspx) to inform Medicaid enrollees about the program and provide links to participating MCOs. The website presents information for members, providers, frequently asked questions, news releases and contact information. Medicaid beneficiaries can read about the enrollment process, use a provider search tool to see what MCOs their providers participate with, use links to open MCO home pages and access the online application. Quality performance information to assist beneficiaries in choosing an MCO is only available from the Cabinet for Health and Family Services website by navigating to the Advisory Council for Medical Assistance (MAC) webpage.

Some, but not all of the Kentucky Medicaid MCOs post HEDIS® and CAHPS® data or other quality performance data on their own websites, but there is currently no comparative quality

data available on Kentucky's Medicaid managed care website. This should, and can be easily remedied by posting the next edition of the *Member's Guide to Choosing a Medicaid Managed Care Plan* with HEDIS® and CAHPS® 2014 data and posting a public version of the EQRO's MCO Dashboard. The state's Quality Strategy should also be made available through the website.

Quality Incentives

Many state Medicaid managed care programs across the country have chosen to use incentives or sanctions to encourage quality performance. In the states reviewed for this summary, Illinois, Kansas, New Mexico and New York all have a Pay for Performance (P4P) incentive. The state of Florida's Quality Strategy, on the other hand, describes a Performance Measure Sanction Strategy to financially penalize MCOs for failing to reach benchmarks.

Financial incentives are often a tool used by MCOs to reward providers for improved data submissions or for adhering to standards of care or benchmarks. MCOs also use incentives for members to encourage members to make appointments for preventive screening, childhood immunizations and prenatal/postpartum care. Member incentives are often in the form of a gift or gift card.

While the concept of reward for performance has merit theoretically, many states choose not to implement a Pay for Performance (P4P) program because it could lead to heightened competition in an already competitive market; it could incentivize MCOs to only focus improvement in the measures included in the P4P; or it could result in MCOs focusing only on ways to augment data collection. Kentucky does not have a state P4P program in place now, but as experience with various P4P programs increases, it may be valuable to review other state programs before implementing one in Kentucky.

Strengths and Opportunities for Improvement

The strengths and opportunities for improvement for Kentucky's Medicaid Managed Care Program are presented in this section as a culmination of this Comprehensive Evaluation Summary. The Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services, dated September 2012, was the basis for this evaluation of program accountability, monitoring mechanisms and compliance assessment systems. Included in this analysis was a review of internal systems, progress as evidenced from written reports and interviews from key stakeholders, namely KDMS staff, the EQRO and staff from each of Kentucky's Medicaid MCOs.

Strengths

Program Administration

- The Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services, was approved by CMS September, 2012 and includes all required elements, adequately described.
- 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 optional activities (conducting focused clinical studies, validation of encounter data and provider network data and development of quality performance report card and dashboard).
- With support from the legislature and Commissioner, KDMS 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 have been appointed and additional staff positions are being recruited.
- All required data collection systems are in place and functioning satisfactorily.

Goals and Benchmarks

- The core program goals, as described in the state's Quality Strategy cover many aspects of managed care quality, access and timeliness.
- Standardized national benchmarks are used to measure program improvement.
- Baseline measure results compare favorably with national benchmarks with as many as eleven (11) measures already meeting or exceeding the benchmark and another eight (8) measures within five percentage points of the targeted national benchmark.

Quality Monitoring and Assessment

- Kentucky's Medicaid managed care program is composed of five MCOs. The total enrolled population served has increased by 44% from 687,187 (Sept. 2013) to 989,197 (April, 2014).

