KENTUCKY CABINET FOR
HEALTH AND FAMILY SERVICES

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

Fiscal Year 2022 Comprehensive Evaluation Summary Commonwealth of Kentucky Strategy for Assessing and Improving the Quality of Managed Care Services

FINAL
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Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

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Introduction

This report presents a comprehensive evaluation and progress summary of the accountability strategy, monitoring mechanisms and compliance assessment system of the Kentucky Medicaid managed care (MMC) program.

Authorizing legislation and regulation for state MMC programs include the Social Security Act (SSA; Part 1915[1] and Part 1932(a)[2]), the Balanced Budget Act of 1997 (BBA),[3] and Title 42, Part 438 of the Code of Federal Regulations (CFR).[4] On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule* in the Federal Register.[5] The Final Rule modernized MMC regulations to reflect changes in the usage of managed care delivery systems and seeks to align Medicaid rules with those of other health insurance coverage programs, modernize how states purchase managed care for beneficiaries, and strengthen consumer experience and consumer protections.

According to federal regulation (42 CFR§438.340 et seq.),[6] all states that contract with a managed care organization (MCO) or prepaid inpatient health plan (PIHP) are required to have a written strategy for assessing and improving the quality of managed care services provided to Medicaid enrollees. Kentucky's first quality strategy was published in September 2012 and included the program descriptions as were then required by federal regulation. With the advent of the Final Rule, new guidelines for state quality strategies were outlined by CMS in the Federal Register.

Kentucky's Department of Medicaid Services (DMS) drafted an updated strategy entitled *Strategy for Assessing and Improving the Quality of Medicaid Managed Care Services,* dated July 2019.[7] Posted on the DMS website, Kentucky's 2019 Quality Strategy identifies five program goals:

Goal 1. Reduce the burden of substance use disorder (SUD) and engage enrollees to improve behavioral health (BH) outcomes.
Goal 2. Reduce the burden of and outcomes for chronic diseases.
Goal 3. Increase preventive service use.
Goal 4. Promote access to high quality care and reduce unnecessary spending.
Goal 5. Improve care and outcomes for children and adults, including special populations.

The intent of this summary report is to review and describe the quality monitoring and management of Kentucky's MMC Program by using updated information, reports, and interviews conducted during the period July 1, 2021, through June 30, 2022. As part of the introduction, recent developments in Kentucky's MMC Program are discussed including a description of program monitoring responsibilities and evaluation methodology.

Medicaid Managed Care in Kentucky – Recent Progress

In 2011, Kentucky initiated a procurement process to contract with MCOs to provide services for Medicaid enrollees statewide. The Patient Protection and Affordable Care Act (ACA) allowed DMS to further expand Medicaid eligibility in 2014.

Effective January 1, 2021, DMS entered into new contracts with six risk-based MCOs serving Kentucky Medicaid enrollees statewide: Aetna Better Health of Kentucky (Aetna), Anthem Blue Cross and Blue Shield (Anthem), Humana Healthy Horizons in Kentucky (Humana), Molina Healthcare of Kentucky (Molina), UnitedHealthcare Community Plan (UHC), and WellCare of Kentucky (WellCare). Molina took over operation of Passport Health Plan (Passport) and contracted with the Kentucky MMC Program as of January 1, 2021. UHC, contracting with the Kentucky MMC Program for the first time as of January 1, 2021, did not submit performance data for measurement year (MY) 2020. UHC and Molina submitted performance improvement project (PIP) baseline reports and also participated in a compliance review in October 2021.

Between April 2020 and April 2022, statewide program enrollment increased by 17.5%, with all MCOs experiencing enrollment growth. Anthem saw the largest percent increase in enrollment of 24.2%, while Passport by Molina had the

lowest percent increase of 8.1%. On 1/1/2021, UHC began managing the presumptive eligible population that was being covered by the fee-for-service (FFS) population in 2020 (**Table 1**).

Table 1: Kentucky Medicaid MCO Enrollment

MCO	Enrollment 4/2020	Enrollment 4/2021	Enrollment 4/2022	Percent Change 2020-2022
Aetna	211,220	244,373	242,842	15.0%
Anthem	136,633	159,978	169,646	24.2%
Humana	147,788	167,293	166,552	12.7%
Passport by Molina[1]	303,197	324,486	327,839	8.1%
UHC	N/A	140,251	67,264	N/A
WellCare	441,271	472,939	482,535	9.4%
Total	1,240,109	1,509,320	1,456,678	17.5%

[1] Passport Health Plan was purchased by Molina Healthcare of Kentucky effective 1/1/2021. Enrollment presented for 4/2020 is for Passport Health Plan, while enrollment as of 4/2021 is for the newly contracted MCO referred to as Passport Health Plan by Molina Healthcare.
Source: Cabinet for Health and Family Services, Kentucky Data Warehouse Monthly Membership Counts by County; run dates respectively, 4/1/2020, 4/1/2021 and 4/6/2022.
MCO: managed care organization; UHC: UnitedHealthcare Community Plan. N/A: not applicable, UHC was not a Kentucky MCO during 2020.

Responsibility for Program Monitoring

Within Kentucky's Cabinet for Health and Family Services (CHFS), DMS oversees the Kentucky MMC Program and is responsible for contracting with Medicaid MCOs, monitoring their provision of services according to federal and state regulations, and overseeing each MCO's quality program. DMS contracts with an external quality review organization (EQRO), IPRO, to assist the state in conducting external quality reviews (EQRs) and evaluations of state and MCO quality performance and improvement.

Within DMS, the Division of Program Quality and Outcomes (DPQ&O) is composed of three branches: Disease and Case Management Branch, Managed Care Oversight – Quality Branch, and Managed Care Oversight – Contract Management Branch. Information regarding DPQ&O branch responsibilities and reports can be accessed on the DMS website.[8]

- The Disease and Case Management Branch of DPQ&O monitors Kentucky MCOs to ensure members have access to quality services through effective disease and case management practices. Working closely with other agencies within DMS, staff provide a broad range of monitoring and coordinating functions, including reviewing and monitoring both MCO and FFS disease and case management programs and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. They coordinate external independent third party review and fair hearing requests for the denial of Medicaid services.
- The Managed Care Oversight – Quality Branch is responsible for oversight and monitoring of the EQRO contract and the Kentucky EQRO Annual Work Plan. They analyze healthcare effectiveness data and information regarding Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys of each participating MCO. They oversee the conduct of two annual focus studies and monitor and review MCO PIPs. The branch is responsible for producing various reports showing MCO performance in relation to healthcare quality and outcomes and offering suggestions to improve MCO quality of care and health outcomes per CMS guidelines.
- The Managed Care Oversight – Contract Management Branch of DPQ&O is responsible for all areas of contract compliance oversight, including the review of encounter reports, issuance and follow-up of letters of concern or corrective action plans and assessing penalties as necessary. Staff reviews MCO marketing and outreach documents and ensures a subject matter expert also reviews prior to MCO utilization. Responsibilities also include oversight of the MCO encounter file submission and resubmission, conducting MCO provider network adequacy reviews, maintaining MCO contact directories, and conducting onsite and offsite contract compliance audits. Additionally, they facilitate monthly MCO operations meetings, assist colleagues in MCO contractual obligations specifically required for program and project activities, and monitor monthly, quarterly, and annual MCO reports.

During this contract year, the 2019 novel coronavirus (COVID-19) pandemic resulted in many challenges for both DMS and the MCOs. DMS reported they were able to use all available tools to make sure they stayed in touch with the MCOs and were able to maintain their monitoring and oversight responsibilities once staff were set up to telecommute. All MCO quality departments also effectively transitioned staff to telecommuting. There were several staff changes within the MCO quality departments, but most positions were reported to have been filled. One MCO discussed the challenges they faced during COVID-19 in adding a team of community health workers (CHWs) during home-based work.

