Cabinet for Health and Family Services

Department for Medicaid Services

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

November 2022

Table of Contents

Tables

FIGURES

List of Appendices

1.0 Introduction

More than 1.6 million Kentuckians are beneficiaries of Medicaid or the Kentucky Children's Health Insurance Program (KCHIP). Approximately 90.5% of these individuals are enrolled in managed care plans under the Section 1915 (b) waiver or Alternative Benefit Plan authority.

The Kentucky Medicaid Managed Care Quality Strategy described in this document represents a cooperative effort across all stakeholder groups. As designed, this updated strategy will be managed by the Department for Medicaid Services (DMS) and is iterative, dynamic, and responsive to changes in the marketplace as well as the evolving needs of beneficiaries.

The methodology used to develop this strategy is based on the *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Toolkit* (Toolkit) released by the Centers for Medicare and Medicaid in June 2021. The strategy builds upon the existing *Kentucky Strategy for Assessing and Improving the Quality of Medicaid Managed Care Services* adopted in July 2019.

As prescribed by the Toolkit, an Interdisciplinary Team of stakeholders, was convened to assist in developing the quality strategy. In addition, in-depth semi-structured interviews of 20 key informants were conducted, analyzed, and used as an information resource. Key informants included beneficiaries, advocacy organizations, multiple provider types, and healthcare systems. Managed Care Organizations (MCO) were engaged as members of the Interdisciplinary Team. Information and input are being gathered through the public posting and solicitation of comments on the strategy. Other information sources include those identified in the Toolkit; specifically, Core Set Reports, External Quality Review (EQR) reports, and Managed Care Plan documents.

1.1 Applicable Federal Quality Strategy Requirements

In accordance with 42 CFR 438.340(a) and 42 CFR 438.340(b), at a minimum, quality strategies must address:

1. The State-defined network adequacy and availability of services standards for §438.68 and §438.206;
2. The State's goals and objectives for continuous quality improvement, which must be measurable and take into consideration the health status of all populations in the State served by the MCOs;
3. A description of:
    a) the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO with which the State contracts, including but not limited to, the performance measures reported in accordance with §438.330(c); and
    b) The performance improvement projects to be implemented in accordance with §438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO or PIHP;

4. Arrangements for annual, external independent reviews, in accordance with §438.350, of the quality outcomes and timeliness of, and access to, the services covered under each MCO, PIHP and PCCM entity contracts that have shared savings, incentive payments, or other financial rewards;
5. A description of the State's transition of care policy required under §438.62(b) (3);
6. The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities;
7. For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of Subpart I of Part 348;
8. The mechanisms implemented by the State to comply with§438.208(c) (1) relating to the identification of persons who need long-term services and supports (Note: this is not relevant to Kentucky Medicaid Services as long-term services are not included in the Managed Care Contract);
9.
10. The information required under §438.360(c) relating to non-duplication of external quality activities;
11. The State's definition of a "significant change" for the purposes of paragraph (c) (3) (ii) of this section.

1.2 Cross-Cutting Considerations

This strategy includes a particular focus on cross-cutting issues. These include:

- Review of performance on CHIP Child and Adult Core Sets to prioritize and articulate the quality improvement goals and objectives. This includes comparisons to both the national median for measures and peer state performance.
- Alignment of the quality strategy with other managed care tools. This includes annual EQR reports, Quality Assessment and Performance Activities (QAPI), directed payments, and sanction activities.
- Health disparities and equity initiatives.
- Intermediate sanctions linked to quality performance.

1.3 Population Health in Kentucky

The general health of the Kentucky population ranks poorly amongst the rest of the country. Many factors contribute to the poor health of the Commonwealth including socioeconomic status and employment. As of 2020, 59.1% of the population aged 16 years and older participated in the civilian workforce. The median household income in 2020 was $54,074, which was 7th lowest in the nation, and 14.9% of people in the state of Kentucky lived in poverty, which ranked 46th in the nation.[1] In addition, 13.8% of the Commonwealth experiences food insecurity and is unable to provide adequate food for one or more household members due to a lack of resources.[2]

Behavioral risks that have contributed to poor health outcomes in the Commonwealth include:

- 21.4% of adults smoke cigarettes (49th in the country)
- 30.6% of the adult population reported doing no physical activity in a 30-day period (50th in the country)

- 15.3% of adults met the federal physical activity guideline in a 30-day period (50th in the country)
- 4.7% of adults reported appropriate fruit and vegetable consumption (50th in the country).[3]

Additional notable public health issues of the Commonwealth include:

