



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

Kentucky Medicaid Managed Care Early Periodic Screening, Diagnostic and Treatment (EPSDT) Services Review of 2015

Final

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Introduction

Background

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federally mandated health program that provides comprehensive and preventive health care services for children and adolescents up to age 21 who are enrolled in Medicaid. EPSDT services are designed to ensure early identification of conditions that can impede children's health and development, and provide for the diagnosis and treatment of physical and mental health conditions in order to improve health outcomes.ⁱ In addition to a comprehensive health and developmental history, with assessments of both physical and mental health and development, EPSDT services include a comprehensive medical exam, vision, hearing, and dental services, age-appropriate immunizations, laboratory tests including blood lead testing, health education, and anticipatory guidance covering topics such as child development, healthy lifestyles and accident and injury prevention.ⁱⁱ The Centers for Medicare & Medicaid Services (CMS) guidelines for state Medicaid programs include informing eligible children and adolescents of available services, as well as providing or arranging for screening and necessary corrective treatment.ⁱⁱⁱ States have the option to either administer the EPSDT benefit outright or provide oversight to contracted entities that administer the benefit for them, such as managed care enterprises.^{iv} In Kentucky, Medicaid managed care organizations (MCOs) administer the EPSDT benefit for children and adolescents enrolled in Medicaid managed care (MMC), with oversight by the Kentucky Department for Medicaid Services (DMS).

Purpose

DMS has contracted with Island Peer Review Organization (IPRO), the Kentucky External Quality Review Organization (EQRO), to validate that the MCOs' administration of EPSDT benefits is consistent with federal and state requirements and expectations. This report provides an assessment of Kentucky Medicaid MCOs' activities to ensure that their eligible enrollees receive:

- Education and outreach regarding EPSDT services, and
- Access to comprehensive EPSDT services, including authorization of medically necessary services.

In addition, the MCOs' EPSDT programs were evaluated for:

- EPSDT provider network adequacy,
- EPSDT provider training and monitoring,
- Case management for EPSDT-eligible members,
- Physical health and behavioral health (BH) coordination,
- Quality measurement and improvement activities, and
- Member satisfaction.

EPSDT programs for each of the five Kentucky Medicaid MCOs participating in 2015 were evaluated, including Anthem Blue Cross and Blue Shield (BCBS) Medicaid, CoventryCares of Kentucky, Humana-CareSource, Passport Health Plan, and WellCare of Kentucky.

Data Sources

Documents and data from 2014 and 2015 received by the end of the first quarter 2016 were included in this evaluation. Key data sources for this comprehensive evaluation of EPSDT services included the following:

- the 2016 EQRO Annual Compliance Review;
- activities and metrics relevant to EPSDT services reported by MCOs in their 2015 statutory reports to DMS;
- the 2015 EPSDT Encounter Data Validation Study conducted by IPRO on behalf of DMS; and
- the 2015 Healthcare Effectiveness Data and Information Set (HEDIS®) performance measure rates reported in the MCOs' 2015 HEDIS Audit Review Tables (measurement year [MY] 2014) and Healthy Kentuckians performance measure rates reported as part of the MCOs' 2015 (MY 2014) Kentucky Performance Measure Validation submission

in Attachment B,¹ a Microsoft Excel spreadsheet that includes numerators, denominators and rates for the Healthy Kentuckians measures.

These key data sources are described below:

1. The 2016 EQRO Annual Compliance Review: The EQRO conducts an annual review of MCO compliance with federal and state contractual requirements on behalf of DMS. The 2016 Annual Compliance Review evaluated MCO compliance with requirements for MY 2015, and included MCO processes, policies and procedures, file reviews, reports, committee meeting minutes, and onsite interviews. For Kentucky, EPSDT contractual requirements are specifically reviewed, as well as requirements for operational areas with relevance to EPSDT. Relevant review areas in the 2016 Annual Compliance Review considered for this report included:

- EPSDT,
- Enrollee Rights,
- Quality Assessment and Performance Improvement (QAPI): Access,
- QAPI: Measurement and Improvement,
- Case Management/Care Coordination, including a review of case management files,
- Grievance Systems, including a review of children's service denials and appeals files, and
- BH Services.

A determination of level of compliance is reported for each contract element in the Annual Compliance Review. In some cases, if the MCO was found to be fully compliant with a particular requirement on the 2014 or 2015 Annual Compliance Review, the requirement was deemed compliant for the 2016 Annual Compliance Review. Annual Compliance Review levels of compliance determinations included:

- Full compliance: met or exceeded requirements;
- Substantial compliance: met most requirements, but may be deficient in a small number of areas;
- Minimal compliance: met some requirements, but has significant deficiencies requiring corrective action; and
- Non-compliance: has not met element requirements.

2. 2015 Kentucky Statutory Reports: Kentucky Medicaid MCOs are required to submit statutory reports on a monthly, quarterly and annual basis. In the 2016 Annual Compliance Review, all five MCOs were found to be compliant with submission of EPSDT-related reports; however, at the time of this report, IPRO was in receipt of a limited number of Quarterly Report #24 Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death from most MCOs (Anthem BCBS Medicaid 4/30/15 and 7/30/15, Humana-CareSource 4/29/15 and 7/28/15, Passport Health Plan 4/30/15 and 7/30/15, and WellCare of Kentucky 4/30/15, 7/30/15 and 2/1/16), with only all four quarterly reports available from CoventryCares of Kentucky. All statutory reports relevant to EPSDT services included:

- Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, which documents quarterly activities for EPSDT outreach, education and case management, as well as EPSDT screening rates;
- Annual Report #93, EPSDT Annual Participation Report, which documents EPSDT screening and participant ratios for eligible MCO members as reported on CMS Form CMS-416;
- Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan, which outlines the scope of activities, goals, objectives and timelines for the MCO's QAPI Program, including activities related to EPSDT;
- Annual Report #85, Quality Improvement Plan and Evaluation, which documents the MCO's assessment of the effectiveness of its Quality Improvement (QI) Program and opportunities for improvement;
- Annual Report #94, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) – Medicaid Child Survey, a report of the results of the annual CAHPS survey, which assesses consumer-reported experience of care, satisfaction and how well health plans are meeting member expectations and goals;

¹ Attachment B is not a part of this report, but a submission from the Performance Measure Validation.

- Annual Report #86, Annual Outreach Plan, which provides an overview of member and community education and outreach activities, some of which may be related to EPSDT;
 - Quarterly Report #18: Monitoring Indicators, Benchmarks and Outcomes; and
 - Quarterly Report #19, Performance Improvement Projects (PIPs).
3. The 2015 EPSDT Encounter Data Validation Study: This study was conducted by IPRO on behalf of DMS and was comprised of a medical record review of well-child visits to validate encounter data codes relevant to the receipt of EPSDT screening of children enrolled in Kentucky MMC. The study provided an overview of services provided during well-child visits relative to EPSDT recommended services.
 4. The 2015 HEDIS Final Audit Report and HEDIS Audit Review Table and Attachment B of the Kentucky 2015 Performance Measure Validation submission: Kentucky Medicaid MCOs are required to report quality measures, including HEDIS measures and Kentucky State-specific Healthy Kentuckians measures, several of which are pertinent to EPSDT.

Member Education and Outreach

CMS guidelines for state Medicaid programs indicate that the provision of EPSDT services includes informing Medicaid-eligible children and adolescents under the age of 21 years about available EPSDT services.^v Kentucky's MMC contractual requirements specify that eligible members and their families should receive education about EPSDT services regarding the benefit of preventive services, availability of screening and medically necessary services, the right to access these services, how to access services, and the right to appeal decisions related to EPSDT services. MCO outreach and education of members eligible for EPSDT services is evaluated as part of the EQRO Annual Compliance Review – EPSDT through review of policies and procedures, evaluation of member and provider educational initiatives and materials, and onsite staff interviews. Kentucky MCO Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan, and Annual Report # 86 Annual Outreach Plan also include documentation of member educational activities.

EPSDT Benefits, Importance and Access to Services

Statewide Overview

The 2016 Annual Compliance Review – EPSDT revealed that all five MCOs were deemed or fully compliant with federal and state contractual requirements to inform members about available EPSDT services, the right to access services, how to access services, and the value of preventive healthcare. Humana-CareSource and Passport Health Plan had been deemed compliant based on the 2014 review of these requirements; Anthem BCBS Medicaid was deemed compliant based on 2015 review. Following findings of full compliance in 2013, CoventryCares of Kentucky and WellCare of Kentucky were again found to be fully compliant in 2016 with all elements related to member education about the availability and benefit of EPSDT services, and how to obtain them.

Member education was conducted in a variety of formats, including member handbooks, mailings, telephonic outreach, home visits, and presentation at community events. Activities reported in Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, and #17, Quality Assessment and Performance Improvement Work Plan, also validated the provision of a variety of educational communications across all MCOs through member newsletters, brochures, fliers, website postings, and personalized cards and calls pre- and post-service due dates.

While all five MCOs included EPSDT service information in mailings, member handbooks and MCO websites, some MCOs reported additional efforts to educate members and families, such as outreach from care managers, EPSDT coordinators and clinic-embedded nurses. Reinforcement and support included assistance with scheduling appointments for needed services such as well-child visits, immunizations or blood lead screening, and enrollment in incentive programs for annual adolescent and dental screenings. One MCO continued to support a comprehensive online library with developmental, behavioral and physical health articles and interactive features for children, adolescents and adults. Annual Report #86, Annual Outreach Plan, described MCO promotion of EPSDT services in community settings such as Family Resource and Youth Service Centers (FRYSCs), Head Start, child care centers, school-based health clinics, and events for homeless children and grandparents raising grandchildren. MCO-specific findings regarding member educational initiatives are further described below.

MCO-Specific Member Education

Anthem BCBS Medicaid: At the time of the 2016 Annual Compliance review, the MCO had been deemed compliant based on the prior year's review. It had been noted child and adolescent enrollment began in July 2014; new members were educated and encouraged to participate in a health screening within 90 days of enrollment, and receive age-appropriate EPDST services within 30 days of screening.

Concomitant to child and adolescent enrollment was the adoption of the maternal child services program New Baby, New Life. The comprehensive case management program stresses the importance of well-child EPSDT and coordinates care with primary care providers (PCPs), specialty providers, ancillary providers and community resources. Well-baby support is offered, with contact once a week, typically for 12 weeks. MCO Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, demonstrated continuation of the program in 2015.

MCO quarterly reports also documented Preventive Health Reminder mailings 45 days prior to each member's birthday, reminding them to schedule age-appropriate services, and Overdue Service Reminder Postcard mailings to members under the age of 21 years non-compliant with the EPSDT periodicity schedule. A growth chart for children, also containing age-appropriate service reminders, had been developed and distributed. An EPSDT-themed newsletter was in the planning stages. The Annual Report #86, Annual Outreach Plan, topic *General Outreach and Marketing – Back to School Events Galore!* listed several such events. Outreach representatives had been increased from five to seven.

CoventryCares of Kentucky: The MCO was found fully compliant with contract requirements regarding EPSDT member education in the 2016 Annual Compliance Review, as evidenced by the 2015 Member Handbook, 2015 Quality Management Program Description, 2015 Prevention and Wellness Program, HEDIS/Healthy Kentuckians Program and EPSDT Clinical Tracking System, as well as Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, and #17, Quality Assessment and Performance Improvement Work Plan.

Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, reported ongoing training for the EPSDT coordinator and distribution of contact information in case management invitations sent to all EPSDT non-compliant families. Additional back-up coordinators had been identified and trained. Prospectively, Current Procedural Terminology (CPT) codes by age from the EPSDT Periodicity Schedule were used to trigger mailings to encourage families to complete visits on time: juvenile birthday cards, It's Time for a Check-up reminders, and lead screening, dental and missed appointment reminders. The HEDIS Quality Management team also called families of members identified through the Navigator System for well-child visit and dental reminders. Outreach was conducted to all families and providers of members with lab-reported elevated blood lead levels; additional interventions were instituted when results were chronically high or non-compliance with follow-up testing was observed.

In addition to various member mailings throughout the year, educational brochures were distributed at public events around maternal, child and family health: community hospitals health fairs, county health fairs, Farm Home and Family Nights, Family Fun Nights, Baby Health Expos, community baby showers and Family Resource Center/Youth Service Center events. The Annual Report #86, Annual Outreach Plan, described CoventryCares of Kentucky's online library, Kidshealth®, containing EPSDT-relevant articles and interactive features offered in English and Spanish.

Humana-CareSource: At the time of the 2016 Annual Compliance Review, the MCO had been deemed compliant with EPSDT member education requirements based on the 2014 Annual Compliance Review, which cited the member handbook, Teens First/Children First brochures mailed biannually, and the online member portal with links to guidelines for preventive services. The 2016 Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, described Baby First, a coupon program to encourage prenatal, postpartum and well-baby visits during the first 15 months of life. The program was transitioning from physician verification of visits, to a reloadable card program, with the card automatically credited when a claim for service was submitted.

Quarterly telephonic outreach to parents and guardians of EPSDT-eligible members delinquent in their well-child visits continued in 2015, with the provision of education and assistance scheduling appointments with the member's PCP. Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan, provided quarterly updates of prospective outreach attempts by the EPSDT coordinator to heads of households with members due for well-child visits, immunizations and dental screenings. Case managers also reviewed lead screening and immunizations for children and adolescents being case managed.

In addition to Teens First and Children First brochures, birthday cards and annual dental reminders were routinely mailed to EPSDT member households. An EPSDT Flyer, with recommendations for well-child visits, immunizations, lead and dental screenings, was distributed at public events. A dental poster was displayed at these events, with participants provided dental education, toothbrushes and toothpaste. While the Humana-CareSource Annual Report # 86, Annual Outreach Plan, did not categorize scheduled events, many of the over 150 calendar entries proposed for 2015/2016 were EPSDT related (e.g., children's, back to school and school health fairs) and included a presence at specialized venues such as Mardi Gras for Homeless Children and the Grandparents Raising Children conference.

Passport Health Plan: At the time of the 2016 Annual Compliance Review, the MCO had been deemed compliant with all contractual requirements for EPSDT member education and outreach based on the results of the 2014 Annual Compliance Review. Member education was provided via the member handbook, confirmation letters, an EPSDT brochure, quarterly mailings and telephonic outreach to targeted member households. Content included the value of preventive care, recommended age-appropriate preventive screenings, and information regarding vision, hearing, dental, and mental health benefits. Assistance with accessing services through member services or dedicated care connectors was described.

Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, also noted the distribution of postcards to parents of newborns prompting them to select a PCP and schedule a well-child/EPSDT exam. Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan, included entries for an automated call system for telephonic outreach and expanded Home Visit Program/department of health contracts to outreach and educate non-compliant members. Clinic-embedded nurses provided face-to-face outreach to members identified on monthly gaps in care reports. Incentives were distributed for adolescent well-child screens and dental visits. Community Engagement participated in 19 back to school events providing education and incentives. Rotating on-hold SoundCare messages re-iterated the importance of regular well-child screens and age-appropriate immunizations.

