

*Cabinet for Health and Family Services  
Department for Medicaid Services*

***COMMONWEALTH of KENTUCKY***  
*Strategy for Assessing and Improving the  
Quality of Managed Care Services*

***2011***

## **A. Introduction**

The Cabinet for Health and Family Services, Department for Medicaid Services' (DMS) Managed Care Quality Strategy (MCQS) is a comprehensive plan incorporating quality assurance monitoring and ongoing quality improvement processes to coordinate, assess, and continually improve the delivery of quality care and services to participants in managed care.

The Department plans to expand Medicaid managed care in order to improve the quality of care provided to Medicaid recipients while reducing inappropriate inefficient utilization of health care resources. Approximately 510,000 Medicaid and CHIP eligible recipients will be enrolled in managed care under 1932(a) state plan amendment or Section 1915(b) waiver authority. Previously, Medicaid recipients were enrolled in a Primary Care Case Management program (PCCM).

The Department's primary goal is to assure that managed care organizations improve and coordinate the care delivery needs of individuals with multiple health issues and providers. Objectives for the state's managed care program include:

1. Improving health care outcomes;
2. Increasing enrollee responsibility by reducing inappropriate and overuse of services;
3. Improving care coordination;
4. Promoting wellness and healthier lifestyles; and
5. Lowering the overall cost of health care.

The MCQS encompasses an interdisciplinary collaborative approach through partnerships with enrollees, stakeholders, governmental departments, contractors, MCOs, community groups and legislators.

## **B. History of Managed Care**

In December 1995, the Commonwealth of Kentucky was granted approval under Section 1115 waiver authority to attempt a truly innovative approach to establishing managed care in urban areas as well as rural and medically under-served areas of the state.

The concept embodied in the Commonwealth's approved waiver was the establishment of health care partnerships. These partnerships were to be coalitions of medical providers in both the public and private sectors who would come together to provide comprehensive medical services through integrated service delivery networks to Medicaid beneficiaries living in a designated region of the Commonwealth. The health care partnerships were to participate in the Medicaid Program as comprehensive risk-based entities paid an actuarially sound capitation rate for each member. The partnerships would serve as sole-source managed care providers in their respective regions and

virtually all Medicaid beneficiaries in the region would be assigned to the plan. Each partnership plan would have significant beneficiary representation on its governing board and providers and beneficiaries would decide together how best to manage both health care needs and costs.

Initially, two (2) such partnerships were developed and implemented in Region 3 (Jefferson and 15 surrounding counties) and Region 5 (Fayette and 20 surrounding counties). Combined, the regions served approximately 34% of the Kentucky Medicaid population. Additional partnerships in six other regions were to be developed in the second and third years of the waiver project. Ultimately, however, partnerships were implemented in only two regions, Region 3 and Region 5. In 1999, the Region 5 partnership notified the Department for Medicaid Services (DMS) that it would no longer be able to provide services to the state's Medicaid population under a managed care arrangement.

Under contract with DMS since November 1997, University Health Care (UHC) (operating as Passport Health Plan (PHP) since November 1997) has been providing services as a managed care organization for Medicaid enrollees residing in the Region 3 partnership counties of Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, and Washington. As a licensed HMO, PHP is accountable for all covered health services for its enrollees, except behavioral health, long term care and waiver services.

The Commonwealth has been granted extensions of this 1115 waiver since 2002. The current waiver expires October 31, 2011 and a request for an extension has been submitted. There are approximately 154,000 Medicaid and CHIP recipients enrolled under this waiver. Medicaid recipients in the balance of the state are enrolled in a primary care management system in which recipients choose or are assigned a primary care physician or provider which provides primary care services and authorizes referrals to all needed specialty services.

Today's health care environment is generating an unprecedented demand for health care delivery approaches that result in more cost effective management of health care services while improving access, quality, and accountability. As a result, in 2011, Kentucky initiated managed care expansion efforts, including procurement process to identify quality health plans to provide health care services statewide. In July 2011, three managed care plans were awarded statewide contracts except for counties designated as Region 3. The three MCO's are Coventry health and Life Insurance Company, Kentucky Spirit Health Plan, Inc., and WellCare of Kentucky, Inc. The three MCO's will provide the majority of Kentucky Medicaid covered services, including behavioral health.

Title XIX (Medicaid) describes the terms under which a state may implement Medicaid managed care. A state must request a waiver of certain Act provisions before implementation and enrollment of special populations is possible. Waivers must be approved by CMS. The DMS submitted a Section 1915(b) waiver to implement risk-based managed care statewide, excluding Region 3 (which will continue to operate under an approved 1115 waiver), and which was approved.

### C. **Quality Strategy Overview**

A goal of DMS is to improve the health status of Medicaid recipients. Statewide health care outcomes, health indicators, and goals have been targeted and designated by the Department in collaboration with the Departments for Public Health (DPH) and Behavioral Health, Developmental and Intellectual Disabilities (BHDID). Federal Medicaid Managed Care regulations at 42CFR 438 Subpart D, require that the MCO measure and report to the State its performance, using standard measures required by the State and/or submit to the State data that enables the State to measure the MCO's performance on quality of care. In accordance with this, the Department established a set of Medicaid Managed Care Performance Measures. The measure set was originally designed to align with the *Healthy Kentuckians 2010 Goals*. *Healthy Kentuckians* was the state's commitment to the national preventive initiative, *Healthy People 2010*, with the overarching goals to increase years of healthy life and eliminate health disparities and included objectives and targets set to meet the needs of Kentuckians. *Healthy Kentuckians* included ten leading health indicators with related goals and objectives. Select indicators, goals and objectives were the basis of the Performance Measures. Other Performance Measures were derived from the managed care Healthcare Effectiveness Data and Information Set (HEDIS®)<sup>1</sup> set, which are reported by managed care organizations nationally, and have national benchmarks for comparison of performance. Still other Performance Measures were developed collaboratively by the Department, the state's sole-source Medicaid managed care organization operating as Passport Health Plan in Partnership Region 3, and the EQRO based on key areas of interest of the Department. Together, the measures address the access to, timeliness of, and quality of care provided to children and adolescents enrolled in managed care, and focus on preventive care, health screenings, prenatal care, as well as special populations (adults with hypertension, children with special health care needs (CSHCN)). Together these measures form the basis of the direction the state will address in new MCO contracts. The State has had an approved Quality Strategy since 2004 that supports the goals of the

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

Medicaid program. This Quality Strategy has been successful and the Commonwealth has seen an improvement in health outcomes for enrollees in the Partnership Region as a result. The Commonwealth used this successful Strategy as a framework in the development of the current Strategy proposed for expansion of managed care statewide.

This Strategy reflects other national changes affecting the health care industry relative to data collection and health care quality standards and quality measures.

- The Kentucky Health Information Exchange (KHIE) is an opportunity to advance health information technology and support healthcare providers coordinate and deliver care more efficiently, to improve healthcare outcomes and quality of care. KHIE provides a common, secure electronic information infrastructure for sharing health information among healthcare providers and organizations, and offers providers functionality to support meaningful use.
- The Commonwealth provides incentives to providers for the adoption and use of Electronic Health Records (EHR) and report meaningful use.
- Changes to data sets such as ICD-10 CM/PCS and captured on encounter submissions, will allow the Commonwealth to more effectively monitor the provision and quality of services provided by MCOs.

#### **D. Process for Quality Strategy Development, Review and Revision**

The Department reviewed the existing Quality Strategy for the Partnership Region 3, Quality Strategies from other states and the CMS Quality Strategy Toolkit and made changes as appropriate for the expansion of managed care. The department will be procuring an External Quality Review Organization (EQRO). All contracts entered into by the Department (MCO's and EQRO) will incorporate the requirements and language imposed under 42 CFR 438.

Additional input will be incorporated from other state agencies, providers, consumers and advocates who will assist in identifying quality activities and metrics of importance to the MCO populations. Results of annual reviews of the effectiveness of the prior year's quality plan and the External Quality Review (EQR) technical reports will provide data to further focus strategy development.

##### **1. EQR Technical Report**

The EQR technical report provides detailed information regarding the regulatory compliance of MCOs as well as results of Performance Improvement Projects (PIPs), Performance Measures (PMs), and results of optional quality-focused activities. Report results provide information regarding the effectiveness of the managed care organizations program, identifies strengths and weaknesses and provides information

about problems or opportunities for improvement. This information is utilized for input into the MCQS and for initiating and developing quality improvement projects.

2. Participant Input

The Contractor shall conduct an annual survey of members' and providers' satisfaction with the quality of services provided and their degree of access to services. The enrollee satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children, administered by an NCQA certified survey vendor. Additional sources of participant input include enrollee grievances and public forums.

3. Public Input

Once this initial strategy document is developed, it will be posted on the DMS website for public comment. By contract, the MCO will establish and maintain an ongoing Quality and Member Access Committee (QMAC) composed of members, individuals from consumer advocacy groups or the community who represent the interests of the member population and public health representatives. The DMS will annually seek and utilize input from the MCO's QMAC; the Medicaid Advisory Council established under 42 CFR 431.12; and Medicaid Technical Advisory Committee's (TACs) with consumer representation. This beneficiary and stakeholder input and public comment will be utilized as appropriate in the DMS's annual review and update of this quality improvement strategy document and the state's quality initiatives.

**E. Implementation**

The MCOs will implement and operate a continuous internal Quality Improvement (QI) Program that provides for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the MCOs. The QI Program will be developed in collaboration with members. The MCOs' QI Program description will be submitted to the DMS at one-year anniversary dates or upon the DMS's request.

The MCOs will annually review, evaluate and modify as necessary, the QI Program. The MCOs will then prepare a report to the DMS, detailing the annual review, completed activities and corrective actions, corrective actions which are recommended or in progress, and the results of all clinical, administrative, provider and member satisfaction surveys conducted during the immediate preceding year. The DMS will review the annual modified quality improvement program report for its completeness and the reasonableness of any implemented and/or planned corrective action plans contained within. The DMS will assess whether the resulting reports conform to submission requirements, and the degree to which the MCOs utilized the results in their Annual QI Plan submission.

Each MCO will conduct an annual survey of member and provider satisfaction with the quality of services provided and their degree of access to services, complete and submit GeoNetwork reports and maps, complete utilization trend and pattern reports, and operate a care coordination program. The MCO will use the results of these annual surveys and access analysis as an input to the annual review, evaluation, and modification of their overall Quality Improvement Program. The DMS will review and approve both the member and provider survey instruments. A description of the methodology to be used in conducting provider surveys and the percentage of providers to be surveyed will also be submitted. Survey results must be reported to the DMS.