Evaluation Methodology

The methodology for this report includes a review of EQR report documents, including compliance review results, validation reports for encounter data, provider networks, and PIPs. Reports from other EQR activities such as access and availability surveys and focus clinical studies were also reviewed and key findings summarized for this evaluation. Data analysis of core measures identified in the 2019 Quality Strategy was conducted using statewide aggregate quality performance data from the Healthcare Effectiveness Data and Information Set (HEDIS®) MY 2020 and benchmarks obtained from the National Committee for Quality Assurance (NCQA) *Quality Compass®*.

An additional component of this evaluation approach is the perspective gained from conference call interviews with key quality staff in DMS and in the MCOs. Dialogue with MCO staff allows the reviewers to obtain insights and information not available in written reports and helps clarify the relationships between the MCOs, state, and the EQRO. Interviews were held with staff from DMS, Aetna, Anthem, Humana, Passport by Molina, WellCare, and UHC.

Core Program Performance Results

This section of the evaluation presents a trend analysis of statewide performance rates based on the goals and core measures selected for the 2019 Quality Strategy. Denominators and change in rates between measurement years 2018 and 2020 are presented for each measure, along with a benchmark designation of how Kentucky's HEDIS MY 2020 statewide rates compare to a percentile ranking from the NCQA *Quality Compass Medicaid*.[9]

NCQA's *Quality Compass Medicaid* is derived from HEDIS data submitted to NCQA by Medicaid MCOs throughout the nation. Using these standardized measures as benchmarks allows states to make meaningful comparisons of their rates to the rates for all reporting MMC MCOs nationwide, and thus allows state policy creators to better identify program strengths and weaknesses and target areas most in need of improvement (**Table 2**).

Table 2: HEDIS Rate Categories and NCQA Quality Compass National Percentiles

Rate Category	HEDIS 2020 Rate Comparison to NCQA Quality Compass National Percentiles
< 25	Below the national Medicaid 25th percentile
> 25	At or above the national Medicaid 25th percentile but below the 50th percentile
> 50	At or above the national Medicaid 50th percentile but below the 75th percentile
> 75	At or above the national Medicaid 75th percentile but below the 90th percentile
> 90	At or above the national Medicaid 90th percentile
N/A	No national benchmarks available for this measure

HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance.

It is important to note that trending HEDIS measures over time may not always be advisable. In February 2021, NCQA released trending determinations for HEDIS MY 2020 measures that had specification changes, which could affect trending. For these measures, one of two trending determinations is recommended:

1. allow trending with caution (specification changes may cause fluctuation in results compared to the prior year); or
2. do not allow trending; the specification changes, such as altering the eligibility or numerator definitions are significant enough to affect the trending results if the HEDIS MY 2020 rate is compared to earlier years.

For the 2019 Quality Strategy Core Measures that follow, there are 13 measures indicated where trending results should be viewed with caution. There are also four measures that are not trended due to significant changes in the measure specifications in MY 2020. **Table 3** presents statewide average data for Kentucky's MMC Program for MY 2018–2020, as outlined in the *Strategy for Assessing and Improving the Quality of Medicaid Managed Care Services*.[10]

Table 3 presents the statewide HEDIS measures listed in the 2019 Quality Strategy. The clinical measures, many of which are drawn from the National Quality Forum (NQF)[11] data set, were not collected in MY 2020. Overall, there were 41 measures evaluated, including 16 discrete measures and 9 measures with two or more sub-categories. Fourteen (14) measures were trendable; of these, 7 (50%) showed improvement in rates between HEDIS MY 2018 and MY 2020, while the other 7 measures (50%) did not show improvement. The remaining measures were either noted by NCQA as not trendable, to be considered with caution, were retired or significantly revised.

Of the 35 measures that could be compared to national benchmarks, rates for 2 of the 35 measures (6%) met or exceeded the national 50th percentile, 5 of the 35 measures (12%) met or exceeded the national 75th percentile, while 15 measures (43%) met or exceeded the national 25th percentile, but were below the national 50th percentile, and another 13 measures (37%) were below the national 25th percentile (**Table 3**).

Table 3: Kentucky Quality Performance Core Measures – Trend and Benchmark Comparison, HEDIS MY 2018–2020

Measure	Goal[1]	Data[2] Admin (A) or Hybrid (H)	Kentucky HEDIS Rate Denominators MY 2018	MY 2019	MY 2020	Kentucky HEDIS Statewide Averages[3] MY 2018	MY 2019	MY 2020	Trend[4] Percentage Point Change HEDIS MY 2018 to MY 2020	Benchmark Kentucky HEDIS MY 2020 vs. National Percentile
Antidepressant Medication Management (AMM)										
AMM: Effective Acute Phase Treatment	1	A	29,645	31,599	32,112	51.49%	51.58%	53.65%	2.16	> 25
AMM: Effective Continuation Phase Treatment	1	A	29,645	31,599	32,112	35.11%	35.04%	37.49%	2.38	> 25
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET) denominator[7]										
IET: Initiation of Treatment: Total	1	A	51,439	49,028	48,495	45.71%	51.12%	51.39%	NT	> 75
IET: Engagement of Treatment: Total	1	A	51,439	49,028	48,495	21.69%	26.28%	25.87%	NT	> 90
Use of Opioids at High Dosage (HDO)[5, 4]	1	A	50,483	39,278	37,715	1.30%	1.91%	1.67%	0.37	> 75
Controlling High Blood Pressure (CBP)[7]	2	H	2,055	2,055	2,055	56.48%	56.48%	54.67%	NT	> 25
Comprehensive Diabetes Care (CDC)										
CDC: Hemoglobin A1c (HbA1c) Testing	2	H	2,976	3,008	2,055	87.38%	88.03%	84.04%	-3.34	> 25
CDC: HbA1c Poor Control (> 9.0%)[5, 4]	2	H	2,976	3,008	2,055	48.19%	47.96%	46.80%	-1.39	< 25
CDC: HbA1c Control (< 8.0%)	2	H	2,976	3,008	2,055	41.89%	42.82%	42.53%	0.64	< 25
CDC: HbA1c Control (< 7.0%)	2	H	2,198	2,198	RT	30.98%	31.09%	RT	RT	RT
CDC: Eye Exam (Retinal) Performed[4]	2	H	2,976	3,008	2,055	50.63%	50.70%	48.70%	-1.93	< 25
CDC: Medical Attention for Nephropathy[4]	2	H	2,976	3,008	RT	90.01%	89.65%	RT	RT	RT
CDC: Blood Pressure Control (< 140/90mmHg)[7]	2	H	2,976	3,008	2,055	59.73%	59.66%	60.43%	NT	> 25
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	2	A	7,712	7,713	7,516	30.78%	28.81%	23.31%	-7.47	> 25
Pharmacotherapy Management of COPD Exacerbation (PCE; 2 measures)										
PCE: Systemic Corticosteroid	2	A	10,204	9,931	7,439	65.87%	67.54%	64.88%	-0.99	> 25
PCE: Bronchodilator	2	A	10,204	9,931	7,439	76.55%	76.73%	76.60%	0.05	< 25
Medication Management for People with Asthma (MMA): Total – Medication Compliance 75%	2	A	15,051	14,603	RT	42.34%	42.61%	RT	RT	RT