WellCare of Kentucky: The MCO was found fully compliant with contract requirements regarding EPSDT member education in the 2016 Annual Compliance Review, supported by EPSDT policies, the member handbook and several sample letters to members. Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, quantified periodicity and 45-day letters sent to member households by age group (first 15 months of life, 3–6 years of age, adolescents, and 0–20 years of age) as reminders to schedule well-child visits and obtain blood lead level screening.

Quarterly Report # 17, Quality Assessment and Performance Improvement Work Plan, included the number of periodicity letters mailed and gift card incentives awarded for dental screening, and tracked the number of appointments scheduled by Centralized Telephone Outreach to members in need of well-child visits. The Work Plan noted providers are responsible for monitoring, tracking and follow-up with members who have not had health screenings, and MCO HEDIS Practice Advisors and Provider Representatives visited offices to distribute care gap reports and toolkits. The MCO Annual Report # 86, Annual Outreach Plan, documented EPSDT-specific newsletters and participation in community baby showers and school-based outreach.

Right to Appeal EPSDT Service Determinations

As of the 2016 Annual Compliance Review – EPSDT, four of five MCOs were considered fully compliant in informing members of their right to appeal decisions related to EPSDT services, via member handbooks and adverse determination letters.

Two MCOs had been deemed compliant based on the 2014 Annual Compliance Review, i.e., Humana-CareSource and Passport Health Plan. However, during the 2014 review, it had been noted for a related requirement that the Humana-CareSource appeal resolution notice lacked language regarding the possibility of member liability for continuation of benefits given a state fair hearing decision not in the member's favor. The omission had been resolved at the time of the 2016 Annual Compliance Review.

Following document and file review, two MCOs were found to be fully compliant the requirement to inform members of the right to appeal, i.e., CoventryCares of Kentucky and WellCare of Kentucky.

The finding for Anthem BCBS Medicaid was upgraded from minimally compliant in 2015 to substantially compliant for the 2016 Annual Compliance Review. The Member Handbook and EPSDT Program Overview contained the required information. Upon file review, Appeal Resolution Letters did not contain information on how to request a continuation of benefits, and potential liability associated with state fair hearing outcomes. At onsite interview, the MCO responded that final Appeal letters had been submitted to NextGen, and final approval was pending.

Provider Network

Kentucky Medicaid MCOs are contractually obligated to provide a sufficient network of trained health care providers to provide EPSDT services to eligible children. PCPs who are assigned to each eligible member are required to provide or arrange for complete assessments at periodic intervals consistent with the American Academy of Pediatrics (AAP) periodicity schedules for preventive care, and at other times when medically necessary. PCPs and other providers in the MCOs' network provide diagnosis and treatment, and out-of-network providers may provide treatment if the service is not available within the MCO's provider network.

MCO EPSDT provider networks were evaluated for adequacy, member-to-PCP ratios, geographic access and appointment availability through the 2016 Annual Compliance Review – QAPI: Access, EPSDT and MCO Annual Report #85, Quality Improvement Plan and Evaluation. Program evaluations further gauged member satisfaction with provider access and availability via select CAHPS survey element and grievance category analyses.

EPSDT Providers

Statewide Overview

All five MCOs were found to require PCPs to provide EPSDT services in the 2016 Annual Compliance Review – EPSDT, either by deeming based on 2014 findings (Humana-CareSource, Passport Health Plan), 2015 findings (Anthem BCBS Medicaid), or full review in 2016 (CoventryCares of Kentucky, WellCare of Kentucky). Therefore, adequacy of PCP networks is discussed in this review.

Four of five MCOs fully met the network requirements for geographic access (PCP sites not more than 30 miles/30 minutes from member residence in urban areas or 45 miles/45 minutes in non-urban areas), member-to-PCP ratios (not to exceed 1500:1) and waiting times (appointment for preventative services available within 30 days of request). Again, Humana-CareSource and Passport Health Plan were deemed fully compliant based on the 2014 Annual Compliance Review – QAPI: Access, Anthem BCBS Medicaid based on the 2015 Annual Compliance Review, and CoventryCares of Kentucky based on full review of these elements.

WellCare of Kentucky was found to be only substantially compliant regarding PCP network requirements. An IPRO access and availability survey found the standards for timely routine and urgent care appointments (within 48 hours of request) were met less than 80% of the time. The MCO submitted provider-specific Corrective Action Plans to the DMS on 11/30/15, and received final approval to implement 2/9/16. Corrective Action Plans were in progress at the time of the final 2016 Annual Compliance Review Report.

MCOs evaluated network adequacy and monitored appointment availability through site visits, secret shopper surveys, review of CAHPS results and analysis of grievances. Secret shopper surveys for routine appointments are likely most reflective of appointments for EPSDT screening. MCO-specific findings regarding network evaluation and attributes are described below.

MCO-Specific Network Evaluation

Anthem BCBS Medicaid: The MCO began enrolling adult members at the beginning of 2014 and submitted its first Annual Report #85, 2014 Quality Improvement Plan and Evaluation, which contained analyses of practitioner availability, service accessibility and member satisfaction with access. The member-to-PCP (family, general, internal medicine and pediatric providers) was reported as 18:1. All urban and rural mileage and travel standards were met. The MCO goal of <0.20 complaints per 1000 members regarding routine access was exceeded, with four such complaints received for a rate of 0.06 per 1000 members. Accessibility of Services and CAHPS surveys were scheduled for 2015, to be conducted by Morpace and Decision Support Systems (DSS) Research respectively, both National Committee for Quality Assurance (NCQA) certified survey vendors.

CoventryCares of Kentucky: In its third Annual Report #85, 2014 Quality Improvement Plan and Evaluation, the MCO provider network was comprised of 4,868 Primary Care Providers and 14,407 Specialty Care Providers (SCP) as of 12/31/14. One hundred percent of members were able to access a Primary Care Provider within the mileage standards.

Plan-wide the member-to-provider ratio was 16:1; however, member-to-PCP ratios were not presented, and as noted, far fewer primary care than specialty care providers participate in the network.

The MCO conducted a telephone survey of 303 randomly selected primary and specialty care providers ensure appointment availability standards were met. The 30-day standard was met when requesting a preventive care visit (e.g., for physical exam or immunization) by 97% of providers, exceeding the MCO goal of 90% compliance. Provider Relations staff educated and followed-up with non-compliant providers; a provider newsletter contained more information on accessibility standards.

The MCO 2014 CAHPS[®] survey of 1,650 children resulted in a Getting Care Quickly composite score of 94%, exceeding the 2013 NCQA Quality Compass[®] national average of 89%. An analysis of complaints and grievances by category, such as access, was not found in the MCO Annual Report #85, Quality Improvement Plan and Evaluation.

Humana-CareSource: The MCO began serving members in Kentucky in 2013, operating in Region 3 only; therefore, the outcomes summarized in their Annual Report #85, 2014 Quality Improvement Plan and Evaluation, represent first year data in a limited membership. Quarterly Provider Access and Availability reports were included; the Year End Outcomes table reported only "GAPS" by specialist, leaving the assumption all mileage and ratio standards related to PCPs had been met.

Regarding appointment availability, the MCO utilized The Meyers Group to conduct a Secret Shopper Survey in the fourth quarter of 2014, with results to be made available in the 2015 program evaluation. Results were to be used to plan and implement provider-specific outreach and education; in the meantime, general provider education included protocols for member access to providers.

The first year CAHPS[®] survey results were based on only 368 respondents, and resulted in a Getting Care Quickly score of 90% (for children, although the number of respondents for children was not specified). The top three member grievance categories for calendar year 2014 were dental network availability, PCP and specialist access. The MCO assisted members with locating participating providers when their preferred provider was not participating, and provided education regarding access standards via the member handbook, website and newsletters.

Passport Health Plan: The MCO Annual Report #85, Quality Improvement Plan and Evaluation, reported an urban member-to-PCP ratio of 53:1, with all members living in urban counties having access to a PCP within 30 miles or 30 minutes of their home. For rural membership, the ratio was 9:1, with all members having access to a PCP within 45 miles or 45 minutes of their home.

To monitor appointment availability, the MCO assessed 15% of the PCP and SCP network annually for accessibility compliance. During 2014, Provider Relations Representatives reviewed the appointment book or computer system of 517 providers, with a finding of 100% compliance.

The 2014 CAHPS[®] Child Medicaid Survey score for Getting Care Quickly of 92% (766 child surveys), was down slightly from the previous year, but exceeded the 2014 Quality Compass Mean. No barriers or interventions were identified. The top member grievances were Attitude and Service, Access, and Quality of Care. Again, no major barriers or interventions were noted.

WellCare of Kentucky: As per Annual Report #85, 2014 Quality Improvement Plan and Evaluation, the MCO achieved 100% PCP network adequacy in all urban and rural areas, with a member-to-PCP ratio within goal all four quarters, and at 90:1 for the year.

Appointment availability audits were conducted on 784 PCPs and 176 pediatricians, with a compliance goal of 95%. Audit results for both exceeded the goal; 97% of PCPs, and 98% of pediatricians, scheduled routine appointments within 30 days of request. The MCO Network Integrity Department notifies providers not meeting the standard in writing, and conducts a second audit approximately 90 days after issuance of the letter. Any provider found to be non-compliant after a second audit is sent a request for a Corrective Action Plan. Providers non-compliant after the second audit, and

who fail to provide an acceptable Corrective Action Plan, are referred to the medical director. No such instances were reported.

The 2014 CAHPS® Child Survey score for Getting Care Quickly of 93% (521 surveys) exceeded the Quality Compass Mean. The top three member grievance categories in 2014 did not include access, although the number of complaints regarding access was not given.

EPSDT Provider Education

Statewide Overview

Kentucky contractual requirements for Medicaid MCOs include maintaining an effective education/information program for providers involved in delivery of EPSDT services. The education/information program should address current guidelines for components of EPSDT screening and special services and emerging health status issues that should be addressed as part of EPSDT services. This requirement was evaluated in the 2016 Annual Compliance Review – EPSDT.

One MCO (Humana-CareSource) was deemed compliant regarding provider education based on the 2014 Annual Compliance Review. Two MCOs sustained full compliance between current and prior reviews (CoventryCares of Kentucky, 2014 and WellCare of Kentucky, 2013). A fourth MCO brought the educational program into full from minimal compliance in 2014 (Passport Health Plan). The fifth MCO remained in only substantial compliance between 2014 and 2016 reviews (Anthem BCBS Medicaid).

MCO-Specific Provider Education

Anthem BCBS Medicaid: As per the 2016 Annual Compliance Review, the MCO policy Provider Administration of EPSDT Screenings and Special Services for Kentucky Medicaid Members described an up-to-date web portal containing pertinent information, resource guides, an EPSDT Provider Toolkit, and other educational materials. On-site training on use of these materials in EPSDT service delivery was conducted in provider offices.

While all training materials had been updated to address nurses, nurse practitioners and physician assistants, the latest review noted the omission of physical assessment components for these professions, as well as for medical residents. It was also recommended the MCO track attendance and training initiatives such as presentations and site visits for providers with suboptimal screening rates. The MCO responded that the above-noted policy and Provider Manual had been updated since the review.

Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, detailed development of the Provider Portal with HEDIS quality guidelines, distribution of the EPSDT Toolkit to high-volume pediatric providers, and additional training and guidance available from the EPSDT coordinator.

CoventryCares of Kentucky: As per the 2016 Annual Compliance Review, EPSDT-specific information was made available via the Provider Manual, Provider Newsletters, and other educational materials. Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, demonstrated EPSDT staff continued to work with providers referring members for special services to facilitate authorization for treatment. EPSDT staff also outreached to providers with members with elevated blood lead levels to discuss possible interventions when re-testing did not occur, or levels remained chronically high. In general, EPSDT staff worked one-on-one with providers to resolve any EPSDT-related issues.

Humana-CareSource: The MCO was deemed compliant with all EPSDT provider education requirements based on the 2014 Annual Compliance Review, which had noted EPSDT information disseminated to providers through the Provider Manual, Provider Newsletters, a Provider Portal and Provider Representative on-site visits. The MCO Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, do not contain a category, or detail activities, related to provider education.

Passport Health Plan: At the time of the 2016 Annual Compliance Review, the finding for requirements regarding provider education had been upgraded from minimal to full compliance. The MCO had developed an EPSDT Provider

Education Manual, EPSDT Training Session and attendance records inclusive of all provider types (nurses, nurse practitioners, physician assistants, medical residents and specialists). EPSDT education and audit visits were conducted by the Quality Improvement Department. A DMS Corrective Action Plan had been received, with response documentation due following the Compliance Review.

WellCare of Kentucky: The MCO was again found fully compliant with provider education standards during the 2016 Annual Compliance Review, as evidenced by a provider presentation on EPSDT health care needs and interventions, a provider tool kit, and successful chart audit of documentation requirements. Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, demonstrated quarterly distribution of HEDIS toolkits and Care Gap Reports to providers.

Monitoring of EPSDT Provider Compliance with Required EPSDT Services

Statewide Overview

Monitoring of EPSDT provider compliance with required EPSDT services was evaluated in the 2016 Annual Compliance Review – EPSDT as part of ensuring that eligible members received all necessary services. Four of five MCOs were found to be fully compliant in oversight of providers' administration of EPSDT services: two had been deemed compliant based on 2015 reviews (Anthem BCBS Medicaid, Humana-CareSource) and two had been found compliant following full review in 2016 (CoventryCares of Kentucky and WellCare of Kentucky). Passport Health Plan had again conducted monitoring and audit of EPSDT providers in Region 3 only during the review period, and therefore had received a finding of substantial compliance in both in 2015 and 2016.

In addition, MCOs' Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, Annual Report #85, Quality Improvement Plan and Evaluation, and Quarterly Report # 17, Quality Assessment and Performance Improvement Work Plan, were reviewed for this report. The five MCOs reported monitoring of provider delivery of EPSDT services during 2015 through provider audits, monitoring of provider-specific rates for relevant performance measures, and monitoring provider member panels for those members lacking age-appropriate screenings.

MCO-Specific Provider Monitoring

Anthem BCBS Medicaid: Per the 2015 Annual Compliance Review, the MCO had been deemed compliant in 2016 with requirements to assure PCPs assigned to EPSDT members provided complete assessments per the periodicity schedule and/or when medically necessary. The MCO Annual Report #85, 2014 Quality Improvement Plan and Evaluation, contained no information regarding results of provider monitoring; however, the Quarterly Report #17, 2015 Quality Assessment and Performance Improvement Work Plan, contained several HEDIS-specific entries regarding EPSDT Physician Monthly Reminders of Overdue Services for well-child and dental visits, as well as for lead screening, immunizations, and weight assessment and counseling. MCO Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, quantified the number of Provider Letters for Overdue Service sent to individual PCPs and group practices.