The MCOs will submit to DMS and to the MCOs ongoing QMAC, a quarterly report of all member grievances and appeals and their disposition. The DMS will review these reports as an input to evaluate whether the MCO is following prescribed rules and regulations.

The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for members, identify areas for potential improvement, carry out individual Performance Improvement Projects (PIPs), undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and member satisfaction. While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to a member. Clinical PIPs should address preventive and chronic healthcare needs of members, including the member population as a whole and subpopulations, including, but not limited to Medicaid eligibility category, type of disability or special healthcare need, race, ethnicity, gender and age. PIPs shall also address the specific clinical needs of members with conditions and illnesses that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality, availability, and accessibility of services provided by the MCO to members and providers. Such aspects of service should include, but not be limited to availability, accessibility, cultural competency of services, and complaints, grievances, and appeals.

The Department strongly encourages the development of collaborative relationships with local health departments, behavioral health agencies and other community based health/social agencies to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives. The Department and the Contractor shall be jointly committed to on-going collaboration in the area of service and clinical care improvements by the development and sharing of best practices and use of encounter data-driven performance measures.

The DMS will assess the thoroughness of these submitted reports, and the reasonableness of the accompanying performance improvement plans and implementation timeframes. Minor discrepancies are brought to the attention of the MCO through regularly scheduled meetings, and in writing for more serious issue or concern.

The Contractor shall be required to collect and report HEDIS data annually. After completion of the Contractor's annual HEDIS data collection, reporting and performance measure audit, the Contractor shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than August 31<sup>st</sup> of each year.

The Commonwealth has had a contract with an EQRO to provide EQR functions for several years. Beginning July 2003 to current, the Commonwealth worked to implement expanded EQR functions and to comply with new BBA requirements and 42 CFR 438. Kentucky requires its contracted EQRO to perform the mandatory and optional EQR activities utilizing the nine protocol documents. Annually, the EQRO will review the MCO's compliance with state and federal regulations and state contract requirements and prepare a final, detailed technical report inclusive of all EQR and EQR related activities. This report will be made available by the DMS to any interested parties.

***Frequency of State reviews of the effectiveness of the strategy.***

- The DMS or its contracted agent will have the right to conduct periodic audits of the MCOs during which DMS will identify and collect management and quality data on the use of services or other information as determined by the DMS. Among other items, these assessments include evaluation of the MCO's QI Program description, QI plan and the MCO's annual evaluation description, policy and procedures, and implementation of the procedures.
- The Commonwealth has contracted with an EQRO to perform an annual review of MCOs compliance with state and federal regulations. This activity includes documentation review and interviews with MCO staff.
- The DMS performs an assessment and analysis of both the MCOs' quarterly and annual reports along with the results from the implementation of this quality plan. This assessment will evaluate the overall quality of service provided and planned improvements by the MCOs. Minor discrepancies are brought to the attention of the MCO through regularly scheduled meetings and in writing for more serious issue or concern. Identified significant deficiencies will result in request(s) for corrective action plan(s) from the MCO as described within the MCO contract.

***Definition of "significant changes" to strategy that will trigger shareholder input.***

- Significant changes to the quality strategy include any written change to policy or procedure that results in a required change to the QI program and plan, which will trigger shareholder input regarding its implementation. Examples might include: changes in federal or state laws and regulations, results of annual reports from the MCOs including consumer surveys, excessive complaints, grievances and appeals, or

results from oversight activity performed by the Commonwealth or the EQRO. Avenues for stakeholder input include submitted complaints (in writing and through telephone calls), written surveys, questionnaires posted on the DMS website, and in extreme cases direct communication by the DMS. The Commonwealth will submit a revised Managed Care (MC) Quality Improvement (QI) Strategy to CMS whenever such significant changes are made.

***Timeframes for updating the quality strategy.***

- The Commonwealth plans to update the strategy, if indicated, during the third quarter of each calendar year when the effectiveness of the QI plan is reviewed.

**F. Managed Care Program Goals and Objectives**

The DMS's mission and priority is to responsibly purchase quality health care and related services that produce positive outcomes for persons eligible for programs administered by the DMS. The primary goal of the Kentucky Medicaid Managed Care program is to improve the health status of Medicaid enrollees and to lower morbidity among enrollees with serious mental illness. Objectives include: 1) improve access and co-ordination of care; 2) provide health care at the local level through the managed care system using public and private providers; 3) redirect the focus of health care toward primary care and prevention of illness; 4) monitor and improve the quality of the health care delivery system; 5) increase health promotion efforts, psychotropic medication management, suicide prevention; and, 6) implement effective and responsive cost management strategies in the health care delivery system designed to stabilize growth in Medicaid costs. Statewide health care outcomes, health indicators, and goals have been targeted and designated by the DMS in collaboration with input from the DPH and BHDID. Certain health care conditions and utilization trends have been identified as statewide health issues in the Kentucky Medicaid population and will be monitored for improvements in health care outcomes. These include:

1. Diabetes
2. Coronary Artery Disease Screenings
3. Colon Cancer Screenings
4. Cervical/Breast Cancer Screenings
5. Mental Illness
6. Reduction in ED Usage / Management of ED Services

Specifically, the Commonwealth has established the following goals and objectives for the preceding targets.

Goal 1: Improve preventive care for adults

Objectives:

- Increase performance on the state aggregate HEDIS Colorectal Cancer Screening measure to meet/exceed the 2012 Medicaid 50<sup>th</sup> percentile or to meet/exceed the

rate that is an improvement of 10 percent of the difference of the baseline rate and the re-measurement rate.

- Increase performance on the state aggregate HEDIS Breast Cancer Screening measure to meet/exceed the 2012 Medicaid 50<sup>th</sup> percentile or to meet/exceed the rate that is an improvement of 10 percent of the difference of the baseline rate and the re-measurement rate.
- Increase performance on the state aggregate HEDIS Cervical Cancer Screening measure to meet/exceed the 2012 Medicaid 50<sup>th</sup> percentile or to meet/exceed the rate that is an improvement of 10 percent of the difference of the baseline rate and the re-measurement rate.

Goal 2: Improve care for chronic illness

Objectives:

- Increase performance on the state aggregate HEDIS Comprehensive Diabetes Care measure (all indicators including, HbA1c testing, eye exam, LDL-C screening, HbA1c control, LDL-C control, BP control and nephropathy) to meet/exceed the 2012 Medicaid 50<sup>th</sup> percentile or to meet/exceed the rate that is an improvement of 10 percent of the difference of the baseline rate and the re-measurement rate.
- Increase performance on the state aggregate HEDIS Cholesterol Management for Patients with Cardiovascular Conditions measure to meet exceed the 2012 Medicaid 50<sup>th</sup> percentile or to meet/exceed the rate that is an improvement of 10 percent of the difference between the baseline rate and the re-measurement rate.

Goal 3: Improve behavioral health care for adults and children

Objectives:

- Increase performance on the state aggregate HEDIS Antidepressant Medication Management measure (on both the Effective Acute Phase and Effective Continuation Phase) to meet/exceed the 2012 Medicaid 50<sup>th</sup> percentile or to meet/exceed the rate that is an improvement of 10 percent of the difference of the baseline rate and the re-measurement rate.
- Increase performance on the state aggregate HEDIS Follow-up After Hospitalization for Mental Illness measure (on both the follow-up within 30 days of discharge and follow-up within 7 days of discharge) to meet/exceed the 2012 Medicaid 75<sup>th</sup> percentile or to meet/exceed the rate that is an improvement of 10 percent difference of the baseline rate and the re-measurement rate.

Goal 4: Improve access to a medical home

Objectives:

- Increase performance on the state aggregate HEDIS Adults Access to Preventive /Ambulatory Health Services measure to meet/exceed the 2012 Medicaid 75<sup>th</sup> percentile or to meet/exceed the rate that is an improvement of 10 percent of the difference of the baseline rate and the re-measurement rate.

- Increase performance on the state aggregate HEDIS Children and Adolescents Access to Primary Care Practitioners measure to meet/exceed the 2012 Medicaid 75<sup>th</sup> percentile or to meet/exceed the rate that is an improvement of 10 percent difference of the baseline rate and the re-measurement rate.
- Change performance on the state aggregate HEDIS Ambulatory Care measure to:
  1. Outpatient visits for all age groups - meet/exceed the 2012 Medicaid 50<sup>th</sup> percentile or to meet/exceed the rate that is an improvement of 10 percent difference of the baseline rate and the re-measurement rate.
  2. ED visits for all age groups - decrease by 10 percent the rate of ED utilization between the baseline rate and the re-measurement rate.

National Medicaid benchmarks originate from the NCQA's Quality Compass and represent the performance of all Medicaid plans that report HEDIS to NCQA. Outcome goals may be adjusted based on re-measurement relative to baseline rates.

The MCOs will provide services in accordance with certain quality standards. The standards address: 1) beneficiary orientation and education, 2) capacity of the provider network to assure access to services, 3) clinical practice, 4) quality, 5) information reporting, 6) licensing/certification of providers, 7) medical records and confidentiality, 8) member services, including grievance procedures, 9) provider education and services, and 10) sufficient staffing for the number of enrollees served.

## **G. Medicaid Contract Provisions**

Kentucky is providing the specific contract provisions in the state's Medicaid MCO Model Contract that incorporate the established standards for access to care, structure and operations, and quality measurement and improvement:

1. Access to care include:
  - Quality and Member Access Committee
  - Assessment of Member and Provider Satisfaction and Access
  - Provider Program Capacity Demonstration
  - Program Mapping
  - Member Services Functions
  - Member Handbook
  - PCP Changes
  - Enrollment
  - Case Management
  - Direct Access Services
2. Structure and operations include:
  - Provider Program Capacity Demonstration
  - Member Services

- Member Services Function
  - Marketing
3. Quality measurement and improvement include:
- Quality Improvement
  - Health Outcomes
  - Reporting Requirements

## **H. State Standards for Access to Care**

The Commonwealth's monitoring methodology to assure access to care utilizes three monitoring areas. First, annual GeoAccess reports are produced and analyzed by the MCOs and DMS. The MCO's administer both enrollee and provider satisfaction surveys. The results of MCOs analysis of their surveys will be provided to the EQRO, who integrates results into their annual Technical Report. DMS refers complaints and grievances to MCOs for response. The MCOs will report complaints and grievances and results to DMS. The EQRO is responsible for reviewing and annually reporting on all services denied by the MCOs or their subcontractors and related appeals. For all these areas, minor discrepancies are brought to the attention of the MCOs through regularly scheduled meetings, and in writing for more serious issues. Identified significant deficiencies will result in request(s) for corrective action plan(s) from the MCO as described within the MCO contract.