Measure	Goal[1]	Data[2]	Kentucky HEDIS Rate Denominators			Kentucky HEDIS Statewide Averages[3]			Trend[4]	Benchmark
		Admin (A) or Hybrid (H)	MY 2018	MY 2019	MY 2020	MY 2018	MY 2019	MY 2020	Percentage Point Change HEDIS MY 2018 to MY 2020	Kentucky HEDIS MY 2020 vs. National Percentile
Statin Therapy for Patients with Cardiovascular Disease (SPC) [4]										
SPC: Received Statin Therapy Total	2	A	11,304	11,453	11,520	75.98%	77.38%	76.02%	0.04	> 25
SPC: Statin Adherence 80% Total	2	A	8,581	8,852	8,748	65.03%	66.69%	69.93%	4.9	> 25
Adult BMI Assessment (ABA)	3	H	1,992	1,992	RT	90.29%	90.72%	RT	RT	RT
Cervical Cancer Screening (CCS)[4,6]	3	H	2,039	2,055	1,613	58.86%	58.86%	55.70%	-3.16	> 25
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) [4]										
WCC: BMI Percentile Total	3	H	2,055	2,055	2,036	82.65%	80.90%	67.93%	-14.72	> 50
WCC: Counseling for Nutrition Total	3	H	2,055	2,055	2,036	61.98%	61.44%	52.30%	-9.68	< 25
WCC: Counseling for Physical Activity Total	3	H	2,055	2,055	2,036	54.93%	55.53%	50.08%	-4.85	< 25
Childhood Immunization Status: Combination 3 (CIS)	3, 5	H	2,055	2,055	2,055	71.02%	70.78%	70.65%	-0.37	> 25
Breast Cancer Screening (BCS) [4]	3	A	50,618	52,094	55,415	51.90%	50.84%	46.90%	-5.00	< 25
Chlamydia Screening in Women (CHL) Total	3	A	54,123	52,708	54,421	55.21%	55.23%	52.99%	-2.22	> 25
Immunizations for Adolescents (IMA)										
IMA: Human Papillomavirus Vaccine for Female Adolescents (HPV)	3	H	2,055	2,055	2,055	33.01%	34.80%	34.49%	10.93	> 25
Annual Dental Visit (ADV)	3	A	456,040	449,035	479,030	59.52%	48.39%	42.44%	-12.25	< 25
Well-Child Visits in the First 15 Months of Life ≥ 6 Visits (W15)[6, 4]	3, 5	H	1,931	1,912	34,902	63.02%	65.46%	57.87%	RV	RV
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) [4]	3, 5	H	1,903	1,903	RT	67.42%	67.42%	RT	RT	RT
Follow-up After Hospitalization for Mental Illness (FUH) [4]										
FUH: 7-Day Follow-up	4	A	12,329	11,047	11,493	35.12%	36.72%	37.77%	2.6	> 25
FUH: 30-Day Follow-up	4	A	12,329	11,047	11,493	55.97%	57.27%	58.77%	2.8	> 25
Appropriate Testing for Children with Pharyngitis (CWP) [4]	4	A	33,531	146,677	125,416	83.52%	80.97%	81.05%	-2.47	> 50
Appropriate Treatment for Children with URI (URI)	4	A	36,753	177,467	157,337	75.35%	71.12%	73.02%	-2.33	< 25
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	4	A	18,376	48,502	41,229	23.64%	34.28%	37.59%	13.95	< 25

Measure	Goal[1]	Data[2]	Kentucky HEDIS Rate Denominators			Kentucky HEDIS Statewide Averages[3]			Trend[4]	Benchmark
		Admin (A) or Hybrid (H)	MY 2018	MY 2019	MY 2020	MY 2018	MY 2019	MY 2020	Percentage Point Change HEDIS MY 2018 to MY 2020	Kentucky HEDIS MY 2020 vs. National Percentile
Use of Imaging Studies for Low Back Pain (LBP)	4	A	23,230	21,687	19,582	60.86%	65.25%	67.07%	6.21	< 25
Follow-up Care for Children Prescribed ADHD Medication (ADD)[4]										
ADD: Initiation Phase	5	A	7,756	8,024	8,057	46.45%	51.41%	51.94%	5.49	> 75
ADD: Continuation and Maintenance (C&M) Phase	5	A	2,354	2,473	2,347	57.22%	63.32%	61.27%	4.05	> 75
Prenatal and Postpartum Care (PPC)[4]										
PPC: Timeliness of Prenatal Care	5	H	2,051	2,051	2,055	82.09%	83.97%	83.80%	1.71	< 25
PPC: Postpartum Care	5	H	2,051	2,051	2,055	60.21%	65.63%	75.18%	14.97	< 25

[1] Kentucky's 2019 Quality Strategy identified five program goals: Goal 1. Reduce the burden of substance use disorder (SUD) and engage enrollees to improve behavioral health outcomes; Goal 2. Reduce the burden of and outcomes for chronic diseases; Goal 3. Increase preventive service use; Goal 4. Promote access to high quality care and reduce unnecessary spending; and Goal 5. Improve care and outcomes for children and adults, including special populations.

[2] A: administrative measures use claims/encounters for hospitalizations, medical office visits, and procedures or pharmacy data. H: hybrid measures combine data obtained from the member's medical record with administrative data.

[3] The statewide average is weighted by adjusting for managed care organization (MCO) enrollment size and is referred to as the weighted statewide average. Weighting the rates by eligible population sizes ensures that the rate for the MCO with more members has a proportionately greater impact on the overall statewide weighted average rate than the rate for an MCO with fewer members.

[4] Due to changes in the measure, trending should be viewed with caution as per the National Committee for Quality Assurance (NCQA).

[5] A lower rate is better.

[6] Humana reported administrative for this measure in Healthcare Effectiveness Data and Information Set (HEDIS) measurement year (MY) 2020.

[7] Break in trending for all product lines due to significant changes to the measure during reevaluation.

NR: not reported; RT: retired; NT: not trendable; RV: revised measured; BMI: body mass index.

Goal 1: Reduce Burden of Substance Use Disorder and Engage Enrollees to Improve Behavioral Health Outcomes

There are five HEDIS measures in Goal 1. The two IET measures, Initiation and Engagement of AOD Abuse and Dependence Treatment, increased steadily over the last 3 years, although they are not trendable due to significant changes to the measure. The two rates for Antidepressant Medication Management (AMM) also showed an increase over the last three years. The Use of Opioids at High Dosage (HDO) measure resulted in a rate that met or exceeded the national 75th percentile, but was below the 90th percentile. It was not trendable over the last few years due to changes in the specification. Both of the AMM measures were at or above the national 25th percentile, but below the 50th percentile.

Goal 2: Reduce the Burden of Outcomes for Chronic Diseases

Measures of chronic disease continue to perform poorly. Of the 14 measures for this goal, 3 measures were not reported for this period due to measure retirement and 2 were not trendable. Only 3 of the remaining 9 showed improvement between HEDIS MY 2018 and HEDIS MY 2020, and the improvement was minimal. Of the Goal 2 measures, seven were rated at or above the national 25th percentile, but below the 50th percentile, and four measure rates were below the national 25th percentile. None of the measures were at or above the 50th percentile.

Goal 3: Increase Preventive Service Use

Kentucky's performance in preventive service did not show improvement between HEDIS MY2018 and MY 2020, with only one measure improving between that time (Human Papillomavirus Vaccine for Female Adolescents [HPV]). Only 1 of 9 (11%) of the Goal-3 measures had a HEDIS MY 2020 rate that was at or above the national 50th percentile, but below the national 75th percentile, leaving opportunities for improvement in the other eight measures, including four measures with HEDIS MY 2020 rates below the national 25th percentile. Three of the measures were not recorded for this period.

Goal 4: Promote Access to High Quality Care and Reduce Unnecessary Spending

Four of the six measures associated with Goal 4 showed improvement in rates between HEDIS MY 2018 and HEDIS MY 2020. One of the six measures, Appropriate Testing for Children with Pharyngitis (CWP), had a HEDIS MY 2020 rate that was at or above the national 50th percentile, but below the national 75th percentile. Rates for both Follow-up After Hospitalization for Mental Illness (FUH) measures (7-Day Follow-up and 30-Day Follow-up) were at or above the national 25th percentile, but below the 50th percentile, and the three other measures (Appropriate Treatment for Children with URI [URI], Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis [AAB], and Use of Imaging Studies for Low Back Pain [LBP]) had HEDIS MY 2020 rates below the national 25th percentile.

Goal 5: Improve Care and Outcomes for Children and Adults, Including Special Populations

There were seven HEDIS measures in Goal 5, including three measures that were also considered in Goal 3 (CIS, W15, and W34). Of these seven measures, four saw an increase between HEDIS MY 2018 and HEDIS MY 2020, one a decrease, and two were not measured during this period. The two submeasures for ADD had a rate at or above the national 75th percentile but below the 90th percentile.