CoventryCares of Kentucky: At the time of the 2016 Annual Compliance Review, the MCO was found fully compliant regarding PCP responsibility to provide EPSDT members initial, periodic, and inter-periodic health assessments, as evidenced by specifications outlined over several pages of the Provider Manual. The MCO Annual Report #85, 2014 Quality Improvement Plan and Evaluation, reported outreach to provider offices to seek medical record documentation of 38,000 members identified as non-compliant for the following HEDIS measures: Well-child visits in the first 15 months of life; Well-child visits in the third, fourth, fifth, and sixth years of life; Childhood immunizations; Lead screening. The MCO also maintained Direct Provider.com, which allowed providers to query HEDIS measure non-compliance by member, or for all members of the MCO receiving services with the specific provider.

Humana-CareSource: Following the 2015 Annual Compliance Review, the MCO was deemed compliant in 2016 regarding confirmation of PCP EPSDT service provision to eligible members. Quarterly Report #17, 2015 Quality Assessment and Performance Improvement Work Plan, contained entries regarding Medical Record Review Audits against Clinical Practice Guidelines for well-child visits and adolescent well care. The Annual Report #85, 2014 Quality

Improvement Plan and Evaluation, noted support of the Clinical Practice Registry and Member Profile, allowing providers management of patient populations by flagging member services needed, rendered, or past due.

Passport Health Plan: For the second consecutive Annual Compliance Review, the MCO received a finding of substantial compliance, as site visits and chart audits to assess PCP provision of EPSDT services had been limited to Region 3, despite a provider sample detailing reviews needed in all regions. In contrast, the third Quarterly Report #17, 2015 Quality Assessment and Performance Improvement Work Plan, reported EPSDT audits had been completed. Quarterly Report, #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, described provider-specific Care Gap Reports in use by embedded MCO nurses.

WellCare of Kentucky: The 2016 Annual Compliance Review found full compliance with the requirement to ensure PCP administration of EPSDT benefits supported by MCO EPSDT policies and procedures. MCO Annual Report #85, 2014 Quality Improvement Plan and Evaluation, interventions addressing several EPSDT-specific HEDIS measures demonstrated ongoing provider monitoring, e.g., notification regarding members due EPSDT services via non-compliant reports, targeted letters, and alerts at eligibility checks in the provider portal. An EPSDT database was used to identify and approach low-performing providers; conversely, well-child visits, adolescent well-care visits, and immunizations were rewarded in the 2015 Pay for Performance program.

The Annual Medical Record Documentation Review included an audit of EPSDT providers, and resulted in a recommendation PCPs utilize a standard documentation method to include all aspects of well-child exams and improve compliance with EPSDT-required components. Subsequent development and posting of an EPSDT Well-Child Exam Form on the MCO website was described in Quarterly Report #17, 2015 Quality Assessment and Performance Improvement Work Plan.

Access to EPSDT Services

Kentucky Medicaid MCOs are required to provide EPSDT services to all eligible members; in general, EPSDT services include screening, diagnostic and treatment services. Specific services include a comprehensive history, physical exam, developmental and BH screening, immunizations, dental services, vision screening, hearing screening, lead screening and anticipatory guidance, as well as follow-up of identified risks.^{vi}

The extent to which Kentucky MMC-enrolled children received recommended EPSDT services was reflected in Form CMS-416, select HEDIS performance measures, and some Kentucky State-specific Healthy Kentuckians performance measures, all of which Kentucky MCOs are required to report. In addition, a retrospective medical record review study was conducted by IPRO on behalf of DMS in 2015 to ascertain which components of EPSDT services children were receiving during well-child primary care visits.

EPSDT Screening and Participation

Kentucky MCOs report EPSDT screening and participation rates using Form CMS-416 in the Kentucky Annual Report #93, EPSDT Annual Participation Report. Form CMS-416 provides basic information used by CMS to assess state EPSDT programs in terms of the number of children who are provided child health screening services, as well as other EPSDT services. Child health screening services are defined as initial or periodic screens as required according to a state's screening periodicity schedule, which in the State of Kentucky is consistent with the AAP periodicity schedule.^{vii,viii} Reported elements on Form CMS-416 include a screening ratio, which indicates the extent to which EPSDT-eligible children receive the expected number of initial and periodic screening services required by the State's periodicity schedule, adjusted by the proportion of the year for which they are Medicaid eligible. A participant ratio is also calculated, which reflects the extent to which eligible children receive any screening services during the year.

CMS has historically set annual goals compelling states to screen at least 80% of EPSDT-eligible children, and provide at least 80% of screenings recommended for those children.^{ix,x} The most recently reported national EPSDT rates (5/5/16 with nine states not yet reported) were a screening ratio of 0.80 and participant ratio of 0.59.^{xi} State of Kentucky rates for federal fiscal year (FFY) 2015 (10/1/14 through 9/30/15) were closely aligned with national averages, with a slightly higher screening ratio of 0.82 and slightly lower participant ratio of 0.58 (Table 1).^{xii}

MCO total ratios, for all ages, are also presented in Table 1. All MCOs reported screening ratios lower than the state average of 0.82 (calling calculation methods into question) and national average of 0.80. All MCOs, with the exception of Passport Health Plan, reported participation ratios lower than the national average of 0.59.

Table 1: EPSDT Screening and Participation Rates Reported by Kentucky MCOs – FFY 2015

Indicator ¹	MCO					Kentucky Statewide Average ²	National Average ²
	Anthem BCBS Medicaid	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky		
2015 EPSDT screening ratio	0.71	0.51	0.49	0.78	0.51	0.82	0.80
2015 EPSDT participant ratio	0.47	0.49	0.39	0.63	0.48	0.58	0.59

¹Rates were reported by Kentucky MCOs on Form CMS-416 for the measurement period from 10/1/14 through 9/30/15 for FFY 2015. Source: Annual Report #93, EPSDT Annual Participation Report.

²State and national rates were reported by CMS at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>.

BCBS: Blue Cross and Blue Shield; MCO: managed care organization; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment.

MCO age-specific ratios are presented in Table 2. With few exceptions, screening ratios do not meet national averages in all age groups, at all MCOs. Among infant members at Anthem BCBS Medicaid, Humana-CareSource, and Passport Health Plan, screening ratios did meet national averages at 1.00. Additionally, among members ages 1–2, 3–5, and 10–

14 years at Passport Health Plan, screening ratios met or exceeded the national averages, indicating only infants across MCOs, and older children at one MCO, were receiving the number of screenings expected.

Similarly, MCO participant ratios, with some exceptions, did not meet national averages in each age category, indicating fewer than average members receiving any screening services. Other than among older members at Passport Health Plan, infant and toddler age groups across MCOs experienced participant ratios close to national averages, but these declined as age increased.

Table 2: EPSDT Screening and Participation Rates by Age Group Across MCOs – FFY 2015

Ratios by Age Group ¹	MCO					Kentucky Statewide Average ²	National Average ²
	Anthem BCBS Medicaid	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky		
Age-specific screening ratio							
< 1 year	1.00	0.62	1.00	1.00	0.38	1.00	1.00
1–2 years	0.88	0.58	0.75	1.00	0.83	1.00	1.00
3–5 years	0.64	0.69	0.46	0.92	0.75	0.83	0.87
6–9 years	0.61	0.61	0.23	0.55	0.33	0.86	0.65
10–14 years	0.39	0.46	0.29	0.66	0.48	0.57	0.65
15–18 years	0.26	0.32	0.21	0.49	0.36	0.41	0.54
19–20 years	0.10	0.17	0.12	0.25	0.28	0.30	0.32
Age-specific participant ratio							
< 1 year	0.86	0.94	0.91	0.91	0.89	0.93	0.92
1–2 years	0.56	0.77	0.66	0.79	0.79	0.79	0.80
3–5 years	0.59	0.62	0.49	0.83	0.65	0.68	0.69
6–9 years	0.58	0.55	0.27	0.53	0.31	0.73	0.54
10–14 years	0.36	0.40	0.33	0.62	0.43	0.47	0.53
15–18 years	0.23	0.27	0.22	0.46	0.32	0.33	0.43
19–20 years	0.10	0.15	0.11	0.22	0.25	0.24	0.23

¹Rates were reported by Kentucky MCOs on Form CMS-416 for the measurement period from 10/1/14 through 9/1/15 for federal fiscal year 2015. Source: Annual Report #93, EPSDT Annual Participation Report.

²State and national rates were reported by CMS at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>.

BCBS: Blue Cross and Blue Shield; MCO: managed care organization.

EPSDT-Relevant HEDIS Measures

Kentucky MCOs report HEDIS access, utilization and effectiveness of care quality measures, and several of these measures are relevant to EPSDT services. Children’s and adolescents’ access to PCPs, well-child and dental visits, as well EPSDT-specific service measures such as lead screening, body mass index (BMI) documentation, and nutrition and physical activity counseling, were reviewed for this report.

The NCQA publishes national Medicaid performance measure rates annually in Quality Compass. In Table 3, Kentucky MCO HEDIS 2015 Quality Measure Rates, as reported on the MCOs’ submitted 2015 HEDIS Audit Review Tables, are compared to the 2015 national Medicaid averages.

Due to initiation of child and adolescent enrollment in July of 2014, Anthem BCBS Medicaid was only able to report limited measures for HEDIS 2015.

Access/Availability of Care

Children's Access to Primary Care Practitioners (CAP) measures the percentage of children with a PCP visit in the MY by the following age categorizations: 12–24 months, 25 months–6 years, 7–11 years and 12–19 years. As noted, Anthem BCBS Medicaid reported fewer than 30 members in each category and did not report CAP measures. During its second HEDIS cycle, Humana-CareSource reported a lower than average proportion of children with PCP visits in all age categories. Notably, all other MCOs, in all age categories, reported higher than average percentages of children with PCP visits in 2014.

The HEDIS measurement Annual Dental Visit (ADV) examines the percentage of members age 2–21 years of age with at least one dental visit during the MY. Again, Anthem BCBS Medicaid and Humana-CareSource, newer to the Kentucky Medicaid market, reported lower than average percentages of members receiving dental care. The remaining MCOs reported more than 50% of members in this age group had a dental visit, exceeding the national average. Dental visits, however, were not restricted to preventive care, and may have been for restorative treatment of caries or other oral health problems.

Utilization

While the Children's Access to Primary Care Practitioners measures assess visits for any reason, the Well-Child Visit measures reflect visits specifically for preventive services, and may be more representative of visits for EPSDT services. Well-Child Visits in the First 15 Months of Life (W15) selects children turned 15 months old during the MY, to assess whether they had six or more well-child visits during the first 15 months of life. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) assess the proportion of children of these ages having had one or more well-child visits during the MY, and Adolescent Well-Care Visits (AWC) reports the percentage of members age 12–21 years with a comprehensive PCP or obstetrician/gynecologist visit documented during the MY or the year prior.

Passport Health Plan, with a much longer presence in Kentucky Medicaid than the other MCOs, was the only MCO to exceed national averages in any, and all, well-care measures by age group. Anthem BCBS Medicaid did not report Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life; for all other MCOs, adherence was highest among this age group, with the greatest opportunity for improvement among adolescent members.

Effectiveness of Care

Effectiveness of care was evaluated via documentation of BMI/BMI percentile, nutritional counseling, and physical activity counseling for 3–17 year old members. Again, only Passport Health Plan exceeded national averages in any, and all, three measurements. With the exception of BMI documentation for Humana-CareSource members, and nutritional counseling provided CoventryCares of Kentucky members, fewer than half of members at the remaining MCOs were provided assessment or counseling.

Effectiveness of care was also evaluated by examining the immunization status of members 2 and 13 years of age. The HEDIS measure Childhood Immunization Status (CIS) -Combination 2 is used to report the percentage of 2-year-old children fully immunized against diphtheria, tetanus and acellular pertussis (DTaP), polio (IPV), measles, mumps and rubella (MMR), H influenza type-B (HiB), hepatitis B (HepB), and chicken pox (varicella zoster, VZV). Only Passport Health Plan and CoventryCares of Kentucky were found to surpass the national average, with over three-quarters of 2-year-olds appropriately vaccinated. Far lower proportions of children had received the appropriate number of vaccinations by this age among Humana-CareSource and WellCare of Kentucky members. Anthem BCBS did not have enough continuously enrolled members to report this measure.

Immunization rates were higher among adolescents at all four reporting MCOs. HEDIS Immunizations for Adolescents (IMA)-Combination 1 rate measures immunization against tetanus, diphtheria and meningococcal disease. Only Humana-CareSource failed to meet the national average of 71%, with the remaining MCOs demonstrating approximately 80% or more of adolescent members vaccinated.

The Centers for Disease Control and Prevention (CDC) recommends all children, despite risk, should be screened for lead poisoning.^{xiii} While only the Passport Health Plan HEDIS Lead Screening in Children (LSC) rate exceeded the national

average of 67%, while CoventryCares of Kentucky, Humana-CareSource, and WellCare of Kentucky reported near-average rates of approximately 60–65% of members tested by their second birthday.