### ***1. State standards for access to care including Availability of Services.***

- (a) The MCO must maintain and monitor a network of appropriate providers. For the MCO to be eligible as a Managed Care Organization under the requirements of this program, they must have a network of providers (including hospitals, home health providers, dentists, vision providers, hospice, pharmacy, prevention, primary care, and at least one provider of maternity care), and have a provider network representing the complete array of provider types including primary care providers, primary care centers, federally qualified health centers and rural health clinics, local health departments and the Kentucky Commission for Children with Special Health Care Needs, among other requirements.
- (b) The MCOs provides female enrollees with direct access to a women's health specialist. The MCO will ensure direct access and may not restrict the choice of a qualified provider by a member to women's health specialists within the MCOs network.
- (c) The MCO provides for a second opinion from a qualified health care professional. The MCO provides for a second opinion related to surgical procedures and the diagnosis and treatment of complex and/or chronic conditions within the MCO's Network, or will arrange for the member to obtain one outside of the network at no cost to the member if unavailable in the MCO's Network, at the member's request. The MCO will inform the member, in writing, at the time of enrollment of the member's right to make a written request for a second opinion.

- (d) The MCO must provide necessary services that are not available in the network. The MCOs will assure that all covered services are as accessible to members (in terms of timeliness, amount, duration, and scope) as the same services as generally are available to commercial insurance recipients, and that no incentive is provided, monetary or otherwise, to providers for the withholding from members of medically necessary services. The MCO will make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in the contract. The MCO will not prohibit or restrict a provider from advising a beneficiary about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under the Contract, if the professional is acting within the lawful scope of practice. If the MCO is unable to provide necessary medical services covered under the contract, it will timely and adequately cover these services out of network for the member for as long as MCO is unable to provide them. The MCO is required to coordinate with out-of-network providers with respect to payment. The MCO will ensure that cost to the enrollee is no greater than it would be if the services were provided within the MCO network.

The MCO will reimburse out of network providers for the following: 1) specialty care for which the MCOs has referred the member to an out of network provider; and, 2) emergency care that could not be provided in the MCO network because the time to reach a network participating provider capable of providing such services would have meant serious damage to the member's health.

- (e) The MCO demonstrates that providers are credentialed. The MCO is responsible for the ongoing review of provider performance and credentialing.
- (f) The MCO will ensure timely access. The MCO's written policies and procedures that are designed to protect the rights of members include (among other items) timely access to care that does not have any communication or physical access barriers, and timely referral and access to medically indicated specialty care.

MCOs must have service availability as follows:

Primary care delivery sites that are: no more than 30 miles or 30 minutes from members in urban areas, and for members in rural areas, no more than 45 minutes or 45 miles from residence or place of employment; with enrollee to PCP ratios not to exceed 1500:1; and with appointment and waiting times, not to exceed 30 days from date of a member's request for routine and preventive services and 48 hours for Urgent Care.

- (g) The MCO and cultural considerations. The MCO participates in the State's effort to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

**2. *Assurances of adequate capacity and services.***

The MCO offers an appropriate range of preventative, primary care, and specialty services. The MCO will provide, or arrange for the provision of, health services, including emergency services, to the extent services are covered for recipients under the then current Kentucky State Medicaid Plan, as designated by the DMS in administrative regulations adopted in accordance with KRS Chapter 13A and as required by federal and state regulations, guidelines, transmittals, and procedures. Kentucky Medicaid covers only Medically Necessary services. These services are considered by the DMS to be those which are reasonable and necessary to establish a diagnosis and provide preventive, palliative, curative or restorative treatment for physical or mental conditions in accordance with the standards of health care generally accepted at the time services are provided, including but not limited to services for children in accordance with 42 USC 1396d(r). Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The amount, duration, or scope of coverage must not be arbitrarily denied or reduced solely because of the diagnosis, scope of illness, or condition.

**3. *The MCO maintains a network of providers that is sufficient in number, mix, and geographic distribution.***

The MCO network will include providers from throughout the provider community. The MCO must comply with the any willing provider as set forth in 907 KAR 1:672 and KRS 304.17A-270. The MCO will have written policies and procedures regarding the selection and retention of the MCO provider network. These procedures must not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that particular provider's licensure or certification. The MCO demonstrates the extent to which its program has incorporated providers who have traditionally provided a significant level of care to Medicaid clients within the MCO service area. The MCO will have in its provider network participating providers of sufficient types, numbers, and specialties in the geographic area, by county, to assure quality and access to health care services as required for the Quality Improvement Program. If the MCO is unable to contract with these providers, it will submit to the DMS, for approval, documentation which supports that adequate services and service sites as required in this Contract will be available to meet the needs of its members.

**4. *Coordination and continuity of care.***

The MCO must ensure that each enrollee has an ongoing source of primary care. Primary Care Provider or (PCP) means a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced registered nurse practitioner, including a nurse practitioner, nurse midwife and clinical specialist, physician assistant, or clinic, including a primary care center and rural health clinic, that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting

privileges, and agrees to provide twenty-four (24) hours a day, seven (7) days a week primary health care services to individuals. For a member who has gynecological or obstetrical health care needs, disability or chronic illness, the PCP can be a specialist who agrees to provide and arrange for all appropriate primary and preventive care. The MCO will have procedures for serving members from the date of notification of enrollment, whether or not the member has selected a PCP. The MCO will be required to send members a written explanation of the PCP selection process within five (5) business days of receiving enrollment notification from DMS. Members will be asked to select a PCP and contact the MCO's Member Services department with their selection. The written communication will include the time frame for selection of a PCP, an explanation of the process for assignment of a PCP if the member does not select a PCP and information on where to call for assistance with the selection process.

**5. *The MCO coordinates all services that the enrollee receives.***

The MCO will establish referral relationships with various human service agencies whose services are outside the MCO's scope of covered services, but important to the health of members. Case Management will be provided by the MCO to members, as appropriate. Additionally, the MCO will provide specialized Case Management services for members with complex and/or chronic conditions. Members may request specialized Case Management Services and the MCO will review all member requests for this service based on contract requirements. The MCO, through its providers, must coordinate assessment, treatment, and follow members as the members utilize multiple providers, services sites, and levels of care. Appropriate information sharing and careful monitoring of diagnosis, treatment, follow up and medication usage is especially important when members use physical and behavioral health systems simultaneously.

**6. *The MCO shares identification and assessment information to prevent duplication of services for individuals with special health care needs.***

The Department for Community Based Services (DCBS) and the Department for Aging and Independent Living (DAIL) population will be enrolled through a service plan that will be completed on each DCBS and DAIL client being enrolled with the MCO. The service plan will be completed by DCBS and DAIL and forwarded to the MCO prior to enrollment and will be used by DCBS, DAIL and the MCO to determine the individuals medical needs and identify the possible need for special case management. The DCBS population includes: Adult Guardianship Clients, Children in Foster Care, and Children Receiving Adoption Assistance. Dual Eligible Members will be identified by the management information system. The MCO and providers will work together to coordinate the care for such members in order to reduce over utilization and duplication of services and cost. The MCO must establish procedures to coordinate care for children receiving early intervention/school-based services and early intervention services. The MCO will monitor the continuity and coordination of care for these children as part of its QI program.

In addition, the MCO will have special processes in place for persons with special health care needs, including:

- (a) Identification;
- (b) Assessment;
- (c) Treatment plans; and
- (d) Direct access to specialists.

- i) Identification: The MCO will report on activities associated with sub-populations and individuals with special healthcare needs. Examples of sub-populations and individuals with special health care needs include enrollees with chronic and disabling conditions, minorities, children enrolled with the Commission for Children with Special Health Care Needs, and any groups identified by the MCO for targeted study.
- ii) Assessment: There will be processes implemented to assess, monitor, and evaluate services to all subpopulations, including but not limited to, the on-going special conditions that require a course of treatment or regular care monitoring, Medicaid eligibility category, type of disability or chronic conditions, race, ethnicity, gender and age.
- iii) Treatment plans: The DCBS and DAIL population will be enrolled through service plans that will be completed on each DCBS or DAIL client being enrolled with the MCO. The service plan will be completed by DCBS or DAIL and forwarded to the MCO prior to enrollment and will be used by DCBS or DAIL and the MCO to determine the individuals medical needs and identify the possible need for special case management. Clinical standards or guidelines will be adopted for treatment of members with special health care needs and complex, chronic conditions. Practice guidelines must be disseminated to MCO Network providers and to members, upon request.
- iv) Direct access to specialists: The MCO's Member Services function will also be responsible for facilitating direct access to specialty physicians in the circumstances of: a) members with long-term, complex conditions; b) aged, blind, deaf, or disabled persons, and c) Individuals who have been identified as having Special Healthcare Needs and who require a course of treatment or regular healthcare monitoring. This access can be achieved through standing referrals from the PCP or by the specialty physician being permitted to serve as the PCP. The MCO will have programs and processes in place to address the preventive and chronic healthcare needs of its population.

**7. *The MCO protects the enrollees' privacy in the process of coordinating care.***

The MCO's written policies and procedures that are designed to protect the rights of members will include, without limitation, the right to respect, dignity, privacy, confidentiality and nondiscrimination. Confidentiality of all enrollee information is mandatory and a breach of confidentiality will be considered as a basis for immediate

revocation of the MCO Contract. The MCO will protect member information from unauthorized disclosure as set forth in the MCO contract. The parties to the MCO Contract agree that all information, records, and data collected in connection with this Contract, including Medical Records, will be protected from unauthorized disclosure as provided in 42 C.F.R. Section 431, subpart F, KRS 194.060, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the HIP AA laws specified in MCO Contract.

**8. Coverage and authorization of services. Identify, determine, and specify the amount, duration and scope of each service that the MCO is required to offer.**

The MCO will provide, or arrange for the provision of covered services to all members in accordance with the standards set forth in the Contract, and according to the DMS's policies and procedures applicable to each category of covered services. The MCO will be required to provide covered services to the extent services are covered for enrollees at the time of enrollment. The MCO will provide, or arrange for the provision of health services, including emergency services, to the extent services are covered for recipients under the then current Kentucky Medicaid State Plan, as designated by the DMS in administrative regulations adopted in accordance with KRS Chapter 13A and as required by federal and state regulations, guidelines, transmittals, and procedures.