It should be noted data collection during the pandemic was a challenge for all the MCOs in MY 2020 due to the COVID-19 pandemic. Using remote access, medical record retrieval was hindered by physician offices that were often closed and by an overall decrease in utilization of services.

Discussion of Core Program Performance Results

A closer look at the selected core measures should be considered as Kentucky moves forward in evaluating the effectiveness of the 2019 Quality Strategy in meeting the five goals. In preparing this analysis, several limitations in the Core Measures listed in the 2019 Quality Strategy[12] were identified. HEDIS measures and clinical measures are listed as indicators for each goal. The clinical measures from the NQF had not been collected by Kentucky Medicaid MCOs for MY 2020 and were not available for analysis in this report. When possible, equivalent HEDIS measures were used in this analysis for the following measures listed in the strategy (**Table 4**).

Table 4: HEDIS MY 2020 Measures Substituted for National Quality Forum Clinical Measures

Goal	Clinical Measures	HEDIS MY 2020 Measures Used
1	Screening for Clinical Depression and Follow-up Plan (NQF 418)	No HEDIS equivalent for MY 2020
2	Statin Therapy for Patients with Cardiovascular Disease (CMS 347v1eCQM)	Statin Therapy for Patients with Cardiovascular Disease (SPC)
2	Diabetes Care: Hemoglobin (HbA1c) Poor Control (> 9.0%) (NQF 59)	CDC: HbA1c Poor Control (> 9.0%)
2	Controlling High Blood Pressure (Hypertension) (NQF 18)	Controlling High Blood Pressure (CBP)
3	Breast Cancer Screening (NQF 2372)	Breast Cancer Screening (BCS)
3	Colorectal Cancer Screening (NQF 32)	Not collected for Medicaid in MY 2020
3	Tobacco Use: Screening and Cessation (NQF 28)	No HEDIS equivalent for MY 2020
3	Body Mass Index (BMI) Screening and Follow-up (NQF 42)	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC: BMI Percentile Total); no HEDIS equivalent for Follow-up
3	Childhood Immunization Status (NQF 38)	Childhood Immunization Status: Combination 3 (CIS)
3, 5	Well-Child Visits, 3–6 years and first 15 months (NQF 1516)	Replaced by Child and Adolescent Well-Care Visits and Well-Child Visits in the First 30 Months of Life (W30)
3, 5	Well-Child Visits, First 15 months (NQF 1392)	Replaced by Child and Adolescent Well-Care Visits and Well-Child Visits in the First 30 Months of Life (W30)
4	Medication Reconciliation Post-Discharge (NQF 97)	No HEDIS equivalent for MY 2020
4	30-day All Cause Readmissions (NQF 1768)	Not collected in Kentucky for MY 2020

HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year.

Four listed HEDIS measures have been retired by NCQA. No current data is available for these measures:

- Adult BMI Assessment (ABA)
- Medication Management for People with Asthma (MMA): Total – Medication Compliance 75%
- CDC: Medical Attention for Nephropathy
- CDC: HbA1c Control (< 7.0%)

Two measures, Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) and Well-Child Visits in the First 15 Months of Life > 6 Visits (W15) were replaced by Child and Adolescent Well-Care Visits (WCV) and Well-Child Visits in the First 30 Months of Life (W30), respectively.

The HEDIS data set has been standardized and validated over the years, including the availability of national level comparisons through the NCQA Medicaid *Quality Compass*; thus, using the above-listed HEDIS equivalents for some of the clinical measures in the Quality Strategy is appropriate. There are, however, no HEDIS MY 2020 equivalents for three clinical measures, while two have equivalent HEDIS measures listed in the strategy, but were not collected in MY 2020. DMS has addressed this limitation with the creation of the QM-03 Report. Using a Microsoft® Excel® spreadsheet format, MCOs will submit rate data for HEDIS and Kentucky-specific measures aligned with the 2019 Quality Strategy measures.

The strategy also notes that DMS will establish state-level baselines for all reported measures and set state-level performance thresholds for each measure using the baseline data as they continue to evaluate the effectiveness of the MMC Program in meeting the goals set forth in this strategy. This is now being addressed in the QM-03 reporting tool as follows: Benchmark Goal, Annual HEDIS Rate and Quarterly Rate Target – In state fiscal year (SFY) 4th quarter, include the annual HEDIS rate for the most recently concluded calendar year (CY) as soon as results are available and no later than August 15th of each year. For the annual HEDIS rate for each measure, set benchmark goal to exceed previous year Quality Compass percentile results for the measure's most recent available annual HEDIS rate. For each quarterly

administrative rate target, set goal to increase the prior CY quarter rate by a minimum of 2 percentage points in the same quarter in the current CY.

Quality Monitoring

This section describes and assesses the review and quality monitoring activities of Kentucky DMS and Kentucky's EQRO.

Data Reporting Systems Review

The Medicaid MCOs in Kentucky are required to maintain a management information system (MIS) to support all aspects of managed care operation including member enrollment, encounter data, provider network data, quality performance data, as well as claims and surveillance utilization reports, to identify fraud and/or abuse by providers and members. The MCO-specific data submitted to DMS in required monthly, quarterly, and annual reports also provide critical information to assist DMS in quality monitoring. MCOs verify, through edits and audits, the accuracy and timeliness of the information contained in their databases. They are expected to screen for data completeness, logic, and consistency. The data must be consistent with procedure codes, diagnosis codes and other codes as defined by DMS, and in the case of HEDIS data, as defined by NCQA.

Of the data submitted to DMS, the EQRO is responsible for validating provider network data and aggregating and reviewing quality performance data.

Provider Network Data

MCO provider networks must include a sufficient number of providers and provider types to deliver contracted services to their target Medicaid populations and meet state and federal network adequacy and accessibility standards. DMS requires the EQRO to audit the provider information submitted by the Kentucky MCOs.

The EQRO completed a recent audit of Kentucky's provider network submissions and web-based directories:

- Managed Care Provider Network Submissions: Final Report December 2021; and
- Web-Based Provider Directory Validations: Final Report March 2021.

FY 2021 Validation of Managed Care Provider Network Submissions: Audit Report – Final Report December 2021

In August 2021, six MCOs (Aetna, Anthem, Humana, Molina, UHC, and WellCare) submitted electronic files to IPRO containing their provider directory data for the most recent month. Random sampling of 84 primary care providers (PCPs) and 83 specialists was performed for each MCO, resulting in a total sample size of 1,002 providers.

The audit was conducted as a two-phase mail survey. A total of 1,002 providers were sent a survey on August 26, 2021. The second mailing was sent on November 1, 2021 to the 890 providers who did not respond to the first mailing, excluding surveys that were returned as undeliverable. The analysis started in mid-December 2021. The analyses were conducted to address the objectives of this study: response rate calculations; accuracy rates on all survey items; comparison of August 2021 and November 2021 results; and comparisons of PCPs and specialists on all applicable survey items.

There were 164 surveys returned, yielding a response rate of 16.4%. PCPs responded at a slightly higher rate than specialists, at 17.3% and 15.6%, respectively. Response rates ranged from 9.8% for Aetna to 26.9% for Humana. Aetna had the highest accuracy rate of 84.6%, followed by WellCare at 80.0%, Molina at 72.2%, UHC at 66.7%, Anthem at 50.0%, and Humana at 16.7%.

Recommendations from the provider network submissions audits suggested that DMS follow up with MCOs to correct provider records for the errors identified in the survey, that they work with the MCOs to enhance the accuracy and completion of critical fields in the provider directory data files, and they expand the data dictionary to include more specificity in the definitions of the date elements to help facilitate MCOs' submission of accurate and complete data.

FY 2021 Web-Based Provider Directory Validation Study #1 Summary Report, Final Report, January 2022

Validation of each MCO's web-based provider directory was conducted by the EQRO to ensure that enrollees are receiving accurate information regarding providers, thus enabling them to contact their providers and schedule appointments that are timely and within easy access to their homes.