Table 3: Kentucky MCO HEDIS Quality Measure Rates Relative to the National Medicaid Average – RY 2015

HEDIS Measure ¹	Measure Description	MCO					Weighted Average All MCOs
		Anthem BCBS Medicaid ²	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	
Access/Availability of Care							
Children's Access to Primary Care Practitioners (CAP) ³	The percentage of members 12 months–19 years of age who had a visit with a PCP						
CAP – 12–24 Months	The percentage of · Children 12–24 months who had a visit with a PCP during the MY	N/A	97.20% ↑	92.39% ↓	98.35% ↑	97.49% ↑	97.49%
CAP – 25 Months–6 Years	The percentage of · Children 25 months–6 years who had a visit with a PCP during the MY	N/A	90.63% ↑	82.52% ↓	90.25% ↑	92.02% ↑	90.91%
CAP – 7–11 Years	The percentage of · Children 7–11 years who had a visit with a PCP during the MY	N/A	96.32% ↑	88.32% ↓	94.19% ↑	96.30% ↑	95.63%
CAP – 12–19 Years	The percentage of · Adolescents 12–19 years who had a visit with a PCP during the MY or the year prior	N/A	95.05% ↑	85.11% ↓	92.92% ↑	95.22% ↑	94.39%
Annual Dental Visit-(ADV)	The percentage of members 2–21 years of age who had <u>at least one dental visit</u> during the measurement year	21.49% ↓	57.34% ↑	46.40% ↓	63.64% ↑	60.36% ↑	59.41%
Utilization							
Well-Child Visits in the First 15 Months of Life (W15) – 6+ Visits	The percentage of members who turned 15 months old during the measurement year and who <u>had six (6) or more well-child visits</u> with a PCP during their first 15 months of life	N/A	50.24% ↓	46.53% ↓	66.24% ↑	47.19% ↓	52.46%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	The percentage of members 3–6 years of age who received <u>one or more well-child visits</u> with a PCP during the measurement year	N/A	57.73% ↓	62.29% ↓	74.77% ↑	59.75% ↓	62.16%

HEDIS Measure ¹	Measure Description	MCO					Weighted Average All MCOs
		Anthem BCBS Medicaid ²	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	
Adolescent Well-Care Visits (AWC)	The percentage of enrolled members 12–21 years of age who had <u>at least one comprehensive well-care visit</u> with a PCP or an ob/gyn (obstetrics and gynecology) practitioner during the measurement year	24.19% ↓	43.07% ↓	32.60% ↓	51.37% ↑	41.85% ↓	43.79%
Effectiveness of Care							
Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) ³	The percentage of members 3–17 years of age who had an outpatient visit with a PCP or ob/gyn and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> · BMI percentile documentation, · Counseling for nutrition, and · Counseling for physical activity 						
WCC – BMI Percentile	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or ob/gyn and who had a <u>BMI percentile/BMI documented</u> during the measurement year	N/A	45.50% ↓	56.69% ↓	86.31% ↑	43.80% ↓	52.97%
WCC – Counseling for Nutrition	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or ob/gyn and who had <u>assessment/counseling for nutrition</u> during the measurement year	N/A	51.34% ↓	49.64% ↓	72.85% ↑	41.36% ↓	51.26%
WCC – Counseling for Physical Activity	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or ob/gyn and who had <u>assessment/counseling for physical activity</u> during the measurement year	N/A	40.88% ↓	47.20% ↓	63.58% ↑	40.39% ↓	45.23%
Childhood Immunization Status (CIS) ³	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday						
CIS – Combination 2	DTaP, IPV, MMR, HiB, HepB, VZV	N/A	75.18% ↑	54.26% ↓	83.53% ↑	64.96% ↓	72.16%

HEDIS Measure ¹	Measure Description	MCO					Weighted Average All MCOs
		Anthem BCBS Medicaid ²	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	
Immunizations for Adolescents (IMA) ³	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine or one tetanus, diphtheria toxoids (Td) vaccine by their 13 th birthday						
IMA – Combination 1	Adolescents who received one meningococcal vaccine on or between the members 11 th and 13 th birthday and one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine or one tetanus, diphtheria toxoids (Td) vaccine on or between the member’s 10 th and 13 th birthdays	N/A	82.11% ↑	67.15% ↓	88.43% ↑	79.23% ↑	81.90%
Lead Screening in Children (LSC)	The percentage of children 2 years of age who had one or more capillary or venous lead <u>blood tests for lead poisoning</u> by their second birthday	N/A	60.58% ↓	65.45% ↓	77.26% ↑	61.11% ↓	64.60%

¹Rates were obtained from MY 2014 for RY 2015. Rates above national Medicaid average are represented by an upward arrow (↑) and rates below national Medicaid average are represented by a downward arrow (↓). Source: 2015 HEDIS Audit Review Tables submitted by MCOs. Please note: Arrows do not reflect comparison of rates to the weighted average for all MCOs in Kentucky.

²Due to Anthem BCBS Medicaid initiation of child and adolescent enrollment 7/14, the MCO was able to report only limited measures for HEDIS 2015.

³The measure has rates reported for its specific subparts (reported in rows below) and has no overall reported rate in and of itself (indicated by gray shading). HEDIS: The Health Effectiveness Data and Information Set; MCO: managed care organization; BCBS: Blue Cross and Blue Shield; N/A: not applicable

Healthy Kentuckians Measures

Kentucky has developed state-specific performance measures, which provide information that augments the reported HEDIS measures. These measures are reflective of the State's Healthy Kentuckians goals and objectives, and many are relevant to EPSDT services. Healthy Kentuckians measures that reflect components of EPSDT services include documentation of child and adolescent height and weight, the percentage of children and adolescents at a healthy weight, and adolescent behavioral risk assessment and counseling.

Healthy Kentuckians measures also address preventive care for children with special health care needs (CSHCN) through use of modified HEDIS access and utilization measures discussed in the previous section: Children and Adolescent's Access to Care and Well-Child, Well-Care and Annual Dental Visits.

Pertinent Healthy Kentuckians performance measure results, as reported in the MCOs' 2015 Kentucky Performance Measure Validation submission Attachment B (MY 2014), are presented in Table 4; CSHCN-specific preventive measures are presented in Table 5 in the following section. Due to Anthem BCBS Medicaid initiation of child and adolescent enrollment in July of 2014, the MCO was able to report only two 2015 EPSDT-relevant Healthy Kentuckian performance measures rates; specifically, Annual Dental and Adolescent Well-Care Visit rates for the CSHCN population.

Despite suboptimal HEDIS BMI/BMI percentile documentation noted earlier, Healthy Kentuckians measures demonstrated child and adolescent height and weight documentation at higher rates, suggesting educational opportunities around BMI calculation and use. Statewide, less than 40% of members age 3–17 years, and having had an outpatient visit, had evidence of a healthy weight for their height. MCO rates of juvenile members with healthy weights for height ranged from 31% to 57%, supporting continued focus on BMI assessment, nutrition/physical activity counseling, and initiatives aimed at childhood obesity.

Most MCOs reported declining rates of adolescent screening and counseling corresponding to the following ranking of behavioral risk: tobacco use, alcohol/substance use, sexual activity, and depression (only WellCare of Kentucky providers addressed depression more often than alcohol/substance use or sexual activity). Adolescent screening and counseling rates were consistently increased from the previous year (data not shown in this year's report), but remain low enough to warrant substantial effort at improvement.

Table 4: EPSDT-Relevant Healthy Kentuckians Performance Measures – RY 2015

Healthy Kentuckians Measure ¹	Description	MCO					Weighted Average All MCOs
		Anthem BCBS Medicaid ²	CoventryCares of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	
Child and Adolescent Height and Weight	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or ob/gyn and who had <u>both a height and weight documented</u> on the same date of service during the measurement year. <i>REPORTING ONLY.</i>	N/A	76.40%	72.26%	94.70%	69.83%	76.98%
Child and Adolescent Healthy Weight for Height	The percentage of child and adolescent members 3–17 years of age who had an outpatient visit with a PCP or ob/gyn who had <u>healthy weight for height</u> during the measurement year. <i>REPORTING ONLY.</i>	N/A	30.50%	44.44%	56.64%	30.95%	39.29%
Adolescent Screening/ Counseling – Tobacco Use	The percentage of adolescents 12–17 years of age who had a well-care/preventive visit in measurement year and received <u>screening/counseling for tobacco use</u>	N/A	47.74%	59.86%	85.19%	62.33%	61.35%
Adolescent Screening/ Counseling – Alcohol/ Substance Abuse	The percentage of adolescents 12–17 years of age who had a well-care/preventive visit in measurement year and received <u>screening/counseling for alcohol/substance use</u>	N/A	36.13%	52.11%	72.84%	38.36%	44.54%
Adolescent Screening/ Counseling – Sexual Activity	The percentage of adolescents 12–17 years of age who had a well-care/preventive visit in measurement year and received <u>screening/counseling for sexual activity</u>	N/A	27.10%	50.70%	61.73%	26.71%	34.32%
Adolescent Screening/ Counseling – Depression	The percentage of adolescents 12–17 years of age who had a well-care/preventive visit in measurement year and had <u>screening for depression</u>	N/A	27.10%	47.18%	44.44%	40.41%	36.76%

¹Rates were obtained in MY 2014 for RY 2015. Source: Healthy Kentuckians performance measure results as reported in the MCOs' 2015 Kentucky Performance Measure Validation submission in Attachment B.

²Due to Anthem BCBS Medicaid initiation of child and adolescent enrollment 7/14, the MCO was able to report only limited 2015 EPSDT-relevant Healthy Kentuckian Performance Measures.

BCBS: Blue Cross and Blue Shield; MCO: managed care organization; N/A: not applicable.

Preventive Care for Children with Special Health Care Needs

Kentucky MCOs report select HEDIS access and utilization measures for the subpopulation of CSHCN, defined by eligibility for Supplemental Security Income (SSI), or foster care/adoption assistance. The Healthy Kentuckians measure set Children with Special Health Care Needs: Access to Care and Preventive Care Services is comprised of Children's Access to Care (CAP), Well-Child Visits (WC15, WC34, AWC), and Annual Dental Visit (ADV) measures by age group. These measures, as reported in the MCOs' 2015 Kentucky Performance Measure Validation submission Attachment B (MY 2014), are presented in Table 5. In order to assess for possible disparities in care, rates were compared to national averages for the general Medicaid population reported in the 2015 Quality Compass.[®]

Children with special health care needs might be expected to access PCPs for any reason more frequently than the general population, and among CSHCN, age-specific CAP rates exceeded those in the general population across reporting MCOs. The exception was Humana-CareSource, with all age-specific CAP rates lower than those in the general population. ADV rates were also higher than those in the general population across MCOs, again with the exception of Humana-CareSource, suggesting access to care for children with special health care needs might be an improvement focus for this MCO. Anthem BCBS Medicaid reported an ADV rate of 0%, which was based on a SSI total membership of less than 30, warranting cautious interpretation.

Regarding preventive visits, Humana-CareSource reported N/A for CSHCN well-child visits in the first 15 months of life (WC15), and rates lower than those of the general population for CSHCN ages 3–6 years (WC34) and CSHCN ages 12–21 years (ACW). WellCare of Kentucky also reported rates lower than those of the general population in all three age groups, suggesting access to PCPs and utilization of preventive care for CSHCN might be an integrated improvement focus for some MCOs. Again, Anthem BCBS Medicaid reported an ACW rate of less than 3%, based on a SSI total denominator of less than 30 members.

Table 5: Child and Adolescent Individuals with Special Health Care Needs Access and Preventive Care – RY 2015

Healthy Kentuckians Measure ¹	Description	MCO					Weighted Average All MCOs
		Anthem BCBS Medicaid ²	CoventryCare of Kentucky	Humana-CareSource	Passport Health Plan	WellCare of Kentucky	
Child and Adolescent Individuals with Special Health Care Needs (ISHCN) Access and Preventive Care							
Children’s and Adolescents Access to Care (CAP) ³	The percentage of members 12 months–19 years of age who had a visit with a PCP						
CAP – 12–24 Months	The percentage of · Children 12–24 months who had a visit with a PCP during the MY	N/A	95.65% ↑	N/A	98.73% ↑	97.88% ↑	98.04%
CAP – 25 Months–6 Years	The percentage of · Children 25 months–6 years who had a visit with a PCP during the MY	N/A	93.49% ↑	86.33% ↓	91.29% ↑	93.92% ↑	92.98%
CAP – 7–11 Years	The percentage of · Children 7–11 years who had a visit with a PCP during the MY	N/A	95.65% ↑	84.35% ↓	93.46% ↑	95.66% ↑	94.72%
CAP – 12–19 Years	The percentage of · Adolescents 12–19 years who had a visit with a PCP during the MY or the year prior	N/A	93.78% ↑	78.26% ↓	91.04% ↑	93.73% ↑	92.44%
Annual Dental Visit (ADV)	The percentage of members 2–21 years who had at least one dental visit during the MY	0.00% ⁴	54.97% ↑	43.68% ↓	62.72% ↑	60.09% ↑	59.22%
Utilization							
Well-Child Visits 15 Months – 6+ Visits (WC15)	The percentage of members who turned 15 months old during the MY and who had six (6) or more well-child visits with a PCP during their first 15 months of life	N/A	70.59% ↑	N/A	51.35% ↓	43.69% ↓	47.57%
Well-Child Visit 3–6 Years (WC34)	The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the MY	N/A	90.69% ↑	65.77% ↓	75.28% ↑	64.51% ↓	71.17%
Adolescent Well-Care Visit (AWC)	The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an ob/gyn practitioner during the MY	2.50% ⁴	55.30% ↑	38.34% ↓	53.88% ↑	37.07% ↓	45.24%

¹Rates were obtained in measurement year (MY) 2014 for reporting year (RY) 2015. Rates above national Medicaid average for the general Medicaid population are represented by an upward arrow (↑) and rates below national Medicaid average for the general population are represented by a downward arrow (↓). Source: Healthy Kentuckians performance measure results as reported in the MCOs’ 2015 Kentucky Performance Measure Validation submission in Attachment B. Please note: Arrows do not reflect comparison of rates to the weighted average for all MCOs in Kentucky.

²Due to Anthem BCBS Medicaid initiation of child and adolescent enrollment 7/14, the MCO was able to report only limited 2015 EPSDT-relevant Healthy Kentuckian Performance Measures.

³The measure has rates reported for its specific subparts (reported in rows below) and has no overall reported rate in and of itself (indicated by gray shading).

⁴Anthem BCBS Medicaid Annual Dental Visit and Adolescent Well-Care rates are based on a Total SSI denominator of < 30 members, and should be interpreted with caution.
BCBS: Blue Cross and Blue Shield; MCO: managed care organization; MY: measurement year; N/A: not applicable.

EPSDT Encounter Data Validation Study

While access to well-child visits and screening can be assessed by evaluating relevant MCO-reported EPSDT screening and participation rates and HEDIS and Healthy Kentuckians performance measures, the content of well-child screening visits is more difficult to ascertain. In order to more completely evaluate the scope of EPSDT services that children received during visits in 2014, a retrospective medical record review study was undertaken to validate that the content of well-child visits was consistent with EPSDT required screenings, diagnostics and treatment services. Well-child visits that occurred between 7/1/14 and 9/30/14 were included in the validation study. All MCOs participated in this EPSDT encounter data validation study by providing medical records for review in fairly equal amounts based on submitted claims for well-child visits.

For the purpose of this review, findings from evaluation of key components of the well-child visit have been selected for presentation and discussion: Comprehensive History, Physical Exam and Measurement (Table 6); Developmental Health, Mental Health and Behavioral Assessment (Table 7); and Documentation of Anticipatory Guidance (Table 8).

As shown in Table 6, past medical history was documented over 90% of the time across all age groups: preschool (ages 1–4 years), school age (5–11 years), and adolescents (12–20 years). A social history was obtained almost as often (range 83–89%). However, a family history was included in only 74%, and review of systems in 68%, of all children’s medical records. Comprehensive physical exams included examination of the eyes, ears/nose/throat, respiratory, cardiovascular and gastrointestinal systems in approximately 90% of all medical records (although documented at slightly lower rates in records of adolescents). Consistent with other performance measures addressing oral health, the Encounter Data Validation Study found medical provider assessment of oral health needs in 61% of juvenile records. Also consistent with other performance measures, height/length and weight were documented at high levels within all age groups, while BMI was documented/assessed in only 66% of records.