**9. Specify what constitutes "medically necessary services".**

Medically Necessary or Medical Necessity means those covered services that are medically necessary as defined in 907 KAR 3:130 and are provided, in accordance with 42 C.F.R. § 440.230, including services for children authorized under 42 U.S.C. 1396d(r). 907 KAR 3:130 defines medical necessity as a covered benefit that is (a) reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy, (b) clinically appropriate in terms of the service, amount, scope, and duration based on generally accepted standards of good practice, (c) provided for medical reasons rather than primarily for the convenience of the individual, the individuals' caregiver, or the healthcare provider, or for cosmetic reasons, (d) provided in the most appropriate location, with regard to generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided, (e) needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent lay person standard; and (f) provided in accordance with ESPDT requirements established in 432 USC 1396r; 42 CFR part 441, and 42 CFR 440.230.

**10. The MCO must have in place and follow written policies and procedures for authorization of services.**

The MCO will have a comprehensive Utilization Management (UM) program that reviews services for medical necessity and that monitors and evaluates on an ongoing basis the appropriateness of care and services. The MCO will have in place mechanisms to check the consistency of application of review criteria. The written clinical criteria and protocols will provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate. The Medical Director will supervise the UM program and will be accessible and available for consultation as needed. Decisions requiring clinical judgment and denials based on lack of medical necessity will be made by qualified medical professionals.

***11. That any decision to deny a service be made by an appropriate health care professional.***

Decisions requiring clinical judgment and denials based on lack of medical necessity will be made by qualified medical professionals.

***12. Detailed information related to the access to care standards, including: Identification of mechanisms the State uses to identify persons with special health care needs to the MCO.***

Individuals with Special Health Care Needs (ISHCN) are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these individuals so the Contractor can facilitate access to appropriate services.

As per the requirement of 42 CFR 438.208, the Department has defined the following categories of individuals who shall be identified as ISHCN. The Contractor shall have written policies and procedures in place which govern how members with these multiple and complex physical and behavioral health care needs are further identified. The Contractor shall have an internal operational process, in accordance with policy and procedure, to target members for the purpose of screening and identifying ISHCN's. The Contractor shall assess each enrollee identified as ISHCN in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment process shall use appropriate health professionals. The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations:

1. Children in/or receiving Foster Care or adoption assistance ;
2. Blind/Disabled Children under age 19 and Related Populations eligible for SSI;
3. Adults over the age of 65;
4. Homeless (upon identification);
5. Individuals with chronic physical health illnesses; and

6. Individuals with chronic behavioral health illnesses.

- The MCO will request all members complete an initial Health Risk Assessment (HRA) within 90 days of enrollment. The questionnaire process may be conducted by the MCO staff, through arrangement with the local health departments or by other means. Information to be collected will include demographic, socioeconomic, current health status and behavioral risk questions and be inclusive enough to determine the member's need for care management, disease management, mental health services and/or any other health services. The information collected will identify the health education needs of members and provide the basis for the health education program.
- Certain medically necessary services are provided for recipients under contract with the Commission for Children with Special Health Care Needs and are covered for children identified with special needs. Coverage includes physician , EPSDT, dental, occupational therapy, physical therapy, speech therapy, durable medical equipment, genetic screening and counseling, audiological, vision, case management, laboratory and x-ray, psychological and hemophilia treatment and related services. The Commission treats children with a variety of medical conditions, acquired or congenital. A listing of clinical programs are: Asthma, Juvenile Rheumatoid Arthritis, Burns, Neurology, Cerebral Palsy Neurosurgery, Cleft Lip & Palate, Eye, Craniofacial, Orthopedic, Cystic Fibrosis, Ear, Hand, Reconstructive Surgery, Heart, Scoliosis, Pediatric and Adult (Over 21) Hemophilia, Seizure, Sickle Cell, Spina Bifida.

***13. Identification of standards the State uses to determine the extent to which treatment plans are required to be produced by the MCOs for individuals with special health care needs.***

The DCBS or DAIL population will be enrolled through a service plan that will be completed on each DCBS or DAIL client being enrolled with the MCO. The service plan will be completed by DCBS or DAIL and forwarded to the MCO prior to Enrollment and will be used by DCBS or DAIL and the MCO to determine the individuals medical needs and identify the possible need for special case management. The DCBS or DAIL population includes: Adult Guardianship Clients, Children in Foster Care, and Children Receiving Adoption Assistance.

**I. Standards for MCO Structure and Operations**

***1. State standards for structure and operations, including provider selection:***

- The MCO will have written policies and procedures regarding the selection and retention of MCO Provider Network. The policies and procedures regarding selection and retention must not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or

based upon that provider's licensure or certification. The MCO policies and procedures must be in compliance with contract requirements, and will be reviewed and approved by the DMS prior to initial adoption and any subsequent adoption of changes.

- The MCO Member Services function will be responsible for facilitating the selection of or explaining the process to select or change Primary Care Providers through telephone or face-to-face contact where appropriate. The MCO will assist members to make the most appropriate PCP selection based on previous or current PCP relationship, providers of other family enrollee's medical history, language needs, provider location and other factors that are important to the enrollee. The MCO will determine a method for assignment of PCP which is consistent with the "Any Willing Provider" statute, KRS 304.17A-270. There are two different processes for choosing a PCP for those members who are eligible for a PCP relationship (non-Medicare primary enrollees), one for members without SSI and one for members who have SSI coverage.

**2. *Each State must establish a uniform credentialing and re-credentialing policy:***

Each of the providers, including individuals and facilities, who will provide health care services in the MCO Network is validly licensed or, where required, certified to provide those services in the Commonwealth, including certification under CLIA, if applicable. Each provider in the MCOs' Network has a valid Drug Enforcement Agency ("DEA") registration number, if applicable. Those providers accountable to a formal governing body for review of credentials will include physicians, dentists, advanced registered nurse practitioners, vision care and other licensed or certified practitioners. The MCO will be responsible for the ongoing review of provider performance and credentialing as specified within the MCO Contract.

**3. *Enrollee information:***

- Member means a recipient who is enrolled with the MCO or as defined in 42 CFR 438.10(a). HIPAA 834 means a monthly report prepared by the DMS which indicates all members enrolled in the Contractor's Network. Enrollment means an action taken by the DMS to add a member's name to the HIPAA 834 following approval by the DMS of an eligible recipient to be enrolled with the MCO. Medical Record means a single complete record which documents all of the treatment plans developed for, and medical services received by, the member including inpatient, outpatient, referral services and emergency care whether provided by MCO Network or Out-of-Network Providers.
- The maintenance of enrollment/enrollee data is required to support claims and encounter processing, Third Party Liability (TPL) processing and reporting functions. The major source of enrollment/enrollee data will be electronically transmitted by DMS to the MCO on a daily basis. A monthly file of enrollees will be electronically transmitted to the MCO.
- Specific data item requirements for the MCO Recipient subsystem will contain such items as maintenance of demographic data, matching PCP's with members,

maintenance information on Enrollments/Disenrollments, identification of TPL information, tracking EPSDT preventive services and referrals.

- The MCO Member Services will also be responsible for sending members written information upon enrollment notification. This will include a Member Handbook and how to access services. Alternate notification methods must be available for persons who have reading difficulties or visual impairments.

#### **4. Confidentiality:**

- Confidentiality of all beneficiary information is mandatory and violation can be terms for immediate revocation of the MCO Contract. The MCO has the responsibility to protect beneficiary information from unauthorized disclosure for any reason.
- The MCO will maintain confidentiality of member information. The MCO's written policies and procedures that are designed to protect the rights of members will include, without limitation, the right to respect, dignity, privacy, confidentiality and nondiscrimination. Confidentiality of all member information is mandatory and a breach of confidentiality will be considered as a basis for immediate revocation of this Contract. The MCO will protect member information from unauthorized disclosure as set forth in the MCO Contract. The MCO agrees to abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164.

#### **5. Enrollment and Disenrollment:**

- Recipients eligible to enroll with the MCO may be eligible beginning with the first day of the application month with the exception of newborns who are eligible beginning with their date of birth and unemployed parent program recipients who are eligible beginning with the date the definition of "unemployment" is met. To be eligible a person must be a resident of the MCO service area, and must have qualified to receive medical assistance under one of the Medicaid assistance categories.
- The MCO will provide for a continuous open enrollment period throughout the term of the MCO Contract. The MCO will accept all recipients, regardless of overall plan enrollment. The MCO will maintain staffing and a service delivery network necessary to adhere to minimum standards for covered services. Except for newborns, and presumptive eligibility, enrolleeship begins at 12:01 a.m. on the first day of the first calendar month for which the member's name appears on the HIPAA 834, and is automatically renewed until the member is disenrolled. All requests by the MCO for the DMS to disenroll a member will be in writing and will specify the basis for the request. If applicable, the MCO's request must document that reasonable steps were taken to educate the member regarding proper behavior, and that the member refused to comply. The MCO may not

request disenrollment of a member based on an adverse change in the member's health. Only the DMS may disenroll a enrollee from the plan.

**6. *Grievance System:***

- The MCO will have an organized Grievance System that includes a grievance process, an appeal process, and access for enrollees to the State's fair hearing system. Any member has a right to file a grievance with the MCO or the DMS if they are dissatisfied with anything related to the MCO. Any member may file an appeal related to actions, or a decision by the MCO related to covered services or services provided. The MCO will have a timely and organized system with written policies and procedures for resolving grievances filed by members. This process will conform to 42 CFR 438 subpart F and other applicable CMS and DMS requirements. The MCO will have a process that consists of methods to address member's oral and written grievances.
- The MCO is to submit quarterly reports to the DMS regarding the number and types of grievances and appeals. DMS staff review these reports and incorporate findings to the EQRO who will review and annually report on all services denied by the MCO or its subcontractors and related appeals. Minor discrepancies are brought to the attention of MCO through regularly scheduled meetings, and in writing for more grievous errors. Identified significant deficiencies will result in request(s) for corrective action planes) from the MCO as described within the MCO Contract.

**7. *Subcontractor relationship and delegation oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor of the MCO.***

- The MCO may, with the approval of the DMS, enter into subcontracts for the performance of its administrative functions or the provision of various covered services to members. All subcontractors of the MCO must be eligible for participation in the Medicaid program as applicable. Each subcontract, and any amendment to a subcontract, will be in writing, and in form and content approved by the DMS in writing prior to the effective date. No subcontract will in any way relieve the MCO of any responsibility for the performance of its duties under the Contract. The MCO will notify the DMS in writing of all subcontracts on a quarterly basis and of the termination of any approved subcontract within ten (10) days following termination.