The objectives of this study were two-fold:

1. assess that all providers included in the MCO provider files are displayed in the web-based provider directory; and
2. ensure that provider information published in the MCO web directories is consistent with the information reported in the MCO file and/or the provider network survey responses.

Using the provider network data files submitted by the six MCOs in August 2021, a random sample of 167 providers from each MCO, i.e., 84 PCPs and 83 specialists, were selected. The web-based provider network audit showed overall accuracy rates of 84% of sampled PCPs across all the plans, and 91% of sampled specialists had accurate information published in the web directories. Aetna had the lowest overall accuracy rate for PCPs (25%) while Anthem had the highest rate at 92%. Passport by Molina had the lowest overall accuracy rate for specialists (40%), while four of the remaining five MCOs had an accuracy rate of 100% for specialists.

It was recommended that DMS follow up with MCOs to ensure that any inaccuracies in provider information from this validation study and the provider network survey are corrected, and those corrections are reflected in the MCOs' provider files and the web directories; work with MCOs to enhance the accuracy and completion of critical fields in the MCO provider files, especially with respect to phone numbers and addresses; and, work with MCOs to enhance the accuracy of the web directories, emphasizing the importance of ensuring that the members have access to the most up-to-date provider information online.

Quality Performance Data

Quality performance data provide the basis for quality management and improvement activities. In Kentucky, the HEDIS and CAHPS quality performance data sets are collected annually by DMS. MCOs are responsible for contracting with a certified HEDIS auditor to conduct an NCQA-approved audit prior to submitting their HEDIS and CAHPS data to DMS. For HEDIS MY 2020, all effectiveness of care, access and availability, dental access, and utilization measures were required to be submitted.

Quality performance data validation and results are presented in the following EQRO documents:

- 2022 Guide to Choosing Your Health Plan; and
- 2022 External Quality Review Technical Report.

2022 Guide to Choosing Your Health Plan

This guide, sometimes referred to as an "annual report card," was developed by the EQRO in collaboration with DMS to provide quality performance information for individuals who are choosing a Medicaid MCO. This document is prepared annually and provided to Medicaid beneficiaries during the annual open enrollment period.

The format for 2022 is a two-page document with an MCO comparison of quality metrics for five performance areas: Getting Care; Children and Adolescent Wellness; Satisfaction with MCO Services; Women's Health; and Treatment. Each area is further defined by a brief list of what information is evaluated. This tool is a consumer-friendly document that assesses each MCO's performance by the number of stars shown (i.e., 5 stars represents highest performance, 4 stars high performance, 3 stars average performance, 2 stars low performance, and 1 star represents lowest performance). There are also five questions to ask when trying to determine which MCO one should choose and a list of MCO phone numbers and website addresses. Quality ratings were determined for five Kentucky Medicaid MCOs using MY 2020 performance data. UHC was not in the Kentucky MMC Program in 2020 and did not report PMs in 2021.

All MCOs showed average or better performance for two of the five metrics, namely Getting Care and Satisfaction with MCO Services. WellCare had two metrics rated highest performance (Getting Care; and Satisfaction with MCO Services), and Humana had one metric rated highest performance (Satisfaction with MCO Services) and a second metric rated high performance (Getting Care). Aetna and Anthem each had two metrics with high performance (Getting Care and Satisfaction with MCO Services). Molina had one metric rated high performance. All Kentucky MCOs showed low performance for the Children and Adolescent Wellness metric as indicated by 2 stars for each MCO. Four of the five MCOs had low performance scores for Women's Health, and three of the five MCOs had low performance ratings for Treatment.

Annually, DMS, in collaboration with the EQRO, has revised the content and format of the report. In light of the Final Rule requirement for MMC programs to develop and publish an annual Quality Rating System (QRS) report, DMS will need to further evaluate the content and format of this annual report card.

During the MCO interviews, all MCOs thought it was a good scorecard for the members. The usage of NCQA methodology was a positive.

Below are some of the suggestions for future report cards.

- Align the report card with the updated quality strategy.
- One MCO would like to see a focus on well-child and chronic conditions, and a reduction in the number of measures.

2021 External Quality Review Technical Report

The BBA requires state agencies that contract with Medicaid MCOs to prepare an annual external, independent review of quality outcomes, timeliness of, and access to healthcare services. The 2022 External Quality Review Technical Report, completed in March 2022 for MCO contract years 2020–2021, includes results for six Kentucky Medicaid MCOs: Aetna, Anthem, Humana, Passport by Molina, UHC, and WellCare. The report provides quality performance data, CAHPS satisfaction data, results of compliance reviews, validation of PIPs, focus studies, the guide to choosing your health plan, and NCQA accreditation status. MCO strengths and opportunities for improvement are also outlined for each MCO. Each year's technical report is required to include a section in which each MCO responds to recommendations listed for their MCO in the previous year's report. The Final Rule maintains the importance of the annual technical report and requires states to finalize and post the annual EQR report on their website by April 30 of each year.[13] The report can be found on DMS website at (https://chfs.ky.gov/agencies/dms/dpqo/mco-qb/Pages/reports.aspx) .

MCO Reporting Requirements

The state's current Medicaid MCO contract incorporates established standards for access to care, structure and operations and quality measurement and improvement. To monitor MCO compliance with these standards, Appendix D. of the 2022 MCO contract (Reporting Requirements and Reporting Deliverables) includes a list of monitoring reports for MCOs to submit on a monthly, quarterly, and/or annual basis. As stated in the contract, this list is subject to change based on a finalized MCO reporting package as well as throughout the contract term should DMS identify a need for different reports. All three branches in DPQ&O have assigned staff responsible for reviewing specific reports to ensure that they are adequately reviewed, and information is tracked and evaluated.

Originally created in September 2011, there were 152 required reports and 11 exhibits with crosswalks, definitions, and codes. The most recently updated version of required reporting from the fiscal year (FY) 2022 MCO contracts, which were effective January 1, 2021, contains 83 active reports. Required report topics cover: administration and finance; BH; claims payment; enrollee services; Supporting Kentucky Youth (SKY) program; pharmacy; population health management; provider services and network; program integrity; quality management; and utilization management.

While DMS has made significant progress in reducing the number of active reports and narrowed the focus of what is required for reporting, these reporting requirements continue to represent a major effort for the MCOs in collecting and submitting the data on schedule, as well as for DMS in reviewing and analyzing the results. To facilitate consistent and comparable data in these reporting requirements, DMS recently created the QM-03 report to aggregate many of the existing reports into one submission tool and also to include the reporting of PM data aligned with the goals and objectives of the 2019 Quality Strategy. Using a Microsoft Excel spreadsheet submission format, MCOs will be required to submit quarterly report data covering a broad spectrum of information separated into 26 worksheets, including tabs for Quality Performance Measures, Kentucky-Specific Performance Measures, HEDIS Performance Measures, and Other Performance Measures.

During the MCO interviews, several MCOs commented on the expected challenges the MCOs will face in completing the QM-03 report. It is a very labor-intensive report to complete. They appreciated that DMS took their suggestions and updated the report as needed. The discussions around the report with DMS and the MCOs were extremely helpful and suggested that it would be helpful if DMS provided more instructions on completing some of the tabs on the report. It was also noted that there is some duplication with other reports. They appreciated DMS' considerations to lessen the reporting requirements when possible.

Annual Compliance Reviews

DMS annually evaluates the MCOs' performance against contract requirements and state and federal regulatory standards through its EQRO contractor. In an effort to prevent duplicative review, federal regulations allow for use of the accreditation findings that were determined equivalent to regulatory requirements. In October 2021, for the review period January 1, 2021 to June 30, 2021, all six MCOs participated in a compliance review: Aetna; Anthem; Humana; Molina; UHC; and WellCare.

Data collected from the MCOs, either submitted pre-onsite, during the onsite visit/remote visit or in follow-up, were considered in determining the extent to which the MCO was in compliance with the standards.