Table 6: Documentation of Comprehensive History and Physical Exam

Component of Well-Child Visit ¹	Age 1–4 Years	Age 5–11 Years	Age 12–20 Years	Total
Comprehensive history				
Past medical history	90%	94%	91%	92%
Family history	70%	73%	78%	74%
Social history	83%	89%	88%	87%
Review of systems	70%	64%	71%	68%
Comprehensive physical exam				
Head	83%	80%	73%	79%
Eyes	95%	93%	87%	92%
Ears/Nose/Throat	96%	94%	88%	93%
Lungs/Respiratory	97%	96%	93%	95%
Heart/Cardiovascular	97%	97%	94%	96%
Abdomen/Gastrointestinal	95%	95%	92%	94%
Skin	91%	87%	87%	88%
Spine/Back	84%	81%	80%	82%
Neurologic	90%	88%	82%	87%
Extremities	78%	79%	74%	77%
Genitourinary	79%	65%	63%	69%
Oral health assessment	61%	71%	52%	61%
Measurements				
Blood pressure ²	88%	95%	96%	94%
Height/Length and weight	99%	99%	97%	98%
BMI assessed ³	50%	69%	79%	66%

¹Measurement period: 7/1/14 to 9/30/14. Source: 2015 EPSDT Encounter Data Validation conducted by IPRO on behalf of DMS.

²Denominator comprised of children age 3 years and older only.

³Children under the age of 16 years had BMI and weight status assessed as a percentile relative to their gender and age.

BMI: body mass index.

Developmental health, mental health and behavioral risk assessment rates, as well as those for vision and hearing screening, are presented in Table 7. While general developmental surveillance was documented for 80% of children in total, rates were lower among adolescents (66%). The use of a formal developmental screening tool is recommended for children ages 1–3 years; a completed, scored, dated tool was included in 18% of medical records for children of this age group.

In addition to an eye exam, age-appropriate vision screening includes assessment of response to visual stimuli for children < 3 years of age, and of visual acuity for children > 3 years of age. Vision assessment was documented for 54% of the youngest age group, but for fewer than half of school-aged children and adolescents. Hearing assessment was evident for approximately 40% of preschool and school-aged children, and decreased to 18% for adolescents.

The proportion of children having received any type of mental health assessment included those with medical record entries regarding use of a formal screening tool, parental concern, or provider inquiry or observation. In total, 73% of EPSDT records documented some mental health assessment; rates increased with age. Depression screening was observed in 61% of adolescents' medical records (ages 11–20 years).

Behavioral risk assessment is also indicated for children ages 11–20 years of age. Consistent with Healthy Kentuckians Adolescent Screening/Counseling measures, the Encounter Data Validation Study revealed adolescents were asked more often about tobacco use (66%) than alcohol or substance use (45% and 40% respectively).

Table 7: Documentation of Developmental Health, Mental Health and Behavioral Assessments

Component of Well-Child Visit ¹	Age 1–4 Years	Age 5–11 Years	Age 12–20 Years	Total
Developmental assessment	88%	84%	66%	80%
Formal developmental screening ²	18%	N/A	N/A	18%
Age-appropriate vision assessment ³	54%	45%	34%	44%
Age-appropriate hearing assessment ⁴	41%	41%	18%	33%
Mental health assessment ⁵	62%	78%	79%	73%
Adolescent depression screening ^{5,6}	N/A	56%	62%	61%
Tobacco use screening ⁶	N/A	49%	70%	66%
Alcohol use screening ⁶	N/A	33%	48%	45%
Drug use screening ⁶	N/A	35%	42%	40%

¹Measurement period: 7/1/14 to 9/30/14. Source: 2015 EPSDT Encounter Data Validation conducted by IPRO on behalf of DMS.

²Developmental screening with a formal tool is indicated for children between the ages of 1–3 years, the denominator for this rate.

³Age-appropriate vision screening includes eye exam and assessment of response to visual stimuli for children younger than 3 years of age, and assessment of visual acuity and ocular alignment for children 3 years of age and older.

⁴Age-appropriate hearing screening includes assessment of response to sound stimuli for children younger than 3 years of age, and assessment of hearing using an audiogram for children 3 years of age and older.

⁵The categories 'any type of mental health assessment' and 'any type of depression screening' include use of a formal screening tool, notation of parental concern, or entries following provider inquiry or observation.

⁶Depression and behavioral risk assessment are indicated for children and adolescents 11 years of age and older; denominator for Age 5–11 Years comprised of 11 year olds only.

N/A: not applicable; indicator is not relevant for age group.

Rates of documented anticipatory guidance, part of EPSDT services, are displayed in Table 8. Anticipatory guidance concerning safety and injury prevention remained the most prevalent counseling topics (75% for preschoolers and 70% for school-aged children). Anticipatory guidance on the subjects of physical activity and screen time, indicated for children 2 years of age and older, were documented in 58% and 39% of records, indicating an emerging opportunity for provider education and support.

Table 8: Documentation of Anticipatory Guidance

Component of Well-Child Visit ¹	Age 1–4 Years	Age 5–11 Years	Age 12–20 Years	Total
Nutrition and diet	65%	69%	52%	62%
Safety/Injury prevention	75%	70%	53%	66%
Physical activity ²	55%	68%	49%	58%
Screen time ²	49%	45%	26%	39%

¹Measurement period: 9/1/14 to 9/30/14. Source: 2015 EPSDT Encounter Data Validation Study conducted by IPRO on behalf of DMS.

²Anticipatory guidance for physical activity and screen time is indicated for children of 2 years of age and older; denominator for Age 1–4 Years comprised of 2–4 year olds only.

EPSDT services include diagnostic and treatment services as well as screening. Some children had problems identified as the result of screening activities, and most received follow-up evaluation and/or treatment. Vision problems were identified for 19 children. Follow-up was documented for all preschool children, and all but one school-aged child, but for only four of seven adolescents. Hearing problems were identified for seven children; all records had evidence of follow-up. Developmental surveillance identified eleven children at risk of developmental delay; all but one had documentation of follow-up for the identified issue. A mental health problem was documented for 45 children; 43 records demonstrated further testing, the provision of medication or counseling, subsequent visits, or referral for evaluation and treatment. Twenty-nine members were specifically diagnosed with depression and all but one received similar interventions.

Regarding behavioral risk assessment, nine member records demonstrated tobacco use, but only four documented follow-up. Three records documented alcohol use, and two drug use, but no subsequent interventions.

An EPSDT Encounter Data Validation Study for dental services provided in 2015 remains in progress at the time of this report.

EPSDT Special Services

The federally mandated Medicaid program for children is divided into two components in Kentucky: EPSDT Screenings and EPSDT Special Services. The EPSDT Special Services Program allows benefits not covered elsewhere in Medicaid. Medically necessary services can be preventive, diagnostic, treatment or rehabilitative. Examples include additional pairs of eyeglasses, additional dental cleanings, general anesthesia for dental treatment, or supplemental nutritional products. MCOs are required to identify providers who can deliver these services, and must develop procedures for authorization and payment for such services. MCO members have the right to appeal EPSDT special services denials.

The 2016 Annual Compliance Review – EPSDT assessed MCO’s compliance with requirements to identify providers to furnish special services, and develop procedures for authorization and payment, whether the servicing providers were in or out of network. Review findings are outlined below.

The right to appeal denials for children’s services was assessed in an earlier section of this review (Right to Appeal EPSDT Service Determinations); the requirement to track member receipt of recommended health assessments and all necessary diagnosis and treatment, including needed EPSDT special services, will be further assessed in the subsequent section (Monitoring and Facilitation of Receipt of EPSDT Services).

MCO-Specific Provision of Special Services

Anthem BCBS Medicaid: During the 2016 Compliance Review, the MCO was found minimally compliant with requirements to identify providers, and develop authorization procedures, for medically necessary special services. The submitted document, Anthem Provider Administration of EPSDT Screenings and Special Services for Kentucky Medicaid Members, included a section Who can provide EPSDT screenings?, but did not address procedures to identify and qualify providers of special services. It was recommended these specifications be drafted in EPSDT Policies and Procedures and the Provider Manual.

The MCO was found substantially compliant with requirements to maintain a tracking system to monitor acceptance and refusal of EPSDT services, including special services. It was recommended the MCO ensure that special services be specifically monitored in the computer application EPSDT Member 360.

As noted earlier, the MCO was also substantially compliant with the requirement to inform members of the right to appeal authorization decisions. The required information was contained in the EPSDT Program Overview and Member Handbook, but appeal resolution letters did not contain information on how to request a continuation of benefits, and potential liability associated with a state fair hearing decision not in the member's favor, information which might be pertinent to a request for special services. The EPSDT Program Overview for Kentucky Medicaid states all EPSDT special services require a request for prior authorization and are reviewed by the medical director.

CoventryCares of Kentucky: The MCO was found fully compliant with requirements for the identification of providers, and procedures for preauthorization and payment of special services, as observed in the Provider Manual during the 2016 Annual Compliance Review. Monitoring acceptance and refusal of EPSDT special services was addressed in the policy and procedure EPSDT Program and seen in the computerized EPSDT Clinical Tracking System. Following document and EPSDT utilization management (UM) file review, the MCO was also found fully compliant with all requirements to inform members of the right to appeal service determinations.

The MCO Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death described a monthly report used to review special services referrals and authorization status, coordinate referrals with providers, and outreach to member families. The EPSDT project manager also identified, contacted, and offered case management services to members with special services needs.

Humana-CareSource: At the time of the 2016 Annual Compliance Review, and based on 2014 Annual Compliance Review findings, the MCO was deemed compliant with EPSDT Special Services requirements around provider identification, prior authorization, and monitoring. The MCO had also been deemed compliant and was not subject to EPSDT UM file review of denials and appeals.

No further information regarding special services was noted in the MCO Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death.

Passport Health Plan: The MCO was also deemed compliant with EPSDT Special Services requirements and EPSDT UM Appeals File Review for the 2016 Annual Compliance Review, following the 2014 Annual Compliance Review. The MCO does not report on the subpopulation of members eligible for special services in their Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death.

WellCare of Kentucky: Review of EPSDT requirements regarding provider identification and authorization procedures for special services resulted in findings of full compliance for the MCO during the 2016 Annual Compliance Review. These requirements, as well as those for monitoring receipt of services, were supported by EPSDT Policy C7QI-034. The MCO considers the submission of claims and encounters as its tracking system for member acceptance of EPSDT services; it is the responsibility of the provider to document and address members' refusal. The MCO provided evidence of submitted encounter codes and medical record review findings monitoring receipt or member refusal of all EPSDT services. The MCO was also found fully compliant with requirements to inform members of the right to appeal MCO denial of prior authorization requests.

Monitoring and Facilitation of Receipt of EPSDT Services

To ensure that eligible members receive required EPSDT services, Kentucky MCOs must establish an effective and ongoing member services case management function to provide education and counseling regarding compliance with EPSDT visits and prescribed treatment. MCOs must also provide support such as transportation and scheduling assistance and follow up with members when recommended assessment and treatment are not received. Outreach efforts, information received from providers, scheduling assistance and follow up with referral compliance should be tracked in a consolidated record.

In order to ensure that eligible children are receiving appropriate EPSDT services, Kentucky MCOs are required to establish and maintain a tracking system and conduct outreach to those in need of services. The system must monitor acceptance and refusal of EPSDT services, whether eligible members are receiving recommended health assessments and all necessary diagnosis and treatment, including EPSDT special services.

EPSDT monitoring systems, MCO outreach to members in need of services, and efforts to facilitate receipt of services were evaluated in the 2016 Annual Compliance Review – EPSDT, and were also reported in Kentucky Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death. Related initiatives were often included in Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan, or Annual Report #85, 2014 Quality Improvement Plan and Evaluation.

Member Monitoring for Receipt of EPSDT Services

Only Humana-CareSource had been deemed compliant with all required components of a member-level tracking system to monitor acceptance and refusal of EPSDT services, and the consolidated record for each eligible member, as a result of the 2014 Annual Compliance Review. Therefore, the level of compliance with monitoring and documentation requirements for the remaining MCOs, following the 2016 Annual Compliance Review – EPSDT, is detailed below.

MCO-Specific Member Monitoring

Anthem BCBS Medicaid: As noted in the EPSDT Special Services section of this report, the 2016 Annual Compliance Review found the MCO only substantially compliant with requirements to maintain an EPSDT monitoring system, in part because of inability to specifically track special services, but also because of inability to track member refusal of any EPSDT services.

However, the MCO received a finding of full compliance for maintenance of a consolidated record, as the computer application EPSDT Member 360 did contain eligibility, authorizations, claims, utilization, and pharmacy and laboratory testing information. Also included were diagnoses, a description of services received, a care summary with alerts, and communication notes and documents. The Care Management Page contained a member assessment, identified problems, and care plan with updated notes.

CoventryCares of Kentucky: As per the 2016 Annual Compliance Review, the MCO was fully compliant with maintenance of a tracking system which allowed evaluation of whether individual members were receiving all recommended health assessments and all necessary diagnosis and treatment services. The consolidated record contained dated notes of member contact regarding education, appointments, rescheduling, referrals and follow-up, as well as communications with primary care and referral providers. All requirements were addressed by policies and procedures in the documents CM-028 EPSDT Program and 2015 Prevention and Wellness Program, with functionality observed in the EPSDT Clinical Tracking System.

Passport Health Plan: During the 2014 Annual Compliance Review, the MCO received a finding of full compliance with tracking system requirements, and was deemed compliant for the 2016 Review. However, during the 2014 Annual Compliance Review, the MCO received a finding of only minimal compliance with consolidated record requirements, as screening and referral databases remained unlinked for the second consecutive review. A Corrective Action Plan had been issued by DMS and received by the MCO, with response documentation due at a date following the 2016 Annual Compliance Review.

However, at the 2016 Annual Compliance Review, full compliance was granted regarding consolidated medical record requirements. The MCO provided a template consolidated medical record, the EPSDT Chart Review Form, which internal programmers were implementing. When a member is referred for evaluation or treatment, the PCP issues the referral, denoting whether it results from an EPSDT screen. EPSDT-related referrals are collected daily for EPSDT Expanded Services outreach. The Expanded Services Referral Outreach Form will be included in the screening database and document recommended diagnostic or treatment services, dates of contact pertaining to appointments and scheduling, treatment services and follow-up, as well as reports and other information received from referral physicians or providers.

WellCare of Kentucky: As noted in the EPSDT Special Services section, subsequent to the 2016 Annual Compliance Review the MCO received a finding of full compliance with all EPSDT monitoring system requirements. The MCO also received a finding of full compliance regarding consolidated record keeping, culminating in documentation of Case Management activities around all member gaps in care.