**8. *Detailed information related to the structure and operation standards, including procedures for the review of the records of MCOs grievances and appeals and for identifying and resolving systemic problems.***

- The MCO will have an organized Grievance System that will include a grievance process, an appeal process, and access for enrollees to the State's fair hearing system. Any member has a right to file a grievance with the MCO or the DMS if they are dissatisfied with anything related to the MCO's Network. Any member

may file an appeal related to actions, or a decision by the MCO related to covered services or services provided. The MCO will have a timely and organized system with written policies and procedures for resolving grievances filed by members. This process will conform to 42 CFR 438 Subpart F and other applicable CMS and DMS requirements. The MCO will have a process that consists of methods to address member's oral and written grievances.

- Every grievance received will be documented in the MCO Management Information System. The MCO will establish written policies and procedures for the receipt, handling and disposition of grievances that will comply with 42 CFR 438 Subpart F and 42 CFR 431. These policies and procedures will include the following (among other requirements): a process for evaluating patterns of grievances for impact on formulation of policy and procedures, access and utilization; and, establish procedures for maintenance of records of grievances separate from medical case records and in a manner which protects the confidentiality of enrollees who file a grievance or appeal.
- The MCO will submit to DMS and to the MCO's QMAC, a quarterly report of all member grievances and appeals and their disposition. The report will be in a format approved by DMS and will include at least the following information: number of grievances and appeals including expedited appeal requests, nature of grievances and appeals, resolution, and timeframe for resolution. DMS or its contracted agent may conduct reviews or onsite visits to follow up on patterns of repeated grievances or appeals. Any patterns of suspected fraud or abuse identified through the data will be immediately referred to the MCO's Program Integrity Unit.
- The MCO is to submit quarterly reports to the DMS regarding the number and type of grievances and appeals. In addition, the EQRO will review and annually report on all services denied by the MCO or its subcontractor and related appeals. DMS reviews these reports and minor discrepancies are brought to the attention of the MCO through regularly scheduled meetings, and in writing for more grievous errors. Identified significant deficiencies will result in request(s) for corrective action plan(s) from the MCO as described within the MCO contract.
- DMS will provide members with a fair hearing process that will adhere to 907 KAR 1:563, 42 CFR 438, Subpart F and 42 CFR 431, Subpart E.

## **J. Standards for MCOs Quality Measurement and Improvement**

- The MCO will implement and operate a continuous internal quality improvement program that provides for the evaluation of access to care, continuity of care, healthcare outcomes, and services provided or arranged for by the MCO. The QI program will be developed in collaboration with members. The MCO's utilization quality improvement subsystem will contain many components, including the monitoring of processes to identify deviations in patterns of treatment from established standards or norms, performance and health outcome measures using standardized indicators. The MCO will provide reports on the status of the QI program and work plan to the DMS on a quarterly basis and/or annual basis. DMS reviews these reports and minor discrepancies are brought to the attention of MCO

through regularly scheduled meetings, and in writing for more grievous errors. Identified significant deficiencies will result in request(s) for corrective action plan(s) from the MCO as described within the MCO Contract.

***1. Practice guidelines based on valid and reliable clinical evidence.***

- The MCOs will implement and operate a continuous internal QI Program that provides for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the MCOs. The QI Program will be developed in collaboration with members. The MCOs QI Program will be submitted in writing to the DMS at one-year anniversary dates of the original approval or upon the DMS's request. Modifications to the program must be submitted to the DMS.
- The MCO's overall Quality Improvement Plan (QIP) will contain a plan for the conduct of annual clinical studies, performance improvement projects and guidelines or standards against which clinical care is compared. Each guideline will be reviewed for consistency with utilization management criteria, medical education, available benefits and disease management programs materials prior to implementation and upon each subsequent renewal and will be based on the most recent health care sciences and reviewed by the persons conducting QI studies. The MCO is encouraged to use national and state clinical care or practice guidelines from all health care disciplines. Clinical standards or guidelines will be adopted for treatment of members with special health care needs and complex, chronic conditions. Practice guidelines must be disseminated to MCO's Network, and to members, upon request. The QIP will also contain mechanisms for assessing and taking corrective actions, when study findings deem action to be appropriate.

***2. Practice guidelines that consider the needs of the MCO's enrollees.***

- The MCO's QI Plan will contain (among other listed items) guidelines or standards against which clinical care is compared. Each guideline will be reviewed for consistency with utilization management criteria, medical education, available benefits and disease management programs materials prior to implementation and upon each subsequent renewal and will be based on the most recent health care sciences and reviewed by the persons conducting Quality Improvement studies.
- The MCO will annually review, evaluate and modify as necessary, the QI Program, including the medical record program; data collection program and program for checking provider credentials, as well as all QI policies and procedures; clinical care standards; practice guidelines and patient protocols; provider incentive plans; and program capacity; member utilization of services; access to covered services; and treatment outcomes. The MCO will prepare a report to the DMS, detailing the annual review; completed activities and corrective actions; corrective actions which are recommended or in

progress; and the results of all clinical, administrative, provider and member satisfaction surveys conducted during the immediate preceding year.

- The MCO will have programs and processes in place to address the preventive and chronic healthcare needs of its population and sub-populations, including but not limited to, Medicaid eligibility category, type of disability or chronic condition, race, ethnicity, gender and age, as well as an ongoing quality assessment and performance improvement program for the services it furnishes to members. This program will be designed to achieve, through ongoing measurements and intervention, significant improvement in clinical and non-clinical areas.
- There will be processes implemented to assess, monitor, and evaluate services to all sub populations, including but not limited to, the on-going special conditions that require a course of treatment or regular care monitoring, Medicaid eligibility category, type of disability or chronic conditions, race, ethnicity, gender and age.
- The MCO will request all members to complete an initial health risk questionnaire of each new member within 90 days of enrollment. The questionnaire process may be conducted by the MCO staff, through arrangement with the local health department or by other means. Information to be collected will include demographic, socioeconomic, current health status and behavioral risk questions and be inclusive enough to determine the member's need for care management, disease management, mental health services and/or any other health services. The information collected will identify the health education needs of members and provide the basis for the health education program.

### ***3. Practice guidelines that are adopted in consultation with contracting health care professionals.***

- The MCO will use appropriate health care professionals in the assessment process.
- The MCO will include practicing physicians and other providers in MCO's Network in the review and adoption of medical necessity criteria.

The MCO will annually review, evaluate and modify as necessary, the Quality Improvement program, including the medical record program; data collection program and program for checking provider credentials, as well as all Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols; provider incentive plans; and program capacity; member utilization of services; access to covered services; and treatment outcomes. The MCO will prepare a report to the DMS, detailing the annual review; completed activities and corrective actions; corrective actions which are recommended or in progress; and the results of all clinical, administrative, provider and member satisfaction surveys conducted during the immediate preceding year. The MCO will submit to the DMS its final annual HEDIS audit report by August 31 of each year.

#### ***4. Quality assessment and performance improvement program.***

(a) Conduct PIPs.

- The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for members, identify areas for potential improvement, carry out individual Performance Improvement Projects (PIPs), undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and member satisfaction. While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to a member. Clinical PIPs should address preventive and chronic healthcare needs of members, including the member population as a whole and subpopulations, including, but not limited to Medicaid eligibility category, type of disability or special healthcare need, race, ethnicity, gender and age. PIPs shall also address the specific clinical needs of members with conditions and illnesses that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality, availability, and accessibility of services provided by the MCO to members and providers. Such aspects of service should include, but not be limited to availability, accessibility, cultural competency of services, and complaints, grievances, and appeals.
- The Department strongly encourages the development of collaborative relationships with local health departments, behavioral health agencies and other community based health/social agencies to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives. The Department and the Contractor shall be jointly committed to on-going collaboration in the area of service and clinical care improvements by the development and sharing of best practices and use of encounter data-driven performance measures.
- The MCO will collect data on all HEDIS performance measures and will submit the validated report annually to DMS.
- In addition, the contracted EQRO will conduct a validation of performance improvement projects (PIP) by evaluating the soundness and results of the projects implemented by the MCO. The EQRO will assess the methodology for conducting the PIP; verify actual PIP study findings; and, evaluate validity and reliability of study results.

(b) Submit performance measurement data

- The MCO will maintain or cause to be maintained detailed records relating to the operation of the MCO's Network, including (among other required items): QI compliance, including a copy of all QI reports. In addition, the MCO will collect data on all HEDIS performance measures and submit the validated report annually to DMS.
- The MCO is required to implement steps targeted at improvement for performance measures identified in the contract in either the actual outcomes or processes used to affect these outcomes. The goals of the MCO are to meet or exceed the specific objectives by the end of the 3rd measurement year.
- The contracted EQRO will conduct an annual validation of these performance measures by evaluating the accuracy of the performance measures reported by the MCO, and determining the extent that the Medicaid specific performance measures follow the specifications established by the DMS for the calculation of the performance measures.
- The MCO will be required to electronically provide encounter data to DMS on a monthly basis. The encounter data will be used by DMS to 1) evaluate access to care, availability of services, quality of care; 2) evaluate contractual performance; 3) validate required reporting of utilization of services; 4) develop and evaluate proposed or existing capitation rates; 5) meet CMS Medicaid reporting requirements.
- The MCO will be responsible for complying with the reporting requirements set forth in the MCO Contract and for assuring the accuracy, completeness and timely submission of each report. The MCO will provide such additional data and reports as may be reasonably requested by the DMS.
- The DMS will use such reports in its annual assessment of the MCO and resultant report to CMS. Minor discrepancies are brought to the attention of MCO through regularly scheduled meetings, and in writing for more grievous errors. Identified significant deficiencies will result in request(s) for corrective action planes) from the MCO as described within the MCO contract.

(c) Have in effect mechanisms to detect both overutilization and underutilization of services.

- The MCO's QI Plan will contain (among other required items) methods for integrating the Quality Improvement activity with other management activities including utilization management. The MCO will also analyze and report on trends in utilization, and any unusual patterns about which the MCO will take subsequent action. In addition, the MCO will report on areas where over-or under-utilization has been influenced appropriately, i.e., pharmacy and ER utilization management.
- The MCO will have a comprehensive UM program that reviews services for medical necessity and that monitors and evaluates on an ongoing basis the appropriateness of care and services. The MCO will develop or adopt

written medical necessity review criteria that are based on sound medical evidence or judgement and will review such criteria periodically and update as needed. The MCO will include practicing physicians and other providers in MCO's Network in the review and adoption of medical necessity criteria. The MCO will have in place mechanisms to check the consistency of application of review criteria.