- KDMS staff closely monitors MCO activities with monthly, quarterly and annual reporting requirements. The EQRO prepared a robust, interactive MCO Dashboard for internal monitoring.
- An annual health plan report card entitled "A Member's Guide to Choosing a Medicaid Health Plan" was prepared for 2013 open enrollment. A 2014 version will be available in written format and will be posted on the Department of Medicaid Services website.
- In an effort to streamline reporting requirements, KDMS is currently reviewing all MCO reporting requirements to determine if the report is needed and/or to identify other possible sources for the information.
- EQRO monitoring is evident in timely, well-written MCO compliance reviews, monthly encounter data validation reports and annual provider network and quality performance validations.
- The annual Technical Report is well prepared and provides a useful summary of monitoring activities for staff and state policy makers.
- HEDIS® and CAHPS® data provide the state with a comprehensive base of measures for access and MCO submitted geo-access reports further describe network adequacy and distance to providers.
- There are excellent lines of communication between the state, the EQRO and the MCOs.

Quality Improvement

- PIP topics selected by Kentucky's MCOs address appropriate areas of improvement.
- In validating the PIPs, the EQRO has established a process that MCOs follow for the duration of the PIP from proposal review, on-going progress, re-measurement and final report. Close communication between the MCOs and the EQRO is a keystone of the process.
- A collaborative, statewide PIP is being planned in cooperation with all MCO Medical Directors, the KDMS Medical Director and MAC members for implementation in September 2014.
- Two recently completed focused studies provide valuable insight for the state and MCOs in reducing readmissions for newborns and postpartum women. All MCOs have responded with an action plan to address issues presented in the reports.
- Kentucky requires all MCOs to become NCQA accredited, which encourages MCOs to aspire to a higher national standard and offers the opportunity to streamline compliance review requirements based on federal deeming guidelines
- MCO quality staff members have a good knowledge of improvement processes and have successfully applied many new interventions to improve care.

Opportunities for Improvement

Program Administration

- Kentucky continues to not take advantage of the many avenues available for public reporting. The KDMS Medicaid Managed Care website is currently underused by KDMS.

- Coordination between KDMS, the MCOs and other state agencies, namely the Division of Community Based Services (DCBS) and the Division of Aging and Independent Living (DAIL) needs to continue to be addressed and improved to better provide care coordination for foster children and aged members.

Goals and Benchmarks

- Kentucky's Quality Strategy could be strengthened by adding goals for childhood preventive health and prenatal/postpartum care.
- After two years of HEDIS® data (with the 2014 submission), a review of benchmarks may be warranted to adjust for measures with baseline rates already above the national benchmark.
- Opportunities for improvement are identified, based on a substantial difference between the Kentucky statewide aggregate HEDIS® 2013 rate and the 2012 national Medicaid benchmark, for the following measures:
    - Cervical Cancer Screening;
    - Comprehensive Diabetes Care: Eye Exam Performed;
    - Follow-up After Hospitalization for Mental Illness within 30 days and within 7 days of discharge; and
    - Outpatient Visits/1,000 Members for All Age Groups.

Quality Monitoring and Assessment

- There is a multitude of quarterly and annual reports required to be submitted which places a burden on MCO staff resources. KDMS needs to continue to focus on building staff expertise to better use encounter data for evaluating quality, utilization, network adequacy and access and in calculating risk-based capitation rates.
- Each MCO has been conducting their own appointment availability survey, which makes it difficult for the state to have a statewide, aggregate view of issues with appointment availability. The state is addressing this by conducting its first statewide availability survey for behavioral health providers.
- The state should consider expanding the use of the MCO Dashboard from an internal tool to a public website version.

Quality Improvement

- KDMS has an opportunity to become more involved with MCO PIPs through a statewide collaborative PIP in a topic selected by the state and coordinated by the EQRO.
- Quality Improvement tools used in other states such as quality incentives, public reporting, communications and collaborations may be of interest to KDMS going forward. This report and the previous evaluation cite numerous initiatives and provide website links to learn more. Contacting other state staff is also informative and can provide valuable insight from their experiences that should be considered before launching a new initiative in Kentucky.