Outreach for Members Overdue for EPSDT Services

Statewide Overview

Kentucky MCOs are required to facilitate EPSDT services for eligible members who are in need of services. The MCOs reported outreach to members overdue for EPSDT services and facilitation of services in a broad range of initiatives. As seen in the Member Education and Outreach section of this report, educational efforts often accompanied member follow-up for overdue services, and included telephonic outreach, mailings and home visits. All MCOs have identified an EPSDT coordinator to facilitate receipt of services and outreach to members requiring services, and MCOs have contracted with local Departments of Health to conduct home visits for non-compliant members.

As referenced in the Monitoring of EPSDT Provider Compliance with Required EPSDT Services section of this report MCOs also engaged providers to facilitate services and ensure member follow-up. All MCOs distributed reports of panel members in need of services; some MCOs flagged member services past due in various computer registries made available to providers. MCO-specific outreach initiatives are described below.

MCO-Specific Initiatives to Facilitate Overdue Services

Anthem BCBS Medicaid: The MCO Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, reported the number of Overdue Service Reminder Postcards sent to all members under the age of 21 non-compliant with the EPSDT periodicity schedule for services, and calls to parents of children with vaccinations due. Provider Letters for Overdue Services were sent to both individual PCPs and group practices. Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan, also contained entries for EPSDT Member and Physician Monthly Overdue Services Reminders by performance measure.

State contract requirements stipulate the Primary Care Provider assigned to each eligible member is responsible for providing or arranging for complete assessments at intervals according to the Department's periodicity schedule; the MCO was deemed fully compliant with this requirement based on the 2015 Annual Compliance Review.

CoventryCares of Kentucky: As verified in the 2016 Annual Compliance Review, the MCO EPSDT coordinator conducts an enhanced outreach program to members with gaps in care, and works with the Department for Community Based Services (DCBS) EPSDT coordinator to address chronic non-compliance with dental care. The MCO Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, noted the addition of HEDIS team members as back-up EPSDT coordinators to perform such outreach.

The MCO Annual Report #85, 2014 Quality Improvement Plan and Evaluation described the secure website Direct Provider.com, which allowed providers to query HEDIS measure non-compliance by member, or for all members of the MCO receiving services with the specific provider. The MCO was found fully compliant with the requirement to assure PCPs provide individuals all EPSDT services specified in the periodicity schedule during the 2016 Annual Compliance Review.

Humana-CareSource: The MCO Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, provided an update of the number of parents and guardians of EPSDT eligible members outreached, spoken with and/or referred to case management following missed well-child visits. Assistance with scheduling overdue EPSDT appointments with the member's PCP was offered during outreach calls. Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan, also noted case manager review and follow-up for well care needs and immunizations for children and adolescents in case management. The Annual Report #85, 2014 Quality Improvement Plan and Evaluation, described the web-based application Clinical Practice Registry and Member Profile, which allowed providers to flag overdue member services for follow-up. The MCO was deemed compliant with PCP assurance of EPSDT service provision based on the 2015 Annual Compliance Review.

Passport Health Plan: MCO Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, provided quarterly updates of telephonic outreach to EPSDT non-compliant members, and Department of Health EPSDT Home Visits to non-compliant members after unsuccessful in-house telephonic outreach. The MCO reported 13 local health departments outside Region 3 joined the EPSDT Home Visit Program to provide outreach in their respective regions. Monthly Care Gap reports by provider identified members due or overdue for age-appropriate screens, and MCO embedded nurses provided face-to-face member outreach. Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan, also quantified provider requests for home visit outreach for EPSDT non-compliant members.

During the 2016 Annual compliance Review, the 2015 EPSDT Program Description and EPSDT Scope of Services 2015 supported evidence that PCPs within the MCO network provided all needed initial, periodic and inter-periodic health assessments in accordance with the Kentucky Administrative Register. However, the MCO received a finding of only substantial compliance as this had not been verified by medical record review beyond Region 3.

WellCare of Kentucky: The MCO Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, and Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan continuously updated the number of periodicity and 45-day letters sent to members non-adherent with timely receipt of EPSDT services. Additionally, the Kentucky Child Health Checkup Compliance database (KY-CHCHUP) is used to monitor care gaps and generate provider reports. HEDIS Clinical Practice Advisors and Provider Representatives visit physician offices to distribute the Care Gap Reports, reiterating that practitioners providing EPSDT services are responsible for monitoring, tracking and follow-up with members who have not had health screenings. MCO policies and procedures contributed to a finding of full compliance regarding provider participation in member outreach for overdue EPSDT services at the 2016 Annual Compliance Review.

EPSDT Case Management Function

Statewide Overview

To ensure that eligible members receive required services, Kentucky MCOs must establish an effective and ongoing member services case management function which provides: member education and counseling regarding compliance with recommended EPSDT visits and prescribed treatment, follow-up with eligible members and families when services are not received, and assistance with appointment scheduling and transportation when needed. Case management is particularly important for CSHCN, who may have challenges to accessing preventive services and require special services. CSHCN include clients of the Department for Community Based Services, such as children in foster care. MCOs are contractually required to identify an EPSDT coordinator with adequate staff to provide EPSDT case management. This requirement was evaluated in the 2016 Annual Compliance Review, which included DCBS member file review for EPSDT claims and/or outreach.

All five MCOs have identified an EPSDT coordinator and EPSDT case management function, and Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, documented activities carried out by the MCOs' EPSDT care management teams as detailed throughout this report. However, not all DCBS clients had documented EPSDT services, or subsequent outreach, upon review of DCBS case management files during the 2016 Annual Compliance Review – Case Management/Care Coordination.

MCO-Specific EPSDT Case Management

Anthem BCBS Medicaid: During the prior year's Annual Compliance Review – EPSDT, general information on care management as related to EPSDT services was found throughout several documents: the 2014 EPSDT Program Overview Kentucky Medicaid, the 2014 Kentucky UM Program Description, and an EPSDT Coordinator Responsibilities document. Information specific to assistance with appointment scheduling and transportation was contained in the 2014 EPSDT Clinic Days Program Guide. The Case Management Program Description did not reference EPSDT services, scheduling, or transportation. The finding of substantial compliance concluded with the recommendation to comprehensively address EPSDT requirements, including follow-up when recommended assessments and treatments are not received, in the Case Management Program Description and corresponding policies and procedures. The MCO responded with a plan to do so, and was found fully compliant at the 2016 Annual Compliance Review – EPSDT.

During the 2016 Annual Compliance Review – Case Management/Care Coordination the MCO was found non-compliant with the requirement to ensure care coordination for all DCBS clients following review of policies and procedures and DCBS client Claims/Case Management files. The requirement to ensure care coordination was addressed in the policy and procedure DCBS – Foster Care Children; however, the policy had not been approved until January of 2016, with submission to DMS and implementation pending during the review period. The full contract requirement was failed in large part because of related reporting deficiencies around indicators measuring utilization, access, grievances and services specific to the DCBS population. And as per the onsite file review summarized in the following paragraph, it was not clear active DCBS clients could be reliably identified, or that receipt of EPSDT services was being tracked.

Although a case listing for DCBS members in case management was requested, the selected sample included many former rather than active DCBS clients, and none were engaged in case management. Of the four active members, one file included a health risk assessment but no care coordination. Another demonstrated coordination to obtain a Medicaid card with an assigned PCP, and to forward a list of suggested referral providers to DCBS, but no further evidence of coordination. One file showed only unsuccessful outreach prior to placement, and the last file contained no EPSDT claims and no evidence of outreach. All four files documented developmental, behavioral, or psychiatric problems; only one documented a PCP visit.

CoventryCares of Kentucky: During the 2016 Annual Compliance Review – EPSDT the MCO achieved full compliance with EPSDT case management requirements as described in EPSDT Program and Prevention and Wellness Program policies, and documented in the EPSDT Clinical Tracking System and 2015 Quality Management and HEDIS/Healthy Kentuckians/EPSDT/Foster Care Work Plans.

During the 2016 Annual Compliance Review – Case Management/Care Coordination the MCO was found substantially compliant with the requirement to ensure care coordination for all DCBS clients, in part, due to lack of clarity around DCBS monthly meeting agendas. The MCO covers approximately 4,000–5,000 DCBS clients, and only those identified as high risk clients were addressed at the monthly meetings. Since it was not possible to hold joint MCO/DCBS monthly care conferences for all clients, the EQRO recommended DMS review the contract requirement and specify whether general or member-specific monthly meetings were required. The MCO demonstrated a look-up tool allowing DCBS caseworkers to access a member's medical history, providers, medications, and other pertinent information.

The MCO otherwise demonstrated a vigorous DCBS case management program, described in the policy Case Management for Members in Foster Care and Members Receiving Adoption Services, and administered by a dedicated foster care team comprised of three registered nurses, one social worker, and one non-clinical staff person. Strategies to monitor and coordinate care, and prioritize outreach, included predictive modeling to identify high-risk members, review of admissions/discharges to BH and general inpatient facilities, and receipt of lists of medically fragile and decertified children. Over 500 members receiving antipsychotic medication were outreached and assessed for case management needs. Another novel approach involved outreach to the mothers with Substance Use Disorder to incentivize and engage them in case management. Notably, ten DCBS client Claims/Case Management files were reviewed and all contained evidence of PCP visits and EPSDT services.

Humana-CareSource: Given findings from the 2014 Annual Compliance Review – EPSDT, in 2016 the MCO was deemed compliant with the requirement to maintain an effective case management system for EPSDT-eligible members.

Similarly, Claims/Case Management file review for EPSDT services or outreach in a sample of DCBS clients was not required at that time.

During the prior Annual Compliance Review – Case Management/Care Coordination a finding of substantial compliance with the requirement to conduct ongoing care coordination for DCBS clients, whether or not enrolled in case management, focused on a lack of policies and procedures stipulating foster care children be enrolled through a DCBS Service Plan, to be used by the MCO to determine the individual's health care needs and need for placement in case management. The 2016 Annual Compliance Review noted all recommendations had been included in an updated policy and procedure and granted full compliance with care coordination requirements. The MCO added they met monthly with DCBS liaisons and case managers to identify and discuss missing Service Plans. The MCO had previously described the computer system Care Advance, which allowed MCO case managers to view assigned DCBS clients with and without Service Plans, and DCBS case workers to upload Service Plans to the shared platform. Further development was to enable DCBS case workers to access information from the system for their assigned cases.

Passport Health Plan: The MCO was deemed compliant for two care coordination contract requirements, and found fully compliant with a third element, during the 2016 Annual Compliance Review – EPSDT, Case Management/Care Coordination. Policies and desktop procedures detailed processes for receiving DCBS Service Plans, assigning case managers, completing assessments, and developing care plans. If a DCBS client was not appropriate for Behavioral or Case Management, the Service Plan was kept on file and reviewed quarterly. The care coordination/case management system JIVA has the capability to schedule dates for outreach and future contacts with DCBS. Foster parent contact information was updated with DCBS at the time of scheduled outreach. Evidence of monthly coordination with DCBS was provided. Regarding DCBS Claims/Case Management file review, ten of ten files were compliant with all requirements.

WellCare of Kentucky: The MCO was deemed compliant regarding EPSDT care coordination requirements, and with Case Management/Care Coordination DCBS client file review, at the time of the 2016 Annual Compliance Review. The MCO received full compliance regarding DCBS care coordination requirements at that time. The MCO presented care coordination procedures for DCBS Service Plan management, DCBS foster member inpatient/subacute/residential treatment notification, and DCBS Utilization Review. This MCO had also followed up with DCBS members receiving antipsychotic medication.

Physical Health/Behavioral Health Coordination

Statewide Overview (EPSDT Review)

Kentucky MCOs are required to establish and maintain a protocol for coordination of physical health services and BH services for members with BH or developmentally disabling conditions. Anthem BCBS Medicaid, Humana-CareSource, and Passport Health Plan had been deemed compliant with this requirement, based on 2014 or 2015 determinations, at the time of the 2016 Annual Compliance Review – EPSDT. CoventryCares of Kentucky and WellCare of Kentucky were found fully compliant based on EPSDT Program policies and procedures; WellCare of Kentucky included information on coordination of physical and BH services in additional documents such as policies for ISHCN and procedures for members with Developmental Disabilities. WellCare of Kentucky also demonstrated linkage agreements with Family First Rehabilitation Services and with Mindful Directions Counseling Services.

MCO-Specific Coordination (Behavioral Health Review)

For the purposes of this report, file review findings regarding care coordination services conducted during the BH component of the 2016 Annual Compliance review were also evaluated. BH files were reviewed for comprehensive assessment, discharge/care planning, provider participation, and care coordination for all members addressing both physical and BH needs. Only Passport Health Plan had been deemed compliant with file review as the result of the 2014 Annual Compliance Review.

Anthem BCBS Medicaid: Coordination between behavior health service providers and PCPs was addressed in a Provider Manual chapter, Coordination of Care between Physical and Behavioral Health Providers, and in the policy and procedure Coordination of Care between Behavioral Health and Medical Management.

The MCO received a finding of substantial compliance with care coordination requirements, as only five of ten members receiving BH services sampled had been contacted and consented, and only four of those files identified both the behavioral and physical health status of the member and demonstrated coordination of services as appropriate. The MCO responded policies and procedures would be revised to ensure care coordination efforts are conducted on behalf of the member related to integration of physical and BH needs. The MCO was developing a PCP/BH specialist provider letter, which could be faxed in either direction, after members enrolled in the BH Case Management Program consented to release of information. The letter would identify all providers involved in the member's care and update any significant changes in the member's treatment plan, including medication changes. Monthly audits of members enrolled in Complex Case Management had been initiated, and contained care coordination and PCP communication indicators.

CoventryCares of Kentucky: The MCO demonstrated full compliance with physical and BH care provider coordination during the 2016 Annual Compliance Review. Direction was provided in the Provider Manual and MHNNet Provider Quick Reference Guide, as well as MHNNet UM chapters Continuity and Coordination of Care, and Care Management and Complex Care Management. Ten of ten BH files reviewed met all requirements for care coordination, including communication among BH specialists and primary care providers.

Humana-CareSource: Communication, collaboration, and care coordination among the MCO and BH MCOs were addressed by several policies and procedures: Continuity and Coordination between Medical Care and Behavioral Healthcare; Exchange of Information Between Behavioral Health, Primary Care Providers and Behavioral Health Practitioners; Collaboration and Referral of Medical and Behavioral Health Cases Between Beacon Health Strategies and Partner MCO; Collaboration and Referral of Medical and Behavioral Health Cases Between Beacon Health Options and Partner Organizations.