- The UM program and processes will be in accordance with 42 CFR 456, 42 CFR 431, 42 CFR 438 and applicable state laws and regulations. Timeframes for service review decisions will conform to those set forth in 42 CFR 456. The program will identify and describe the mechanisms to detect under-utilization as well over-utilization of services.
  - The utilization/quality improvement subsystem combines data from other subsystems, and/or external systems, to produce reports for analysis which focus on the review and assessment of access, availability and continuity of services, quality of care given, detection of over and under utilization of services, and the development of use defined reporting criteria and standards. This system profiles utilization of providers and members and compares them against experience and norms for comparable individuals.
  - The contracted EQRO is required to conduct an annual analysis of utilization patterns of services and delivery sites to determine shifts in access to care, e.g., under-utilization or inadequate access to healthcare providers.
- (d) Have in effect mechanisms to assess quality and appropriateness of care to enrollees.
- The MCO will be required to implement steps targeted at improvement in either the actual outcomes or processes used to affect those outcomes. Certain screening and outcome benchmarks are required of the MCO. In the event that either federal or state laws are modified to require different healthcare measures, the parties agree to amend the Contract.
  - The MCO will establish and maintain an ongoing QMAC composed of members, individuals from consumer advocacy groups or the community who represent the interests of the member population and public health representatives. Members of the committee will be consistent with the composition of the member population, including such factors as age category, gender, geographic distribution, parents, as well as adult enrollees and representation of racial and ethnic minority groups. Responsibilities of the committee will include (summarizing from among other required items): providing review and comment on quality and access standards; providing review and comment on the grievance and appeals process as well as policy modifications needed based on review of aggregate grievance and appeals data; review and provide comment on Member Handbooks; reviewing member education materials prepared by the MCO; recommending community outreach activities; and providing reviews of and comments on MCO and DMS policies that affect members.

- The MCO will conduct an annual survey of members' and providers' satisfaction with the quality of services provided and their degree of access to services. Completion and submittal of Geo Access reports and maps, completion of utilization trend and pattern reports and operation of a care coordination program will also be performed and submitted to the DMS and EQRO.
  - The EQRO will annually review MCO compliance with state and federal standards and state MCO contract requirements and will produce a report that describes the manner in which data from all EQR and EQR related activities were aggregated and analyzed, and conclusions drawn as to the quality, timeliness and access to care furnished by the MCOs.
  - The MCO is required to submit reports to the DMS on the status of the Quality Improvement program on a quarterly and/or annual basis. The DMS will use such reports in its annual assessment of the MCO and resultant report to CMS. Minor discrepancies are brought to the attention of MCO through regularly scheduled meetings, and in writing for more grievous errors. Identified significant deficiencies will result in request(s) for corrective action plan(s) from the MCO as described within the MCO contract.
- (e) Measure performance and/or report performance data to the State
- The MCO will implement and operate a continuous internal Quality Improvement Program that provides for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the MCO. The QI Program will be developed in collaboration with members. The MCO's QI Program will be submitted in writing to the DMS at one year anniversary dates of the original approval or upon the DMS request. Modifications to the program must be submitted to the DMS.
  - The MCO will prepare a report to the DMS, detailing the annual review; completed activities and corrective actions; corrective actions which are recommended or in progress; and the results of all clinical, administrative, provider and member satisfaction surveys conducted during the immediate preceding year. The MCO will submit to the DMS its final annual HEDIS audit report by August 31<sup>st</sup> of each year.
  - The EQRO will annually conduct a validation of performance measures reported by the MCO to 1) evaluate the accuracy of Medicaid performance measures reported by or on behalf of the MCO; 2) determine the extent that Medicaid specific performance measures follow specifications established by the state for the calculation of performance measures.
  - The MCO will provide reports on the status of the QI program and work plan to the DMS on a quarterly basis and/or annual basis. Minor discrepancies are brought to the attention of MCO through regularly scheduled meetings, and in writing for more grievous errors. Identified significant deficiencies will result in request(s) for corrective action plan(s) from the MCO as described within the MCO contract.

(f) Report the status and results of each project to the State as requested

- The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for members, identify areas for potential improvement, carry out individual Performance Improvement Projects (PIPs), undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and member satisfaction. While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to a member. Clinical PIPs should address preventive and chronic healthcare needs of members, including the member population as a whole and subpopulations, including, but not limited to Medicaid eligibility category, type of disability or special healthcare need, race, ethnicity, gender and age. PIPs shall also address the specific clinical needs of members with conditions and illnesses that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality, availability, and accessibility of services provided by the MCO to members and providers. Such aspects of service should include, but not be limited to availability, accessibility, cultural competency of services, and complaints, grievances, and appeals.
- The Department strongly encourages the development of collaborative relationships with local health departments, behavioral health agencies and other community based health/social agencies to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives. The Department and the Contractor shall be jointly committed to on-going collaboration in the area of service and clinical care improvements by the development and sharing of best practices and use of encounter data-driven performance measures.
- The studies will include the selection of national or state guidelines for practice and the subsequent evaluation of consistency of clinical care with these guidelines.
- In addition, the MCO is required to collect and report on targeted health care measures. DMS, as well as the MCO, are responsible for monitoring these health care outcomes. The DMS reserves the right to assess the MCO's achievement of goals related to these health care outcomes. The DMS and the MCO will agree to the annual benchmark goals. The EQRO will conduct a validation of the performance measures.

- If the DMS determines the goals have not been achieved, a corrective action plan will be submitted by the MCO. Additionally, there is to be a mechanism to update standards and guidelines and disseminate revised information to practitioners.
- (g) State must review at least annually, the impact and effectiveness of the MCO's quality assessment and performance improvement program
- The MCO will annually review, evaluate and modify as necessary, the QI Program, including the Medical Record program; data collection program and program for checking provider credentials, as well as all Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols; provider incentive plans; and Program capacity; member utilization of services; access to covered services; and treatment outcomes. The MCOs will prepare a report to the DMS, detailing the annual review; completed activities and corrective actions; corrective actions which are recommended or in progress; and the results of all clinical, administrative, provider and member satisfaction surveys conducted during the immediate preceding year. The MCO will submit to the DMS its final annual HEDIS audit report by August 31<sup>st</sup> of each year.
  - The MCO will be responsible for complying with the reporting requirements set forth in the Contract and for assuring the accuracy, completeness and timely submission of each report. The MCO will provide such additional data and reports as may be reasonably requested by the DMS.
  - The MCO will provide reports on the status of the QI program and work plan to the DMS on a quarterly and/or annual basis.
  - The state has contracted with an EQRO who will use the federally approved EQRO protocols for review of the impact and effectiveness of the MCO.
  - The DMS will use such reports in its annual assessment of the MCO and resultant report to CMS. Minor discrepancies are brought to the attention of the MCO through regularly scheduled meetings, and in writing for more grievous errors. Identified significant deficiencies will result in request(s) for corrective action plan(s) from the MCO as described within the MCO contract.

### ***5. Health Information Systems***

- (a) Collect data on enrollee and provider characteristics as specified by the State.
- The MCO will be required to maintain a Management Information System (MIS) that will provide support for all aspects of a managed care operation to include the following subsystems: enrollee, third party liability, provider, reference, encounter/claims processing, financial utilization data /quality improvement and surveillance utilization review. The MCO will also be required to demonstrate sufficient analysis and interface capacities. The MCO's MIS must be able to assure medical information will be kept

confidential through security protocol, especially as that information relates to personal identifiers and sensitive services.

- The primary purpose of the MCO Member subsystem is to accept and maintain an accurate, current, and historical source of demographic information on recipients to be enrolled with the MCO.
- The MCO Provider subsystem will contain such items as demographic data, identification of provider type, specialty codes, maintenance of payment information and identification of licensing, credentialing and recredentialing information and monitoring of PCP capacity for enrollment purposes.
- The MCO Financial subsystem function shall encompass claim payment processing, adjustment processing, accounts receivable processing, and all other financial transaction processing. This subsystem ensures that all funds are appropriately disbursed for claim payments and all post-payment transactions are applied accurately. The financial processing function is the last step in claims processing and produces remittance advice statements/explanation of benefits and financial reports.
- The MCO's Financial subsystem shall contain such items as: update of provider payment data, tracking of financial transactions, including TPL recoveries and maintenance of adjustment and recoupment processes.
- The MCO Utilization/Quality Improvement subsystem will have the ability to contain such items as: monitoring of primary care and specialty referral patterns; monitoring and identifying deviations in patterns of treatment from established standards or norms; monitoring encounters in all settings, emergency room use, outpatient drug therapy, EPSDT and out-of-network services; provider profiling; occurrence reporting, including adverse incidents and complications.
- The MCO Surveillance Utilization Review Subsystem (SURS) in accordance with 42 CFR 455, the Contractor shall establish a SURS function which provides the capability to identify potential fraud and/or abuse of providers or members. The SURS component supports profiling, random sampling, groupers (for example Episode Treatment Grouper), ad hoc and targeted queries.

(b) Ensure the data received from providers is accurate and complete.

- The MCO will ensure that data received from providers is accurate and complete by:
  - Verifying, through edits and audits, the accuracy and timeliness of reported data;
  - Screening the data for completeness, logic and consistency, and:
  - Collecting service information in standardized formats to the extent
  - feasible and appropriate.
  - Compiling and storing all claims and encounter data from the subcontractors in a data warehouse in a central location in the Contractor's MIS; and
  - At a minimum, edits and audits must comply with NCCI.

- The MCO will be required to use procedure codes, diagnosis codes and other codes in accordance with guidelines defined by the DMS.
- In the performance of encounter data validation, the contracted EQRO will determine the accuracy and adequacy of claims submitted by the MCO and its subcontractors.

(c) Make all collected data available to the State.