In developing its review protocols, IPRO followed a detailed and defined process, consistent with the CMS EQRO protocols for monitoring regulatory compliance of MCOs. For each set of standards reviewed, IPRO prepared standard-specific tools with standard-specific elements (i.e., sub-standards). The tools included the following:

- Statement of federal, state, and MCO contract requirements and applicable state regulations;
- Prior results and follow-up;
- NCQA deemable citation and NCQA determination;
- Reviewer compliance determination;
- Descriptive reviewer findings and recommendations related to the findings;
- Overall compliance determinations and scoring grid; and
- Suggested evidence.

In addition, where applicable (e.g., Grievance System), file review worksheets were created to facilitate complete and consistent file review. Reviewer findings on the tools formed the basis for assigning preliminary and final designations.

Pre-onsite Activities – Prior to the onsite visit, the review was initiated with an introduction letter, documentation request, and request for eligible populations for all file reviews. The documentation request was a listing of pertinent documents for the period of review, such as policies and procedures, sample contracts, program descriptions, work plans and various program reports. The eligible population request required the MCOs to submit case listings for file reviews. For example, for member grievances, a listing of grievances for a selected quarter of the year; or, for care coordination, a listing of members enrolled in care management during a selected period of the year. From these listings, IPRO selected a random sample of files for review onsite.

IPRO began its "desk review," or offsite review, when the pre-onsite documentation was received from the MCO. Prior to the review, a notice was sent to the MCO including a confirmation of the onsite/remote review dates, an introduction to the review team members, onsite/remote review agenda and list of files selected for review.

Onsite Activities or Remote Activities – In light of the COVID-19 pandemic restrictions, the onsite visit could also take the form of remote online meetings and offsite reviews. This part of the review commenced with an opening conference where staff was introduced and an overview of the purpose and process for the review and agenda are provided. Following this, IPRO conducted, when applicable, a review of additional documentation provided, as well as file reviews. Staff interviews were conducted to clarify and confirm findings. When appropriate, walkthroughs or demonstrations of work processes were conducted. The onsite/remote review concluded with a closing conference, during which IPRO provided feedback regarding the preliminary findings, follow-up items needed and the next steps in the review process.

In order to make an overall compliance determination for each of the domains, an average score was calculated. This was determined by assigning a point value to each element based on the designation assigned by the reviewer. The numerical score for each domain was then calculated by adding the points achieved for each element and dividing the total by the number of elements reviewed in the domain. The overall compliance determination was displayed as a percentage.

The standard designations and assigned points used are shown in **Table 5.**

Table 5: Kentucky Medicaid Managed Care Compliance Monitoring Standard Designations

Standard Designations	Interpretation	Points
Met	MCO has met or exceeded requirements.	1
Partially met	MCO has met most requirements, but may be deficient in a small number of areas.	0.5
Not met	MCO has not met the requirements.	0
Deemed	MCO fully met requirements in NCQA's accreditation review	1
Not applicable (N/A)[1]	Statement does not require a review decision; for reviewer information purposes.	-

[1] Elements determined to be non-applicable were not included in the overall determination calculation.
MCO: managed care organization; NCQA: National Committee for Quality Assurance.

To support the MCO's compliance with federal and state regulations and contract requirements, IPRO reviewed documents relevant to each standard under review such as: policies and procedures; sample contracts; annual quality improvement (QI) program description, work plan, and annual evaluation; member and provider handbooks; access reports; committee descriptions and minutes; case files; program monitoring reports; and evidence of monitoring, evaluation, analysis and follow-up. Supplemental documentation could also be requested for areas where IPRO deemed it necessary to support compliance.

The review determination was based on IPRO's assessment and analysis of the evidence presented by the MCO. For elements where the MCO was less than fully compliant, IPRO provided a narrative description of the evidence reviewed, and reason for the determination. The MCO was provided preliminary findings and had 20 business days to submit a response and clarification of information for consideration. The MCOs could only clarify documentation that had been previously submitted; no new documentation was accepted at this time. IPRO reviewed the MCO responses and prepared the final compliance determinations. DMS reviewed MCO responses/clarifications and IPRO's determinations. In accordance with the DMS/MCO contract, DMS determined if further action by the MCO was required.

All six MCOs participated in the 2021 Compliance Review. Aetna had 800 elements reviewed while Anthem, Humana, Molina, UHC and WellCare each had 730 elements reviewed for a total of 4,450 elements reviewed overall (**Table 6**).

Kentucky MCOs showed strong performance in the 2021 Compliance Review. All six MCOs received 100% compliance for 3 of the 11 standard domains: availability of services; assurances of adequate capacity and services; and practice guidelines (**Table 6**). Humana and WellCare each had 100% compliance for 10 of the 11 standard domains, followed by Anthem with 8 domains at 100% compliance; Aetna and UHC had 6 domains with 100%; and Molina had 4 domains with 100% compliance.

There were 23 elements that received Not Met determinations, including UHC with 12 elements receiving Not Met determinations, followed by Molina with 7 elements, Aetna with 3, and Anthem with 1 element determined to be Not Met. Humana and WellCare did not have any elements determined to be Not Met (**Table 6**).

Table 6: Overall Compliance Score – Reviews Conducted in October 2021

CFR Standard Name	CFR Citation	State Citation	Aetna	Anthem	Humana	Molina	UHC	WellCare
Availability of services	436.206	28.0, 28.1, 28.2, 28.3	100%	100%	100%	100%	100%	100%
Assurances of adequate capacity and services	438.207	28.4, 28.5, 30.1, 30.2	100%	100%	100%	100%	100%	100%
Coordination and continuity of care	438.208	34.0, 34.1, 34.2, 34.3, 34.4, 34.5, 34.6, 35.0, 35.1, 35.2, 35.3, 35.4	98%	99%	99%	98%	86%	100%
Coverage and authorization of services	438.210	20.0, 20.1, 20.2, 20.3, 20.4, 20.5, 20.6, 20.7	100%	100%	100%	91%	94%	100%
Provider selection	438.214	27.7, 28.6, 28.7, 28.8, 28.10	100%	100%	100%	99%	100%	100%
Confidentiality	438.224, 438.100, 438.10	22.9, 22.1, 22.2, 20.3	98%	100%	100%	95%	100%	100%
Grievance and appeal systems	438.228	24.0, 24.1, 24.2, 24.3, 27.1	98%	100%	100%	100%	98%	100%
Subcontractual relationships and delegation	438.230	4.3, 6.0, 6.1, 6.2	100%	100%	100%	98%	88%	99%
Practice guidelines	438.236	20.3	100%	100%	100%	100%	100%	100%
Health information systems	438.242	16.1	97%	97%	100%	97%	100%	100%
QAPI	438.330	19.1, 19.2, 19.3, 19.4, 19.5, 19.6, 19.10, 21.2, 21.3, 21.4	99%	98%	100%	96%	93%	100%
Elements Reviewed			800	730	730	730	730	730
Elements Not Met (% of total)			3 (0.4%)	1 (0.1%)	None	7 (1.0%)	12 (1.6%)	None

Source: 2021 External Quality Review Annual Technical Report.
CFR: Code of Federal Regulations; UHC: UnitedHealthcare; QAPI: quality assurance and performance improvement.

Monitoring Access to Care

The MCOs are required to meet contract standards for access to providers by county and by average distance (in miles) to a choice of providers for all members. The MCOs monitor compliance with these network standards through geo-access analysis of providers, including primary care, dental care, specialty care providers, non-physician providers, health care sites, pharmacies, and clinics. MCOs also monitor access to high-volume specialists, such as those specializing in cardiology, obstetrics/gynecology, and surgery. Each MCO regularly conducts surveys to monitor appointment availability for urgent or non-urgent care in accordance with contract availability standards.

In this contract year, the EQRO completed one survey regarding access to care.