Recommendations

- Additional materials need to be posted on Kentucky's Medicaid Managed Care website to better inform members and the general public about the efforts of KDMS to monitor and improve quality including the annual health plan report card, the EQRO's MCO Dashboard, results of focused clinical studies and the state's Quality Strategy document.
- KDMS needs to continue to review program monitoring and reporting requirements including determining if there are any unnecessary monthly or quarterly reports; identifying other sources of information for current report topics and streamlining the requested compliance review documents, if possible.
- KDMS should consider adding goals and objectives for childhood preventive health and prenatal/postpartum care to their Quality Strategy and should evaluate current benchmarks using data from two consecutive years of HEDIS® and CAHPS® data (2013 and 2014).
- KDMS should continue to plan a statewide collaborative PIP in a topic selected by the state and coordinated by the EQRO.

Attachment A: Quality Improvement Initiatives from Other States

State (Program Name)	Date of Strategy	Medicaid Agency	Quality Monitoring and Improvement Initiatives
California Medi-Cal	June 2013	Dept. of Health Care Services (DHCS) Medi-Cal Managed Care Division	***EQRO*** – annual technical report; 3 mandatory plus CAHPS® survey every 2 years.; encounter data validation ***PIPs*** – 2 active annually – one is statewide collaborative, other can be internal or small group of plans. Most PIPs are 3 years long ***QI*** – NCQA certification required; full disclosure of quality rates and reports on website; uses quality in auto-assignment
Florida	April 2014	Florida Agency for Healthcare Administration (AHCA)	***EQRO*** – annual Technical Report; 3 mandatory activities; validate encounter data; focused studies; dissemination and education; technical assistance ***PIPs*** – 4 ongoing each year ***QI*** – require NCQA accreditation; Performance Measure Sanction Strategy – require action plans to improve poor performance
Illinois	2012–2013	Department of Healthcare and Family Services (HFS) Division of Medical Programs	***EQRO*** – annual technical report; 3 mandatory activities; EPSDT measure validation. ***PIPs*** – 1 new PIP initiated each year each lasting 2-4 years. Statewide mandatory PIPs determined by state. ***QI*** – NCQA accreditation accepted for deeming; Performance Tracking Tool; Pay 4 Performance; Cross-State Agency Collaboratives (ex. Care Coordination Innovation Project ; Enhancing Developmentally Oriented Primary Care project; Medical Home Primer for Community Pediatricians and Family Medicine; Bright Futures promotion)
Kansas (KanCare)	June 2013 Version	Kansas Medicaid	***EQRO*** – annual technical report and 3 mandatory activities ***PIPs*** – 2 during each year; PIP can last more than 1 year. ***QI*** – Plan accreditation required; Pay for Performance Incentives – selected measures
Massachusetts (MassHealth)	December 2013	MassHealth Quality Office (MQO)	***EQRO*** – annual technical report and 3 mandatory activities; planning to add encounter data validation ***PIPs*** – 2-year duration; goals defined by MassHealth w/ list of interventions to choose ***QI*** – HEDIS® and Satisfaction results posted on website; Program Management Dashboards

State (Program Name)	Date of Strategy	Medicaid Agency	Quality Monitoring and Improvement Initiatives
			developed
New Mexico (Centennial Care)	July 2013	New Mexico Human Services Department, Medicaid Assistance Division, Quality Bureau	***EQRO*** – annual technical report and 3 mandatory activities ***PIPs*** – 1 annual ***QI*** – HEDIS® results posted on website ; Pay 4 Performance; Critical incident database for reporting fraud and abuse; disease management programs.
New York State (Partnership Plan)	November 2012	Department of Health, Office of Quality and Patient Safety	***EQRO*** – annual technical report; 3 mandatory; validate encounter data, provider network and HEDIS®; CAHPS®surveys; focused studies; access & availability surveys; member services surveys; technical assistance and conferences ***PIPs*** – 1 annual collaborative or topic selected by plan ***QI*** – Quality Performance Matrix – root cause analysis/action plan; full disclosure of quality rates and reports on website; Quality Incentive (P4P); quality in auto-assignment
North Dakota	January 2014	Department of Human Services, Medical Services Division	***EQRO*** – RFP to be issued in July, 2014; will include annual technical report and 3 mandatory activities ***PIPs*** **-** 2 PIPs ongoing each year, at least one must be behavioral health ***QI*** – State convenes 2 – 4 meetings/year with MCO Medical Directors and Quality Improvement Directors to communicate updates and discuss quality issues