- The MCO will be responsible for complying with the reporting requirements set forth in the Contract and for assuring the accuracy, completeness and timely submission of each report. The MCO will provide such additional data and reports as may be reasonably requested by the DMS.
- The DMS will work with the MCO to resolve problems in obtaining data at all times. The MCO acknowledges its responsibility to provide data on enrolled members upon request.
- The MCO and any subcontractor of the MCO will make all of its books, documents, papers, provider records, medical records, data, surveys and computer databases (collectively "Records") available for examination and audit by the DMS, the Attorney General of the Commonwealth of Kentucky, the Office of Insurance of the Commonwealth of Kentucky, authorized federal or Commonwealth personnel, or the authorized representatives of the governments of the United States and the Commonwealth of Kentucky including, without limitation, any employee, or agent of the DMS, Cabinet for Health Services and CMS.
- At a minimum, the MCO is required to electronically provide encounter data to DMS on a monthly basis. Encounter data must follow the format, data elements, and method of transmission specified by the DMS.
- If the MCO knowingly fails to submit healthcare data derived from processed claims or encounter data as required by the terms of the contract or data from processed claims otherwise specified by the DMS under the the contract, the DMS shall apply penalty.

**K. Detailed information regarding quality measurement and improvement standards, including:**

*1. Description of the methods and timeframes to assess the quality and appropriateness of care and services to all Medicaid beneficiaries*

- Quality Improvement Program: The MCO will implement and operate a continuous internal QI Program that provides for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the MCO.
- Annual Quality Improvement Review: The MCO will annually review, evaluate and modify as necessary, the QI Program, including the medical record program; data collection program and program for checking provider credentials, as well as all QI policies and procedures; clinical care standards;

practice guidelines and patient protocols; provider incentive plans; and program capacity; member utilization of services; access to covered services; and treatment outcomes.

- External Evaluation: DMS or its contracted agent will have the right to conduct periodic audits of the MCO during which DMS will identify and collect management and quality data on the use of services or other information as determined by the DMS. The EQRO will also perform an annual external, independent review of the quality outcomes and timeliness of, and access to, services provided by the MCO.
- Quality Improvement Plan: The Quality Plan itself.
- Healthcare Outcomes: The MCO will be required to implement steps targeted at improvement in either the actual outcomes or processes used to affect those outcomes.
- Performance Improvement Projects (PIPs): The MCO will have programs and processes in place to address the preventive and chronic healthcare needs of its population and sub-populations, including but not limited to, Medicaid eligibility category, type of disability or chronic condition, race, ethnicity, gender and age, as well as an ongoing quality assessment and performance improvement program for the services it furnishes to members. The MCO will conduct PIPs.
- Quality and Member Access Committee: The MCO will establish and maintain an ongoing Quality and Member Access Committee composed of members, individuals from consumer advocacy groups or the community who represent the interests of the member population and public health representatives.
- Utilization Management: The MCO will have a comprehensive Utilization Management (UM) program that reviews services for medical necessity and that monitors and evaluates on an ongoing basis the appropriateness of care and services.
- Adverse Actions: The MCO must give the member written notice, that meets the language and formatting requirements for enrollee materials, of any action (not just service authorization actions) within the timeframes for each type of action.
- Assessment of Member and Provider Satisfaction and Access: The MCO will conduct an annual survey of member and provider satisfaction with the quality of services provided and access to services.
- Reporting Requirements: The MCO will provide reports on the status of the QI program and work plan to the DMS on a quarterly and/or annual basis.
- Cultural Consideration: The MCO will participate in the State's effort to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

***2. An identification of the populations the State will consider when determining individuals with special health care needs.***

- ISHCN are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these individuals so the Contractor can facilitate access to appropriate services.
- As per the requirement of 42 CFR 438.208, the Department has defined the following categories of individuals who shall be identified as ISHCN. The Contractor shall have written policies and procedures in place which govern how members with these multiple and complex physical and behavioral health care needs are further identified. The Contractor shall have an internal operational process, in accordance with policy and procedure, to target members for the purpose of screening and identifying ISHCN's. The Contractor shall assess each enrollee identified as ISHCN in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment process shall use appropriate health professionals. The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations:
  1. Children in/or receiving Foster Care or adoption assistance ;
  2. Blind/Disabled Children under age 19 and Related Populations eligible for SSI;
  3. Adults over the age of 65;
  4. Homeless (upon identification);
  5. Individuals with chronic physical health illnesses; and
  6. Individuals with chronic behavioral health illnesses.
- There will be processes implemented to assess, monitor, and evaluate services to all subpopulations, including but not limited to, the on-going special conditions that require a course of treatment or regular care monitoring, Medicaid eligibility category, type of disability or chronic conditions, race, ethnicity, gender and age.
- The MCO will request all members to complete an initial health risk questionnaire within 90 days of enrollment. The questionnaire process may be conducted by the MCO' staff, through arrangement with the local health departments or by other means. Information to be collected will include demographic, socioeconomic, current health status and behavioral risk questions and be inclusive enough to determine the member's need for care management, disease management, mental health services and/or any other health services. The information collected will identify the health education needs of members and provide the basis for the health education program.

- Certain medically necessary services are provided for recipients under contract with the Commission for Children with Special Health Care Needs and are covered for children identified with special needs. Coverage includes physician, EPSDT, dental, occupational therapy, physical therapy, speech therapy, durable medical equipment, genetic screening and counseling, audiological, vision, case management, laboratory and x-ray, psychological and hemophilia treatment and related services. The Commission treats children with a variety of medical conditions, acquired or congenital. Clinic programs include: Asthma, Juvenile Rheumatoid Arthritis, Burn, Neurology, Cerebral Palsy Neurosurgery, Cleft Lip & Palate, Eye, Craniofacial, Orthopedic, Cystic Fibrosis, Ear, Hand, Reconstructive Surgery, Heart, Scoliosis, Pediatric and Adult (Over 21) Hemophilia, Seizure, Sickle Cell, Spina Bifida.

***2. The state standards for the identification and assessment of individuals with special health care needs.***

- The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for members, identify areas for potential improvement, carry out individual Performance Improvement Projects (PIPs), undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and member satisfaction. While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to a member. Clinical PIPs should address preventive and chronic healthcare needs of members, including the member population as a whole and subpopulations, including, but not limited to Medicaid eligibility category, type of disability or special healthcare need, race, ethnicity, gender and age. PIPs shall also address the specific clinical needs of members with conditions and illnesses that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality, availability, and accessibility of services provided by the MCO to members and providers. Such aspects of service should include, but not be limited to availability, accessibility, cultural competency of services, and complaints, grievances, and appeals.
- The Department strongly encourages the development of collaborative relationships with local health departments, behavioral health agencies and other community based health/social agencies to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives. The Department and the Contractor shall be jointly committed to on-going

collaboration in the area of service and clinical care improvements by the development and sharing of best practices and use of encounter data-driven performance measures.

- The MCO will request all members to complete an initial health risk questionnaire within 90 days of enrollment. The questionnaire may be conducted by the MCOs' staff, through arrangement with the local health departments or by other means. Information to be collected will include demographic, socioeconomic, current health status and behavioral risk questions and be inclusive enough to determine the member's need for care management, disease management, mental health services and/or any other health services. The information collected will identify the health education needs of members and provide the basis for the health education program.
- The MCO must use appropriate health care professionals in the assessment process.
- Case management will be provided by the MCO to members, as appropriate. Additionally, the MCO will provide specialized case management services for members with complex and/or chronic conditions.

***3. Procedures the state will use to separately assess the quality and appropriateness of care and services furnished under the State's MCO Contract to all Medicaid enrollees and to individuals with special health care needs.***

- The DMS requires the MCO to report regularly (quarterly and annually) data and other summary reports to assess the quality and appropriateness of care and services supplied under the MCO Contract to all recipients, including those populations previously identified in this document as special populations.
- Quarterly and annually, the MCO will submit a report on quality assurance activities during the reporting period. A description of the activities such as current or proposed quality improvement projects, updates on these projects including any relevant attachments, results of medical record review(s) or chart abstraction activities for establishing baselines. Included will also be a discussion of the MCO's use of encounter data in monitoring utilization and quality and identification of any problems regarding the completeness and accuracy of the data. The MCO will also report on activities during the reporting period associated with sub-populations and individuals with special healthcare needs.
- The Commonwealth has also contracted with an EQRO who will use the federally approved EQRO protocols to conduct an annual review of MCO compliance with state and federal standards and the state MCO contract. Upon completion of the annual review of the MCO program, the EQRO will produce a detailed technical report that describes the manner in which data from all EQR and EQR related activities were aggregated and analyzed, and conclusions drawn as to the quality, timeliness and access to care furnished by the MCO. The report will also include an assessment of the MCOs' strengths and weaknesses and recommendations for improvement for each of the

activities conducted. This report will be made available by the State to any interested parties.

**4. *A description of the state's information system and how these systems support the initial and ongoing operation and review of the State's quality strategy; for example, a description of how the state intends to use its MMIS and any other system to monitor quality, produce reports on performance indicators, collect data on different quality measures, etc.***

- The MCO will ensure that encounter data is consistent with 42 CFR 434. At a minimum, the MCO will be required to electronically provide encounter data to DMS on a monthly basis. Encounter data must follow the format, data elements and method of transmission specified by the DMS. DMS will process the encounter data through defined edit and audit requirements and reject encounter data that does not meet its requirements.
- The MCO will be required to use procedure codes, diagnosis codes and other codes used for reporting encounter data in accordance with guidelines defined by DMS. The MCO must also use appropriate provider numbers for encounter data as directed by DMS. The encounter data will be received and processed by DMS' fiscal agent and will be stored in the existing MMIS.
- The MCO will ensure that data received from providers is accurate and complete by:
  - Verifying, through edits and audits, the accuracy and timeliness of reported data;
  - Screening the data for completeness, logic and consistency, and:
  - Collecting service information in standardized formats to the extent
  - feasible and appropriate.
  - Compiling and storing all claims and encounter data from the Subcontractors in a data warehouse in a central location in the Contractor's MIS; and
  - At a minimum, edits and audits must comply with NCCI.
- The MMIS performs audits and edits prior to acceptance of encounter data. If there is more than a five percent rejection rate of encounters, the entire submission must be corrected and resubmitted. Audits are performed at the claim level.
- The Commonwealth also has a contract with an EQRO to perform encounter data validation including assessment of the MCO systems.
- Once the encounter data is validated as complete and accurate, the MMIS can generate reports, and the Commonwealth's Decision Support System can utilize Decision Support Software for ad hoc reporting.
- Encounter data is used by Kentucky to:
  - Assess and improve quality of care and services delivered by the MCO
  - Monitor Program integrity
  - Determine capitation rates
  - Calculate performance measures in addition to those reported by the MCO and validated by the EQRO