The MCO received a finding of substantial compliance with care coordination requirements, as few sample member files contained a comprehensive assessment or care plan; only two of ten files showed identification and coordination of both physical and BH needs. Many files were considered not applicable (N/A) for review of these elements due to failed outreach, and IPRO recommended the MCO explore ways to enhance member contact for successful outreach and engagement. The MCO acknowledged six of the seven 'unable to reach' cases were transient, and had been assigned to the Care Management tier Care Coordination (brief Case Management Intervention) to assist with community follow-up following hospitalization. The MCO intended to enhance partnerships with community shelters and work to ensure each

record, regardless of tier assignment (consultation, care coordination, intensive case management), clearly documented physical and BH status.

WellCare of Kentucky: The MCO policy Behavioral Health Care Coordination and Management addresses continuity of care protocols, including PCP receipt of information about emergency BH services. Quality Improvement policies state “It is the responsibility of the PCP to maintain a primary medical record for each member, which contains sufficient medical information from all providers involved in the Member’s care, to ensure continuity of care.” Per the Practitioner Compliance with Medical Record Documentation Standards, the Annual Medical Record Reviews evaluates a random sample of PCP charts to assess documentation of consultations from BH providers. The Provider Manual also emphasizes coordination between physical and BH providers.

The MCO received a finding of substantial compliance with care coordination needs, as nine of ten BH records documented identification/care coordination of physical and BH care needs; seven of ten records included a comprehensive assessment of both domains. IPRO recommended the clinical needs assessment process be improved to ensure care coordination covering all members’ needs. It was further recommended the MCO explore communication between the Utilization Management and Case Management departments, specifically to involve case managers in discharge planning, who could subsequently follow-up with all providers. The MCO responded with the development of protocols to facilitate ongoing communication, the first of which was to include BH on all UM monthly meeting agendas.

Quality Measurement and Improvement

Statewide Overview

Kentucky MCOs are required to submit reports of certain EPSDT services using Form CMS-416, incorporated into Annual Report #93, EPSDT Annual Participation Report, which includes: the screening ratio (actual number of assessment screens provided compared to a calculation of expected screens); the participant ratio (number of members having received at least one screen compared to a calculation of members who should receive any screens), the total eligibles referred for corrective treatment, those having received any and specific dental services, and number of blood lead tests performed.

Further EPSDT annual reporting required by the Kentucky DMS and reviewed for this report include: Report # 85, Quality Improvement Plan and Evaluation; Report #94, Consumer Assessment of Healthcare Providers and Systems (CAHPS) – Medicaid Child Survey; and Annual Report #86, Annual Outreach Plan.

EPSDT entries in the following required quarterly reports provided updates: Report # 17, Quality Assessment and Performance Improvement Work Plan; Report #18, Monitoring Indicators, Benchmarks and Outcomes; Report #19, Performance Improvement Projects; and Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death. All five MCOs were compliant with submission of statutory EPSDT reports for 2015.

Some MCOs treated EPSDT as a distinct program area in their Annual Report #85, 2014 Quality Improvement Plan and Evaluation and Quarterly Report # 17, Quality Assessment and Performance Improvement Work Plan. Performance measures related to EPSDT, i.e. HEDIS and Healthy Kentuckians measures, were included in all annual QI program evaluations and quarterly QI work plans, with evidence MCOs had prioritized areas for improvement and implemented interventions. The Annual Report #85, 2015 Quality Improvement Plan and Evaluation, is due 7/31/16; therefore 2014 program evaluations were reviewed for this report, with MCO-specific highlights outlined below.

MCO-Specific Measurement and Improvement

Anthem BCBS Medicaid: Enrollment of child and adolescent member was initiated in July of 2014, and the MCO Annual Report #85, Quality Improvement Plan and Evaluation for 2014, did not yet contain a section specific to EPSDT service measurement and improvement. The MCO was able to report only limited measures for HEDIS 2015, i.e., Annual Dental Visit and Adolescent Well-Care Visits.

Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan, contained distinct sections to track EPSDT-focused HEDIS and non-HEDIS measurement results, benchmarks, results-to-date and activities to continuously improve performance. The MCO Quarterly Report #18, Monitoring Indicators, Benchmarks and Outcomes, demonstrated monthly monitoring of HEDIS administrative rates. As per Quarterly Report #19, Performance Improvement Projects, the Behavioral Health Collaborative PIP addressing antipsychotic medication management in children and adolescents was in progress, and the PIP Proposal, "Increasing Annual Dental Visits in EPSDT Members" had been submitted.

CoventryCares of Kentucky: EPSDT-related measurement and performance improvement activities were integrated throughout the MCO Annual Report #85, 2014 Quality Improvement Plan and Evaluation. The Program Evaluation noted the second year HEDIS measures were completed in 2014 (MY 2013), which were presented with comparison to Quality Compass national percentiles. The MCO targeted a minimum achievement of the 50th percentile, with an overall performance goal of continuous improvement in all measures. The majority of provider communications focused on HEDIS education, and member communications consisted of cards, mailers and calls covering HEDIS/EPST-related topics such as well-child visits, childhood immunizations, lead screening and dental care. In addition to educational initiatives, the MCO collaborated with high-volume pediatric practices and health departments, identified members in need of special services, and provided transportation assistance.

Both the Program Evaluation and Quarterly Report #19, Performance Improvement Projects, provided updates on the BH Collaborative PIP, "Measuring the Appropriate Use and Management of Antipsychotics for Children and Adolescents," as well as an MCO PIP, "Follow-Up Care for Children Prescribed ADHD Medication."

Humana-CareSource: The MCO Annual Report #85, 2014 Quality Improvement Plan and Evaluation, contained the EPSDT-dedicated chapters Children’s Health and Early Periodic Screening, Diagnosis and Treatment and Preventive Health Care for Children with Special Health Care Needs. Outcomes summarized in the evaluation reflected first year data since statewide expansion; 2015 goals were established using HEDIS baseline results and 2014 NCQA Quality Compass benchmark data. Specific HEDIS measurements were evaluated by age group and enrollment category: SSI, foster care and TANF (Temporary Assistance for Needy Families) children.

Barrier analysis found invalid phone numbers, use of mobile phones and frequently changed numbers, transportation issues, and inappropriate use of emergency rooms as challenges to improving outcomes for these populations. In addition to member and provider outreach conducted in 2014, initiatives planned for 2015 included increasing resources for telephonic outreach, enhancing member outreach by including information on how to use the transportation vendor, enhancing provider education by use of the Clinical Practice Registry and Member Profile, and continuing collaboration with the Home of the Innocents and the Commission for Children with Special Health Care Needs (CCSHCN).

Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan tracked the entries for Quality & Appropriateness of Physical Health and Behavior Health Care to Enrollees w/Special Needs and noted MCO care managers of medically fragile children who attended individualized health plan (IHP) meetings run by CSHCN nurses. Quarterly Report #19, Performance Improvement Projects, updated the status of the PIP “Safe and Judicious Antipsychotic Use in Children and Adolescents.” Production had begun on reports identifying children receiving antipsychotic medication but not psychosocial care, those receiving multiple antipsychotic medications, and those receiving higher than recommended doses of antipsychotic medication. Prescriber guidelines to insert into orientation packets were in development.

Passport Health Plan: EPSDT-related measurement and performance improvement activities were discussed with select HEDIS measure results, annual medical record review findings, and in a distinct section covering Programs for Populations with Special Needs (e.g., CSHCN, foster care, asthma, sickle cell disease and behavioral health) within the MCO Annual Report #85, 2014 Quality Improvement Plan and Evaluation. Key findings included increased proportions of members receiving well-child, adolescent well-care, and dental visits; goals are to increase scores not yet at the NCQA Quality Compass 90th percentile. Key interventions included posting tools for BMI measurement, nutritional counseling, and anticipatory guidance to the provider website. Novel initiatives included maintenance of a 1-800 psychiatrist line for providers, and the use of embedded case managers at high volume hematology/oncology clinics treating children with sickle cell disease and embedded respiratory therapist case managers to educate families with children diagnosed with asthma.

While the annual medical record review found most pediatric records met documentation standards, assessment of members 12 years or older for at risk sexual behaviors was lacking, and was included with Provider Notifications regarding the top 5 areas in need of improvement, and on the agenda for the Annual Provider Workshop. The Program Evaluation detailed the interventions, status, and outcomes for EPSDT-related PIPs in progress or concluded during the review period: “Reduction of Inappropriately Prescribed Antibiotics in Children with Pharyngitis and Upper Respiratory Infections,” “You can Control Your Asthma! Development and Implementation of an Asthma Action Plan,” and “Antipsychotic Monitoring for Children and Adolescents,” as described above.

Performance Measures and related activities were documented in the MCO Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan, and demonstrated discussion in various quality committees, including the Child and Adolescent Committee. Report #18, Monitoring Indicators, Benchmarks and Outcomes, references stratification of certain HEDIS measures by category of aid, race, ethnicity, gender and age to develop targeted interventions for non-compliance in those populations. Quarterly Report #19, Performance Improvement Projects noted the submission of the 2015–2016 PIP Proposal “Promoting Healthy Smiles through Increased Utilization of Preventative Dental Care.”

WellCare of Kentucky: The MCO Annual Report #85, 2014 Quality Improvement Plan and Evaluation, presented EPSDT-related measurement and performance improvement activities with relevant HEDIS measure results, with specific HEDIS

results in the section EPSDT for Children and Adolescents, and with Healthy Kentuckians results in the section State Clinical Performance Indicators. The HEDIS measures Childhood Immunization Status – Combination 2 and Lead Screening in Children did not meet goal, and were therefore included in the annual assessment of practitioner compliance with Clinical Practice Guidelines, specifically the Child and Adolescent Preventive Health Guideline. In addition, the MCO distributed the following EPSDT-relevant Clinical Practice Guidelines: ADHD, Asthma, Depressive Disorders in Children and Adolescents, Diabetes in Children, and Obesity in Children.

The MCO also successfully implemented a Pay-for-Quality Program for eligible PCPs targeting six measures for improvement, and instructed providers to include claim codes for BMI/percentile calculation, nutritional/physical activity counseling, and adolescent screening and counseling (regarding tobacco use, alcohol/substance use, sexual activity, depression) even though they do not yield additional reimbursement. The MCO contracted with two additional registered nurses for medical record review to assess compliance with EPSDT documentation standards; significant improvement in compliance was attributed to the adoption of formal standardized documents used at all Kentucky State Health Departments and School-Based Health Services.

Integrated Case Management was available for children with special health care needs, lead toxicity, and medical or behavioral chronic conditions (e.g., Asthma, HIV/AIDS, hemophilia, sickle cell anemia, anxiety or depression). Case Management metrics, as well as all performance measurements and quality improvement activities, were tracked in related statutory reports. In 2014, the PIP “Behavioral Health Medications in Children” aimed at an increase in medication use and follow-up for ADHD was in progress, and the PIP Proposal “Antipsychotic Medication Use in Children and Adolescents” had been submitted.

Member Satisfaction with EPSDT Services

Kentucky MCOs are required to submit to DMS Annual Report #94, Consumer Assessment of Healthcare Providers and Systems (CAHPS) – Medicaid Child Survey. With the exception of Anthem BCBS Medicaid, all MCOs addressed CAHPS results and member grievance analysis in their Annual Report #85, 2014 Quality Improvement Plan and Evaluation, and Quarterly Report #17, 2015 Quality Assessment and Performance Improvement Work Plan. CAHPS Medicaid Child Survey results and member grievances were reviewed as part of the 2016 Annual Compliance Review. Although not necessarily EPSDT-specific, member satisfaction with children’s services can provide some indirect insight into access and appropriateness of EPSDT services.

MCO-Specific Evaluation of Member Satisfaction

Anthem BCBS Medicaid: In 2015, the MCO submitted its first Annual Report #94, Consumer Assessment of Healthcare Providers and Systems (CAHPS) – Medicaid Child Survey, including the full report from its vendor DSS Research containing the CAHPS questionnaire. Therefore, analysis and performance improvement initiatives could not be included in the MCO’s 2014 Program Evaluation. However, each questionnaire item was contained in Quarterly Report #17, 2015 Quality Assessment and Performance Improvement Work Plan, along with entries addressing member complaints, in a distinct section titled Member Satisfaction. Additionally, the MCO had participated in a local MCO CAHPS workgroup to review results and share best practices.

As per the MCO Annual Report #85, 2014 Quality Improvement Plan and Evaluation, and further discussed in this review (Access to EPSDT Services), the majority of complaints occurred in the first quarter of 2014, and involved locating an in network provider, providing evidence of coverage, and balance billing. In response, efforts were made to ensure members received the welcome packet containing benefit information. A member liaison worked with members to coordinate care, and Provider Relations conducted ongoing education regarding appropriate billing practices within the network. Complaint analysis and initiatives were discussed at Medical Advisory Committee and Board of Director meetings.

CoventryCares of Kentucky: In 2014, the MCO completed its second Annual Report #94, Consumer Assessment of Healthcare Providers and Systems (CAHPS) – Medicaid Child Survey, with discussion and improvement initiatives presented in its Annual Report #85, 2014 Quality Improvement Plan and Evaluation. The MCO exceeded its goal for meeting or exceeding Quality Compass national averages in most categories for children. Rates at less than national averages resulted from the measures Rating of Health Plan Overall and Rating of Personal Doctor Overall, which

included the submeasures: Staff treated you with courtesy and respect, and Doctor showed respect for what you had to say. The MCO identified a knowledge deficit regarding communication and expanded provider education. Orientation and other educational forums covered members' rights and responsibilities, with future topics to include shared decision making. MCO opportunities and priorities for 2015 targeted member satisfaction; specifically, how well doctors communicate with members.

A discussion of complaints and grievances in the MCO Program Evaluation covered only procedural issues, and did not include content, analysis, or follow-up; categorization was found in MCO Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan. Most notably, the MCO received a finding of non-compliance regarding required review of aggregate grievance data and policy modification during the 2016 Annual Compliance Review. The element had been scored minimally compliant for three successive review years because grievances were not discussed or addressed by the Quality Management Access Committee (QMAC). Following the compliance finding, the MCO responded that specific and intentional recruitment for QMAC members had been initiated, with roles and responsibilities clearly defined. WebEx technology had been employed to improve attendance, and an agenda template had been developed which included grievance and appeals items.

Humana-CareSource: In 2014, the MCO completed its first Annual Report #94, Consumer Assessment of Healthcare Providers and Systems (CAHPS) – Medicaid Child Survey, with interventions conducted in 2014/planned for 2015 presented in its Annual Report #85, 2014 Quality Improvement Plan and Evaluation. The MCO also conducted a Behavioral Health Member Satisfaction Survey of both adults and children. Upon receipt of the survey results a workgroup had been convened and the interventions developed. Each member satisfaction activity (MSA) was tracked in the Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan. Interventions included implementation of a new interactive voice recognition system with self-service options allowing members to order identification cards, look up providers, and change PCPs, among other functions. Improvements were made to the member website to ease navigation and allow on-line completion of health risk assessments.