References

[1] Cabinet for Health and Family Services, Department of Medicaid Services, "Commonwealth of Kentucky Strategy for Assessing and Improving the Quality of Managed Care Services, September 2012.
[2] http://www.ssa.gov/OP_Home/ssact/title19/1915.htm
[3] http://www.ssa.gov/OP_Home/ssact/title19/1932.htm
[4] http://www.govtrack.us/congress/bills/105/hr2015
[5] http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=b4058b30e1d1a47b9abd147b7dced4cc&rgn=div5&view=text&node=42:4.0.1.1.8&idno=42#PartTop
[6] NCQA Quality Compass, available for purchase at: http://www.ncqa.org/HEDISQualityMeasurement/QualityMeasurementProducts/QualityCompass.aspx
[7] According to NCQA contract stipulations, we cannot publish NCQA Quality Compass percentile rates.
[8] http://www.ssa.gov/OP_Home/ssact/title19/1915.htm
http://www.ssa.gov/OP_Home/ssact/title19/1932.htm
[9] 42 CFR Part 438.
[10] http://www.fdhc.state.fl.us/medicaid/quality_mc/pdfs/Florida_Medicaid_Revised_Comprehensive_Quality_Strategy_2013-2014.pdf
[11] Consumer Assessment of Healthcare Providers and Systems (CAHPS) provided by the Agency for Healthcare Research and Quality; http://cahps.ahrq.gov/about.htm.
[12] For the most recent protocols, refer to http://www.medicaid.gov/Medicaid-CHIP- Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html
[13] Toppe, Kristine Thurston, National Committee for Quality Assurance. NCQA Medicaid Managed Care Toolkit 2012 Health Plan Accreditation Standards Effective July 1, 2012-June 30, 2013; Assistance for State Agencies in Using NCQA Accreditation for Medicaid Managed Care Oversight, March 2012.
[14] https://www.urac.org/
[15] Centers for Medicare and Medicaid Services. Initial core set of children's health care quality measures:technical specifications and resource manual for federal fiscal year 2012 reporting. Updated November 2012.
[16] Medicaid Managed Care Performance Improvement Projects: 2009-2010 Pediatric Obesity – Summary of Projects. Access at: http://www.health.ny.gov/health_care/managed_care/reports/pediatric_obesity.htm
[17] http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/Studies_Quality_Strategy/QualityStrategyRpt_2013.pdf.
[18] http://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf
[19] http://www.fdhc.state.fl.us/medicaid/quality_mc/pdfs/Florida_Medicaid_Revised_Comprehensive_Quality_Strategy_2013-2014.pdf
[20] http://www2.illinois.gov/hfs/SiteCollectionDocuments/QS_IL_2012-13_Report_Final.pdf
[21] http://www.kancare.ks.gov/download/Attachment_J_State_Quality_Strategy.pdf
[22] http://www.mass.gov/eohhs/docs/masshealth/research/qualitystrategy-05.pdf
[23] http://www.hsd.state.nm.us/uploads/files/Public%20Information/Centennial%20Care/Draft%20Quality%20Strategy/State%20of%20New%20Mexico%20Quality%20Strategy%20for%20Centennial%20Care%20stc%20rev%208%201%2013.pdf
[24] http://www.nd.gov/dhs/info/pubs/docs/medicaid/draft-quality-strategy-plan.pdf
[25] Toppe, Kristine Thurston, National Committee for Quality Assurance. NCQA Medicaid Managed Care Toolkit 2012 Health Plan Accreditation Standards Effective July 1, 2012-June 30, 2013; Assistance for State Agencies in Using NCQA Accreditation for Medicaid Managed Care Oversight, March 2012.