- Conduct performance improvement projects in addition to those conducted by the MCOs;
- Conduct quality of care focused studies;
- Validate surveys conducted by the MCO;

## **L. State Monitoring and Evaluation**

*1. Arrangements for external quality reviews. A description of the state's arrangements for an annual, independent external quality review of the timeliness, outcomes, and accessibility of the services covered under the MCO contract. This section should include a broad description of the scope of the contract (e.g., calculating HEDIS measures or designing performance improvement projects), including the term of the contract.*

- Effective July 1, 2003 until current, the Commonwealth procured through an enhanced and BBA compliant contract, an EQRO to perform external quality review functions. Therefore, the EQRO has contracted to perform the federally required reviews of access to care, quality of care and the effect of care coordination.
- EQR is the analysis and evaluation by an EQRO of aggregated information on quality, timeliness, and access to the health care services that a MCO or their subcontractors furnish to Medicaid recipients. Requirements and procedures for EQR of Medicaid MCOs are established in the Code of Federal Regulations (42 CFR Parts 433 and 438) Final Rule. Three mandatory activities that must be conducted to provide information for EQR are identified in 42 CFR 438.358, which include the following:
  - the review of compliance with structural and operational standards;
  - the validation of performance measures; and
  - the validation of performance improvement projects.
- States may determine which optional activities are included in the EQR and what types of performance measures and performance improvement projects to require of their contracting MCO. The Final Rule also requires that aggregated information must be obtained from activities that are consistent with protocols, as defined in the rule, to ensure that data to be analyzed are collected using sound methods widely used in the industry. Kentucky has contracted with a single EQRO to perform the mandatory and optional EQR activities. The State has established standards for encounter data accuracy and completeness
- EQRO Reports:
  1. Quarterly Reports containing a summary of EQR activities for the quarter are provided to DMS on a quarterly schedule.
  2. An Annual Report is provided that contains a detailed technical report that describes the manner in which the data from all EQR and EQR related activities were aggregated and analyzed, and conclusions drawn as to the quality, timeliness, and access to care furnished by the MCO. The report will include an assessment of the MCO's strengths and weaknesses and

recommendations for improvement for each of the activities conducted. This report is made available by the State to any interested parties.

**2. *Nonduplication of mandatory external quality review activity***

- To avoid duplication, the State may use in place of a Medicaid review by the State or its agent, or EQRO, information obtained from a Medicare or private accreditation review to provide information otherwise obtained from the mandatory activities specified in 42 CFR 438.360 if the conditions of 42 CFR 438.360 (b) or (c) are met.
- The DMS is currently working with the NCQA Toolkit for States to determine which standards can be deemed as met with accreditation. Once the MCO Contracts have been finalized DMS will submit an updated strategy when all deemed standards are identified.

**M. *Procedures for Race, Ethnicity, and Primary Language***

**1. *A description of how the state identifies the race, ethnicity, and primary spoken language of each Medicaid MCO enrollee and how it will provide this information on each Medicaid enrollee to the MCO at the time of enrollment.***

The Commonwealth identifies the race and primary language of Medicaid MCO enrollees at the time of application for Medicaid at the DCBS local office. Note that currently ethnicity data is intertwined with race data.

**2. *A description of the state's efforts to collect information on ethnicity and primary language spoken for any beneficiaries receiving Supplemental Security Income, as this information is not available from the Social Security Administration.***

SSI data enters through a sister system to KAMES known as State Data Exchange (SDX). The DMS has requested semi-annual reports (Medicaid's limited English proficiency reports) from SDX for the MCOs use.

**3. *An identification of the State's race, ethnicity, and primary language categories, including a description of how it defines and categorizes "ethnicity."***

Kentucky has multiple systems that capture race and primary language categories, but currently has not defined nor captures ethnicity. The race codes that are collected in MMIS are:

- 03 -Pacific Islander/Hawaiian
- 04 -White
- 05 -Black
- 06 -Asian
- 07 -Hispanic

08 -American/Indian  
09-Unknown  
99 -Refused to Answer

The HIPAA compliant KYMMIS code which indicates the recipient's race (16), valid values are:

7 -Not Provided  
8 -Not Applicable  
A -Asian or Pacific Islander  
B -Black  
C -Caucasian  
D -Subcontinent Asian American  
E -Other Race or Ethnicity  
F -Asian Pacific American  
G -Native American  
H -Hispanic  
I -American Indian or Alaskan Native  
J -Native Hawaiian  
N -Black (Non-Hispanic)  
O -White (Non-Hispanic)  
P -Pacific Islander  
Z -Mutually Defined

The KYMMIS does not carry Ethnicity or Primary Language data.

The KAMES system currently carries the following Race (7) codes:

3 -Pacific Islander/Hawaiian  
4 -White  
5 -Black  
6 -Asian  
7 -Hispanic  
8 -American Indian/ Alaskan  
99 -Refused to Answer

The KAMES system currently carries the following Primary Language (8) codes:

1 -English  
2 -Vietnamese  
3 -French  
4 -Spanish  
5 -Italian  
6 -Russian  
7 -Sign Language  
99 -Other

The KAMES system does not carry Ethnicity data.

The SDX system currently carries the following Race (8) codes:

- A -Asian
- B -Black
- H -Hispanic
- I -North American Indian
- N -Negro
- a -Other
- U -Not determined
- W -White

The SDX system currently carries the following Primary Language (27) codes:

- 01 -English
- 02 -Spanish
- 03 -American Sign Language
- 04 -Arabic
- 05- Armenian
- 06 -Cantonese
- 07 -Farsi
- 08 -French 1
- 09 -German
- 10 -Greek
- 11 -Haitian-Creole
- 12 -Hindi
- 13 -Hmong
- 14 -Italian
- 15 -Japanese
- 16 -Khmer
- 17 -Korean
- 18 -Laotian
- 19 -Mandarin
- 20 -Polish
- 21 -Portuguese
- 22 -Russian
- 23 -Samoan
- 24 -Tagalog
- 25 -Vietnamese
- 26 -Yiddish
- 27 -Other

The SDX system does not carry Ethnicity data.

The PA-62 system currently carries the following Race (5) codes:

- 4 -White
- 5 -Black
- 6 -Asian
- 7 -Hispanic

## 8 -American Indian/Alaskan

The PA-62 system does not carry Ethnicity or Primary Language data.

Note: Out of the Kentucky total population of approximately 4.3 million, 120,000 or (2.7%) were identified as Hispanic, the largest ethnic group as identified by the 2010 census.

### **N. National Performance Measures and Levels**

The DMS will draft changes once CMS has adopted the final rule on CHIPA and CHIPRA to the state's quality strategy.

(Note: at this time no national performance measures and levels have been developed. At the point CMS undertakes their development; the States will be consulted in each phase of the development process, including the specification of the level of information to be included in the State's quality strategy.)

### **O. Intermediate Sanctions**

Description of how the Commonwealth uses intermediate sanctions in support of CMS's quality strategy. These sanctions must, at a minimum, meet the requirements specified in 42 CFR 438 Subpart I. The description describes the methodology for using sanctions as a means for addressing identified quality of care problems.

- Requirement of Corrective Action: The DMS may require corrective action in the event that any report, filing, examination, audit, survey, inspection, or investigation should indicate that the MCO, or any subcontractor or supplier is not in compliance with any provision of the contract, or in the event that the DMS receives a substantiated grievance or appeal respecting the standard of care rendered by the MCO, or any subcontractor or supplier. The DMS may also require the modification of any policies or procedures of the MCO relating to the fulfillment of its obligations under the contract. Should the DMS desire to take any such corrective action it must issue a written deficiency notice and require a corrective action plan to be filed by the MCO within fifteen (15) days following the date of the notice. A corrective action plan will delineate the time and manner in which each deficiency is to be corrected. The plan will be subject to approval by the DMS, which may accept the plan as submitted, accept the plan with specified modifications, or reject the plan. The DMS may extend or reduce the time allowed for corrective action depending upon the nature of the deficiency.
- Notice of MCO Breach: If the MCO fails to cure a default in accordance with a plan of correction or comply with Sections 1932, 1903(m) and 1905(t) of the Act, the DMS will issue a written notice to the MCO indicating the violation(s) and advising the MCO that failure to cure the violation(s) within a defined time period not less than thirty (30) days, to the satisfaction of the DMS, may lead to the imposition of any sanction or combination of sanctions provided by the terms of the contract, or

- otherwise provided by law, including but not limited to the following: (a) suspension of further enrollment for a defined time period; (b) suspension of capitation payments; (c) suspension or recoupment of the capitated rate paid for any month for any member who was denied the full extent of covered services meeting the standards set by the contract, or who received or is receiving substandard services; (d) assessment of liquidated damages under the contract; or (e) termination of the contract.
- Health Care Data Sanctions: If the MCO knowingly fails to submit health care data derived from processed claims or encounter data as required by the terms of the contract, the DMS may withhold an amount commensurate with harm but not to exceed ten (10%) percent of the MCO's capitation payment for the month following non-submission of data. The amount withheld will be retained by the DMS until the data is received and accepted by DMS. Any other health care data requested by the DMS or required under the contract, including social and demographic data, will be submitted in accordance with time frames developed by the DMS.
  - Intermediate Sanction and Civil Money Penalties: In the event the MCO fails to comply with the terms and conditions of 42 United States Code Section 1396b(m), the DMS may do any of the following: (a) Appoint temporary management to oversee the MCO if there is a substantial risk to the health of enrollees; (b) Permit individuals to disenroll without cause; (c) Suspend default enrollment; or (d) Suspend payment for new enrollees.
  - Prior to imposing the intermediate sanctions, the DMS must give the MCO timely written notice that explains the basis and nature of the sanction, and any other due process protections that the State elects to provide.
  - Before terminating the contract under 42 CFR 438.708, the DMS must provide the MCO with a pre-termination hearing. The State must give the MCO written notice of its intent to terminate, the reason for termination, and the time and place of the hearing. The DMS must give the MCO, after the hearing, written notice of the decision either affirming or reversing the proposed termination of the contract and for an affirming decision, the effective date of termination of the contract. The DMS must also give members notice of the termination, and information consistent with 42 CFR 438.10, on their options for receiving Medicaid services following the effective date of termination.
  - The DMS may impose civil money penalties for the circumstances set forth below if the MCO does any of the following: (a) Fails substantially to provide medically necessary items and services that are required under law and under applicable Contracts; (b) Imposes excess premiums and charges; (c) Acts to discriminate among members; (d) Misrepresents or falsifies information; (e) Violates marketing guidelines.