Complaint and grievance analysis in the MCO Program Evaluation demonstrated dissatisfaction with access and billing issues. Grievance specialists and member services representatives worked with members to locate network providers when the member's preferred provider was not participating. Access issues were escalated to Provider Relations in order to assess the current network. Grievance specialists reached out to provider billing contacts to confirm providers would discontinue billing members, and billing issues were escalated to Provider Relations and Claims. The 2016 Annual Compliance Review noted Quality Assessment Committee (QAC) and QMAC minutes demonstrated evaluation and integration of satisfaction and grievance data.

Passport Health Plan: Although child CAHPS Survey rates exceeded 2014 Quality Compass means for Getting Care Quickly and Getting Needed Care, the MCO Annual Report #85, 2014 Quality Improvement Plan and Evaluation, reported several interventions to improve member satisfaction with access to care. The Rapid Response Outreach Team assisted members with urgent issues, with rapid response urgent care nurses utilized to handle urgent needs. Access and availability was monitored during site visits and through provider surveys, followed by targeted education. Enhanced telephonic member outreach assisted new members with PCP selection.

Several interventions addressed the child CAHPS customer service composite (Getting Information or Help Needed, Treated with Courtesy and Respect). Member Service staff was increased, a call auditor position was added, and refresher training classes held. No barriers or interventions were identified in response to the remaining CAHPS measurements, although in general, focus areas for 2015 included maintenance of national ranking (21st per NCOA's Medicaid Health Insurance Plan Rankings 2013–2014) by further improvement in HEDIS and CAHPS scores.

Passport Health Plan was the only MCO to include a subcategory specific to EPSDT within the larger Attitude/Services complaints category. However, EPSDT-specific information is not broken out and tracked with complaint data in Quarterly Report #17, Quality Assessment and Performance Improvement Work Plan. Complaints by EPSDT-relevant subpopulations such as DCBS, Foster Care, and SSI are monitored via the work plan. The 2016 Annual Compliance Review found consideration of grievance data by the Quality Medical Management Committee (QMMC) and QMAC.

WellCare of Kentucky: As reported in the MCO Annual Report #85, 2014 Quality Improvement Plan and Evaluation, CAHPS – Medicaid Child Survey rates exceeded 2014 Quality Compass means in seven of the eight areas, and exceeded the 75th percentile in four of eight areas. Benchmarks were not available for Shared Decision Making, but rates had increased over the previous year. Survey results were used to develop quality improvement initiatives; the member website had been revamped to provide additional resources and information, member and provider communication tips to maximize office visits had been distributed, Customer Service training on the top member call reasons had been conducted, and the MCO continued the Member Satisfaction Workgroup to identify barriers and develop interventions. Each CAHPS measure was tracked in the Quarterly Report #17, 2015 Quality Assessment and Performance Improvement Work Plan.

As per the MCO Annual Report #85, 2014 Quality Improvement Plan and Evaluation, the most frequent member grievances were reported for the categories Billing/Claims and Physician. Initiatives were similar to those developed in response to CAHPS survey results: increased member education around demonstrating eligibility, and provider education around checking eligibility and correcting computer billing programs. Although not categorized by age or program, grievances were tracked in MCO Quarterly Report #17, 2015 Quality Assessment and Performance Improvement Work Plan. The 2016 Annual Compliance Review found barriers, opportunities, and recommendations reviewed by the Quality Management Access Committee and UM Medical Advisory Committee, as well as the Member Satisfaction subcommittee.

Discussion and Conclusion

A review of Kentucky MCOs' Annual Compliance Review findings, reported performance measures, and statutory reports provided an overview of Kentucky MMC-enrolled children and adolescents' receipt of EPSDT services and MCOs' initiatives to ensure and facilitate age-appropriate EPSDT services in 2015. The five MCOs have varying tenure in Kentucky Medicaid, with Humana-CareSource having initiated enrollment in 2013, and Anthem BCBS Medicaid initiating child and adolescent enrollment midway through 2014. Passport Health Plan, which has participated in Kentucky MMC the longest, consistently demonstrated higher rates among the suite of EPSDT-related performance indicators, and often more advanced quality improvement initiatives. Frequently, several indicators within an MCO would point to the same opportunities for improvement, and many opportunities were shared across MCOs.

Given that many children were still relatively new to MMC, or a particular MCO, in 2015, education and outreach to members were particularly important. Kentucky MCOs were compliant with contractual requirements to inform members about the availability of EPSDT services and facilitate utilization; most demonstrated a multi-faceted approach to member education, utilizing a variety of educational mailings, personalized postcards pre- and post-service due dates, telephonic outreach, website postings, and presentation at community and back-to-school events. All MCOs employed an EPSDT coordinator to reach out and educate members whose receipt of services did not adhere to periodicity schedules. Some MCOs employed clinic-embedded nurses or contracted with local health departments to provide face-to-face education. All MCOs engaged PCPs in member outreach and education.

Every MCO required PCPs to provide EPSDT services; four of five MCOs met all PCP network requirements for geographic access, member to PCP ratios, and appointment scheduling wait times. A DMS Corrective Action Plan was in progress for WellCare of Kentucky, where standards for timely routine and urgent care appointments were met < 80% of the time. Four of five MCOs assessed CAHPS – Medicaid Child Survey results in 2014 program evaluations; each reported results for the Getting Care Quickly composite measure at 90% or greater. MCOs newer to the market, such as Anthem BCBS Medicaid and Humana-CareSource, reported few complaints regarding access and assisted members with locating participating providers. However, analysis would be enhanced if all MCOs categorized complaints (e.g., EPSDT – Access) and discussed content in addition to operational performance.

Four of five MCOs were fully compliant regarding provider education conducted via provider manuals, websites, newsletters, resource guides, tool kits, and on-site visits. A recurring issue is the development of educational materials for non-physician providers such as nurses, nurse practitioners and physician assistants. Anthem BCBS Medicaid received a finding of substantial compliance, with recommendations to include physical assessment components in the educational materials for these professionals, and document training provided at site visits for providers with suboptimal screening rates. Although Passport Health Plan had moved from minimal to full compliance, a DMS Corrective Action Plan remained in progress, with the recommendation to expand training to include health department non-physician professionals providing EPSDT home visits.

Four of five MCOs were compliant with monitoring provider delivery of EPSDT services through medical record review against Clinical Practice Guidelines, tracking provider-specific performance measure rates, and monitoring provider member panels for Care Gaps. Most MCOs supported secure web-based applications which allowed providers to query for members in need of services, or flagged individual member records with needed services, or flashed alerts at eligibility checks. Passport Health Plan was found only substantially compliant with EPSDT provider oversight as medical record review had not yet been expanded beyond Region 3.

State of Kentucky screening and participant ratios for members of all ages were 0.80 and 0.59, respectively. These ratios compared favorably to national screening and participant ratios of 0.82 and 0.58, respectively. However, all MCO reported screening ratios were less than the statewide screening ratio, which suggests DMS may want to investigate MCO calculation methodology. Incidentally, corrected MCO CMS-416 Forms had been requested and received by IPRO during the course of this review.

With few exceptions, notably Passport Health Plan, MCO screening ratios by age group did not meet national averages and decreased with age, indicating primarily infants are receiving the expected number of screenings. A similar pattern was seen in participant ratios, indicating relatively more infants and toddlers received any screening services during the

review period. Despite MCO efforts at outreach, education, monitoring and care coordination, significant challenges to engaging families of older children persist.

HEDIS Access/Availability and Utilization of Care measures also demonstrated fewer PCP and well-care visits among adolescents compared to infants and toddlers. Strikingly, with the exception of Passport Health Plan, all MCOs reported all age-specific Well-Child Visit rates below Quality Compass national means. MCO Annual Dental Visits rates, while both above and below the national average, ranged from approximately 21%-60%, and may represent restorative, not preventive, care. Generally, Healthy Kentuckian Access and Utilization of Care measures demonstrated better rates of PCP and Well-Child Visits among CSHCN.

HEDIS Effectiveness of Care submeasures comprising Weight Assessment and Counseling for Nutrition and Physical Activity were also below average in all age groups at all reporting MCOs (again with the exception of Passport Health Plan). Healthy Kentuckian measures, and the Encounter Data Validation Study, demonstrated height and weight documentation more frequently than BMI assessment, suggesting educational opportunities around BMI calculation and use for nutrition/activity counseling and goal setting.

HEDIS measures, Healthy Kentuckian measures, and the Encounter Data Validation Study all revealed low rates of screening, counseling or anticipatory guidance regarding nutrition, physical activity and screen time. Further, Healthy Kentuckian measures revealed only 40% of children statewide had a healthy weight for height, supporting initiatives aimed at childhood obesity.

Adolescent BH risk assessment and counseling, also assessed by both Healthy Kentuckian Screening/Counseling measures and the Encounter Data Validation Study, revealed members were more consistently asked about tobacco use than alcohol/substance use or sexual activity. As per Healthy Kentuckian measures, adolescents were screened for depression less than half of the time; the Encounter Data Validation Study revealed higher rates of mental health assessment (71%) and depression screening (66%), but broad definitions included parental concern, provider observation or inquiry, or use of a formal screening tool. General developmental surveillance was documented for 80% of children; however, use of formal developmental screening tool is recommended for children ages 1–3 years, and was documented in only 18% of member records for that age group. Furthermore, the results of age-appropriate vision and hearing assessment were also reported in fewer than half of all member records, verifying the need for continued evaluation of the content, as well as frequency, of well-care visits.

MCOs are charged with monitoring receipt of all EPSDT services, including diagnostic, treatment and special services, through the use of a consolidated member record. Most MCOs were fully compliant with record and monitoring requirements. Although a DMS Corrective Action Plan remained active, Passport Health Plan was granted full compliance based on programming specifications for the planned linking of screening and referral databases. Anthem BCBS Medicaid was found substantially compliant, lacking the ability to monitor member refusals and receipt of special services.

In addition to being followed by EPSDT coordinators, members enrolled with all MCOs could be referred to more intensive case management programs as needed. DCBS clients comprise a particularly challenging subpopulation of CSHCN, and Case Management DCBS member files were reviewed for evidence of outreach, care coordination and PCP visits. Anthem BCBS was found only minimally compliant with care coordination requirements, as it was not clear active DCBS members could be identified, or receipt of EPSDT services tracked. All MCO Case Management files reviewed documented developmental, behavioral, or mental health issues; only one documented unsuccessful outreach, and another a PCP visit. Some MCOs have implemented electronic records which allow sharing of member information between the MCO and DCBS case managers.

Medicaid-eligible children are at substantial risk for developmental and mental health problems, and although not specific to EPSDT, BH file review findings were assessed to gauge care coordination between Behavioral and Physical Health.^{xiv} Three of four MCOs subject to BH file review during the 2016 file review were found substantially compliant with care coordination requirements, due to insufficient communication between BH specialists and primary care providers.

Kentucky MCOs conduct Quality Measurement and Improvement Programs, as evidenced by submission of all statutory reports, formal program evaluations, detailed work plans, and EPSDT-themed PIPs. Specific initiatives in response to MCO operational metrics, performance measures, satisfaction surveys, member characteristics and other indicators are varied and plentiful, as detailed earlier in this review. However, only two MCOs treat EPSDT as a distinct program area within program evaluation documents, and only three MCOs within ongoing work plans. The EPSDT Program profile and effectiveness might benefit by a consolidated consideration of program components currently found throughout MCO evaluation documentation.

Limitations

MCOs most recently doing business in the Kentucky MMC market were able to submit only limited performance measures, or those with results derived from small sample sizes. Data used in this review were dispersed among several documents, and not all documents were uniformly prepared across MCOs. Data sources, particularly file review findings, were not restricted to EPSDT membership. The most current data from the Annual Report #85 Quality Improvement Plan and Evaluation, and Annual Report #94, Consumer Assessment of Healthcare Providers and Systems (as interpreted in MCO program evaluations), were not yet available at the time of this report. An EPSDT Dental Encounter Data Validation Study remains in progress. MCO comparisons should be interpreted with caution.

Recommendations

Recommendations for MCOs

- In light of opportunity for improvement in screening and participation, well-child visit, and adolescent well-care rates, MCOs should evaluate the effectiveness of member education and outreach initiatives and tailor strategies to enhance outreach efforts. Engagement of adolescent members and their families should be prioritized.
- MCOs should continue to actively monitor the content of EPSDT visits through medical record audits, and promote age-appropriate vision and hearing assessment, the use of developmental screening tools, full behavioral risk assessment, mental health assessment including depression screening, and age-appropriate anticipatory guidance. Components of a comprehensive adolescent well-care visit remain a priority for evaluation, education and improvement initiatives.
- BMI assessment and nutritional/physical activity counseling rates present another improvement priority, and an excellent opportunity to expand education to non-physician providers.
- Care management training, audits, and unit evaluation should emphasize care coordination for DCBS clients and, in general, the integration of behavioral and physical health assessment and service provision.
- MCOs might consider a clear-cut EPSDT program evaluation which includes not only pertinent performance measures, but evaluation of indicators such as EPSDT-specific care coordination metrics, grievances, denials and appeals for special services.

Recommendations for DMS

- Given the variation among MCOs in performance measure rates, the Department should consider sponsoring forums for sharing of best practices, such as a Medicaid/EPSDT web page or newsletter highlighting challenges and MCO success stories, or all-plan calls convened to cover selected topics or share PIP implementation experiences. Several potentially promising practices could be shared/discussed in these forums: PCP notification of member BH ED visits, two-way letters between PCPs and BH specialists updating member treatment plans and medication profiles, and data sharing platforms between MCOs and DCBS.
- MCO reporting of preventive dental services, through measures such as the Children's Health Insurance Program Reauthorization Act (CHIPRA) core measure Percentage of Eligibles that Received Preventive Dental Services would facilitate monitoring of preventive dental visits as part of EPSDT services.
- The Quarterly Report #24, Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death, Pregnant Women, Maternal and Infant Death, could be standardized to facilitate comparative evaluation of MCO initiatives. Content should be expanded beyond service due reminder mailings, and report activities around diagnostic, treatment and special services. EPSDT team staffing, back-up and training, as well as provider education, should be included.

- UM EPSDT member file review, Case Management/Care Coordination DCBS member file review, and BH general membership file review were included in this report. Evaluation would be more expedient, representative, and applicable if file review was centralized within the EPSDT Program area at the time of the Annual Compliance Review. Review of special services (preauthorization requests and dispositions) could be included.
- DMS should continue to evaluate EPSDT services through validation studies of services provided in well-child visits, with a focus on areas identified to be in need of improvement, including evaluation of follow-up services received.
- Given the percentage of children and adolescents reported to have a weight category other than healthy and the lack of documented monitoring and counseling, a focused study to evaluate the prevention, identification and management of childhood obesity would be of benefit to MCOs in addressing this topic.

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