Access and Availability PCP, Behavioral Health, and Substance Use Disorder Survey FY 2021, Final Report, April 2021

The EQRO completed one recent audit of Kentucky's provider network access and availability for PCPs, BH and SUD providers. The purpose of this survey was to assess MCO provider network compliance with their state contract requiring that routine services be provided within 30 days and urgent care must be provided within 48 hours. Providers must also offer 24-hour telephone access 7 days a week. Kentucky MCOs are expected to maintain a compliance rate of at least 80% to satisfy applicable appointment standards.

In December 2020, each MCO electronically submitted their provider network data, used to populate their web directory, to IPRO. Random sampling was performed to select 250 providers from each plan, resulting in a total of 1,250 providers.

A "secret shopper" methodology was used to conduct this phone call survey. Surveyors were instructed to role-play as MMC members seeking care and using scripted scenarios attempted to get appointments for care as early as possible. The survey tool included data entry sheets that were developed by IPRO to capture any contact with a provider's office, as well as a Microsoft Access database that was used for data collection.

Data from the Access and Availability Survey for PCPs, BH and SUD providers indicated that 57.9% of the time appointments could be made for routine care and 64.3% of the time appointments could be made for urgent care; however, only 34.9% of the routine appointments and 19.5% of the urgent appointments were compliant with Kentucky's respective appointment standards. The proportion of providers compliant with after-hours access ranged from 66.7% for WellCare providers to 33.3% for Passport by Molina, resulting in an overall rate of 48.5%.

Although the sample sizes for both the provider network submissions audits and the access and availability survey were relatively small, they both indicate a need for improvement in data accuracy as well as appointment availability. Access and Availability Survey results indicate a need for DMS to work with the MCOs to increase contact and appointment rates for PCPs, BH and SUD providers. It is important for members to be able to access providers and obtain appointments with providers.

During the MCO interviews it was discussed that several of the prior reports showed low appointment availability. It was noted that most MCOs have adequate networks as shown in their Geo Access reports. Some of the challenges are due to COVID pandemic. Several of the MCOs noted that they are working with their vendors to try and increase appointment timeliness. MCOs continually educate their providers in an attempt to provide better appointment availability. The MCOs perform their own provider appointment availability surveys, but these surveys do not employ the secret shopper methodology.

During the interview with DMS, it was noted that the latest access and availability survey results for dental providers was extremely low, and DMS requested the MCOs' latest in-house reports to compare to IPRO's. DMS also monitors the GeoAccess reports from the MCOs.

Care Coordination

The Disease and Case Management Branch in the DPQ&O is responsible for ensuring that members have access to quality care coordination services. Their oversight responsibility for Medicaid enrollee care coordination includes resolving provider issues identified in grievances and appeals.

To identify new enrollees with care coordination needs, the MCOs are required to request that all members complete an initial health risk assessment (HRA). MCOs also identify enrollees in need of care coordination by using encounter data algorithms or predictive modeling to track high-risk diagnosis codes, high utilization, frequent use of hospital emergency departments (EDs), frequent inpatient stays, and hospital readmissions as markers. DMS's Disease and Case Management Branch plays an active role in working with the MCOs to enhance care coordination and case management referrals for special populations, such as medically fragile children, foster children, and adults in guardianship.

Five MCOs had overall partially met review determination, and one was fully met for the Case Management/Care Coordination review domain.

State-MCO-EQRO Communication

Communication and collaboration are important in promoting effective quality monitoring and improvement. On a regular basis, and sometimes ad hoc, communication between the state, MCOs, and the EQRO has evolved over time. IPRO continues to communicate regularly with both DMS, and with each MCO, by email and telephone to gather information for EQR activities and to provide technical assistance. IPRO conducts regular follow-up meetings with the MCOs to address PIP review findings and coordinate statewide PIP workgroups via Cisco WebEx®. DMS convenes several topic specific meetings with the MCOs including Operations, Information Technology (IT), and Medical Directors. During the COVID-19 pandemic these meetings have all been remote. It was noted that the turnout has been better than the in-person meetings.

DMS posts MMC program information on the CHFS website, including reports and data generated by all three branches of the DPQ&O and several EQR reports including the quality strategy, compliance review reports, the member's guide to Medicaid MCOs and the annual technical report.

The MCOs would like to have the quality meetings continue to be collaborative and have suggested that perhaps the MCOs can share best practices based on the topic of the month.

Strategies and Interventions to Promote Quality Improvement

DMS, in collaboration with the EQRO, conducts activities focused on QI, including PIPs and focus studies. This section discusses the current projects completed or ongoing by the MCOs, DMS and the EQRO.

Performance Improvement Projects

A protocol for conducting PIPs was developed by CMS[14] to assist MCOs in PIP design and implementation. Federal regulations require that all PIPs be validated according to guidelines specified by CMS. In Kentucky, the EQRO is responsible for validating all PIPs.

The EQRO's process for validating MCO PIPs starts with DMS approval of the PIP topic. The EQRO reviews the PIP proposal, topic rationale, methodology, planned interventions, and study indicators, and then, follows each PIP through to completion with conference calls with each MCO to discuss progress and problems. In addition, the EQRO also conducts training for MCOs on PIP development and implementation.

The PIP assessments are conducted using tools developed by IPRO and consistent with the CMS EQR protocol for PIP validation. The EQRO reviews PIPs for compliance at interim and final remeasurement. For all final reports, the interim PIP score is re-evaluated based upon the extent to which the MCO addressed the interim PIP review comments. Additional points are earned for sustained improvement, as well as a corresponding interpretation of which goals were/were not met, lessons learned and follow-up activities.

There are three levels of compliance based on final report scores:

- Level 1 compliance (93–100 out of 100 points): requirements met with comments and no recommendations.
- Level 2 compliance (60–92 points): requirements met with recommendations.
- Level 3 compliance (0–59 points): requirements not met with corrective action plan required.

The current PIPs for Kentucky are ongoing and will receive a validation determination upon final reporting. The final determination will be made as to the overall credibility of the results of each PIP, with assignment of one of three validation categories:

- There were no validation findings that indicate that the credibility was at risk for the PIP results.
- The validation findings generally indicate that the credibility for the PIP results was not at risk; however, results must be interpreted with some caution. Processes that put the conclusions at risk are enumerated.
- There are one or more validation findings that indicate a bias in the PIP results. The concerns that put the conclusion at risk are enumerated.

Each state's MMC program determines the number of PIPs required to be conducted each year. In Kentucky, two new PIP topics had been proposed each year and were generally completed in up to 3 years. In FY 2017, DMS reduced the number of PIPs required to two active PIPs in a year. Over the last several years, the MCOs have been completing PIPs in progress, and in 2021 will begin two new state-designated PIP topics:

- Improving Diabetes Management (January 1, 2020, to December 31, 2022);
- Improving Assessment, Referral and Follow-up for Social Determinants of Health (SDoH) (January 1, 2020, to December 31, 2022);
- Aetna will also be conducting a third PIP, entitled "Improving Weight Assessment, Counseling for Nutrition and Physical Activity, and Referrals for Overweight and Obesity Management in Children and Adolescents in the Supporting Kentucky Youth (SKY) Program."

Focus Studies of Healthcare Quality

Described in federal regulation as an optional quality review activity, Kentucky includes focus studies in their QI Program. A focus study examines a particular aspect of clinical or non-clinical service. The EQRO initiates two new topic selections each year by developing proposals that are reviewed and discussed with the DMS staff, medical director, and the commissioner, if applicable.

The following studies were completed in FY 2021:

- Access to Colorectal Cancer Screening and Care Management for Kentucky Medicaid Managed Care Enrollees; and
- COVID-19 Hospital Encounters, Mortality and Access to Telehealth Services among Kentucky Medicaid Managed Care (MMC) Enrollees.

The purpose of the COVID-19 Hospital Encounters, Mortality and Access to Telehealth Services among Kentucky Medicaid Managed Care (MMC) Enrollees study was to profile healthcare utilization, including hospitalizations and ED visits for COVID-19, as well as utilization of telehealth services, overall, and among Kentucky Medicaid Managed Care enrollees with COVID-19 symptoms. The results of this study confirmed the importance of DMS's contractual requirement for MCOs to establish and operate an integrated population health management (PHM) program to address both medical and non-medical drivers of health. Further, variability in access to telehealth services by MCO indicates opportunities for MCOs to identify and address barriers to telehealth services.

The purpose of the Access to Colorectal Cancer Screening and Care Management for Kentucky Medicaid Managed Care Enrollees study were to evaluate disparities in access to colorectal cancer (CRC) screening among enrollees aged 45–75 years overall and to evaluate their access to timely initial CRC screening. It further sought to assess receipt of care coordination and case management for enrollees with a CRC diagnosis. The results of this focus study highlighted several opportunities for MCOs to improve the quality of preventative care provided to Kentucky MMC enrollees by enhancing member outreach, education, and engagement in CRC screening. Furthermore, case management programs merited improvement by expanding to meet the specialized physical health, mental health, and SDoH needs of individuals with cancer.

Strengths, Opportunities for Improvement and Recommendations

The strengths and opportunities for improvement in Kentucky's MMC Program are presented in this section as a culmination of this comprehensive evaluation summary.

Strengths

- Kentucky has a contract in place for EQR that includes review of compliance with state and federal regulations, validation of PIPs, and several optional EQR activities. The EQRO also prepares the Annual External Quality Review Technical Report as required by regulation.
- In 2019, DMS updated their quality strategy entitled *Strategy for Assessing and Improving the Quality of Medicaid Managed Care Services*.[15] It is currently posted on the DMS website. DMS has enlisted a multidisciplinary team composed of MCOs, DMS and University of Northern Kentucky staff to update its quality strategy.
- Compared to national benchmarks, 9 of the 41 quality strategy measures met or exceeded the national 50th percentile, including 1 measure (2%) that met or exceeded the national 90th percentile and 3 measures (10%) that met or exceeded the national 75th percentile, but were below the national 90th percentile.
- Of the 14 HEDIS MY 2020 measures aligned with the quality strategy goals that could be trended, 7 measures showed improvement in rates between HEDIS MY 2018 and HEDIS MY 2020.
- The MCOs participated in the October 2021 Compliance Review, with results indicating a high level of compliance with contract, state, and federal regulations. All six MCOs received full overall determinations availability of services, assurances of adequate capacity and services, and practice guidelines.
- As discussed during the MCO interviews, it was noted that DMS continues to strive to maintain and improve communications as evidenced by regularly scheduled meetings for workgroups, EQR activities and MCO operations.
- DMS continues to engage the EQR in conducting focus studies in order to better examine clinical issues in Kentucky. Two focus studies were in progress during FY 2021 on the following topics: Access to Colorectal Cancer Screening and Care Management for Kentucky Medicaid Managed Care Enrollees; and COVID-19 Hospital Encounters, Mortality and Access to Telehealth Services among Kentucky Medicaid Managed Care (MMC) Enrollees.
- DMS continues to strengthen its oversight and reporting requirements, as evidenced by the introduction of the QM-03 reporting tool. Though labor intensive it, captures MCO PM results quarterly, enabling DMS and the MCOs to address areas of need in a more timely manner.

Opportunities for Improvement

- Statewide average rates for 7 of the 14 trendable HEDIS measures listed in the 2019 Quality Strategy did not improve between HEDIS MY 2018 and MY 2020.
- The HEDIS MY 2020 statewide average rates were below the national 50th percentile for 28 of the 35 trendable measures, including 15 measure rates that met or exceeded the national 25th percentile, but were below the national 50th percentile, and another 13 measure rates that were below the national 25th percentile.
- Not all core measures from the 2019 Quality Strategy were included in this analysis. In addition to HEDIS measures, the strategy includes clinical measures, many of which are drawn from the NQF data set. Where possible, HEDIS measures that are equivalent to the NQF measures were included, but there were no HEDIS equivalent measures for three of the NQF measures, and there were an additional two measures that were not collected in Kentucky in reporting year (RY) 2021; these measures are therefore not represented in this evaluation.
- UHC had two areas of the compliance review that scored less than 90%. As this was their first year for a Kentucky compliance review, this will be an area for improvement.
- Opportunities for improvement exist based on findings from several EQR monitoring and validation reports:
    - Validation of provider network submissions suggested that DMS follow up with MCOs to correct provider records for the errors identified in the survey, that they work with the MCOs to enhance the accuracy and completion of critical fields in the provider directory data files, and they expand the data dictionary to include more specificity in the definitions of the date elements to help facilitate MCOs' submission of accurate and complete data
    - Results from the web-based provider directory validation indicated that there is still opportunity to enhance the accuracy and completeness of the web directories regarding critical fields in the MCO provider files, especially with respect to phone numbers and addresses.

    - Results of the FY 2021 Access and Availability Survey of PCPs, Behavioral Health and Substance Use Disorder Providers indicated that overall compliance rates of 34.9% for scheduling routine appointments, 19.5% for scheduling urgent appointments, and 48.5% for after-hours availability are well below expectations.
- Reporting requirements continue to represent a major effort for the MCOs in coordinating the collection of data and submitting the reports on schedule. The addition of the QM-03 report has been noted as very labor intensive, but a step in the right direction as far as consolidating many of the reporting requirements.

Recommendations

- In collaboration with the EQRO and the MCOs, it is recommended that Kentucky DMS address the above-listed opportunities for improvement.
- The updated quality strategy, entitled *Strategy for Assessing and Improving the Quality of Medicaid Managed Care Services,* provides a well-constructed framework to enhance quality monitoring and improvement as Kentucky's MMC Program seeks to achieve its five program goals. Limitations discussed in this evaluation regarding the strategy's core measures are being addressed by the inclusion of PM data in the newly created QM-03 report. DMS should also consider establishing state-level baselines for all reported measures and setting state-level performance thresholds for each measure in order to better evaluate the effectiveness of the MMC Program in achieving the goals set forth in the quality strategy. Thresholds should be quantifiable, actionable, and able to be sustained over time. Benchmarks targeting national Medicaid performance, such as NCQA's national *Quality Compass*, as well as incremental improvement over baseline rates offer potential sources for future evaluation.
- DMS should continue to engage the MCOs in discussions related to contract reporting requirements in order to determine what needs to be monitored through MCO reporting and how best to obtain this information on a regular basis. Considerations to lessen the reporting and review burden could include reducing the frequency of report submissions and/or using other state administrative sources for some of the requested data.
- DMS, in collaboration with the EQRO, may want to consider taking a more proactive role in initiatives to promote QI such as providing feedback to the MCOs regarding HEDIS rate improvement, including face-to-face or WebEx conferences and trainings based on lessons learned from focus studies and PIPs. Reaching out to other states and engaging them in webinars to share their QI initiatives could also be informative. Using the DMS website to share quality performance data results as well as publishing EQR report findings can also be a valuable initiative to support data transparency and promote QI.
- DMS may want to consider identifying care management metrics that MCOs can report to help monitor their care management programs, such as engagement and completion rates, number of case-managed members receiving specialty services, etc., considering the poor performance observed in some of the MCOs' reported PMs that reflect care provided to members who can benefit from care management services, such as members with chronic conditions (e.g., diabetes, BH [especially follow-up care and antidepressant management] and maternity care [timeliness of prenatal care and postpartum visits]).
- DMS may want to consider changing their PIP requirements to allow MCOs to conduct one of the two required PIPs in a topic area of their own choosing based on an observed need within their plan and aligned with the quality strategy. Once the PIP has been completed, MCOs can share results, barriers, and interventions with the other Medicaid MCOs in Kentucky, since the needs are likely to be the same. In this way, several problem areas can be studied concurrently and successes be spread throughout the state.
- Since there is a likely high degree of overlap in the MCOs provider networks, perhaps the state can consider tasking IPRO in identifying providers who consistently fail the access and availability surveys over time and who contract with more than one MCO. In this way, MCOs can collaborate in developing and implementing improvement strategies, and together, with one voice, may have more success in counseling these providers.

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