- In 2019, 29.7% of Kentucky high school youth reported currently using a tobacco product[4]
- 24.2% of adults have been diagnosed with a depressive disorder (49th in the country)
- 31.3 deaths per 100,000 population occurred due to drug injury (42nd in the country)
- 8.7% of infants weighed less than 2,500 grams (5 pounds, 8 ounces) at birth (32nd in the country)
- 16.1% of adults have been diagnosed with multiple chronic conditions (49th in the country)
- 36.6% of adults are obese (45th in the country).[2]

The care provided to Medicaid beneficiaries needs to be intentionally prioritized to address the health concerns identified within the state. This quality strategy has been deliberately developed to address several of these health concerns within the identified goals and objectives. With the proper prioritization of performance improvement projects and value-based programs, MCOs should improve the care provided to Medicaid beneficiaries and thus help to improve the health of the Kentucky population.

Building on the 2019 Quality Strategy and its activities since implementation, DMS proposes in this updated Quality Strategy a comprehensive approach to transforming Medicaid through innovative delivery system reforms for substance use disorder (SUD), chronic disease, and managed care that will improve both quality and outcomes.

DMS seeks to achieve this overall vision by focusing the following quality goals:

- Improve enrollee health outcomes through improved screening and treatment retention for individuals with behavioral health conditions;
- Improve outcomes associated with people with diabetes mellitus, hypertension, COPD, and asthma;
- Increase preventative service utilization;
- Increase access to high-quality care while reducing unnecessary spending;
- Improve outcomes for identified special populations;
- Improve assessment, referral, and follow-up for social determinants of health (SDOH).

Foundational to achieving this vision are several components:

- Access to care
- Clear agreement on evidence-based practice
- Adoption and optimization of health delivery systems including information technology
- New payment models that reward quality and value.

Finally, DMS proposes to work collaboratively with MCOs, health care providers, enrollees and families, and other partners and stakeholders to continue to advance:

- Identification of shared goals and objectives

- Selection of interventions that achieve these goals and objectives
- Measurement and monitoring of progress toward these goals and objectives
- Definitions for the starting point and targets for performance
- Feedback loops and transparency, including a continuous review of performance relative to the targeted goals and objectives.

2.0 Managed Care in Kentucky

Kentucky Medicaid is currently served by six managed care organizations (MCOs) using risk-based contracts. All have 1915(b) authority and serve both Medicaid Children and Medicaid Adults. As of July 2022, as depicted in Table 1, there were 1.65 million Kentucky Medicaid beneficiaries, representing almost 37% of the population based upon the US Census Bureau most recent Kentucky population estimate of 4.5 million. More than 90% of the beneficiaries are enrolled in managed care plans; the remaining 150,000 are enrolled in the fee-for-service (FFS) option. Given the prevalence of managed care plans, enhanced MCO cross-collaboration and engagement with additional stakeholders will be key in moving toward improved positive outcomes for Kentuckians.

Table 1: July 2022 Kentucky Medicaid Market Share[5]

Plan Type	Unduplicated Member Count	Market Share
Aetna Better Health of Kentucky	249,504	15.10%
Anthem Blue Cross Blue Shield	174,448	10.56%
Fee-for-Service	157,473	9.53%
Humana Healthy Horizons in Kentucky	168,447	10.19%
Passport Health Plan by Molina Health Care	333,594	20.19%
UnitedHealthcare Community Plan	79,746	4.82%
WellCare of Kentucky	488,329	29.56%
Total	**1,651,541**	**100%**

As indicated in Table 2, according to the Kentucky Cabinet for Health and Family Services (CHFS) approximately 616,000 individuals are covered under Kentucky CHIP.

Table 2: March 2022 KY Child Medicaid Counts[6]

KCHIP	KCHIP Expansion	Medicaid	Grand Total
52,123	69,785	494,111	616,019

The MCO UnitedHealthcare Community Plan was added since the 2019 Quality Strategy was adopted. The relative market share for the MCOs is depicted in Table 3.

Table 3: MCO Enrollment Trends 2017-2022

MCO	Enrollment 4/2017	Enrollment 4/2018	Enrollment 4/2019	Enrollment 4/2020	Enrollment 4/2021	Enrollment 4/2022	Percent Change
Aetna Better Health of Kentucky	294,501	230,100	214,613	213,013	241,917	249,504	0.00%
Anthem Blue Cross Blue Shield	117,133	126,733	129,436	140,174	161,267	174,448	+48.93%
Humana Healthy Horizons in Kentucky	139,259	146,530	144,391	150,891	167,906	168,447	+20.96%
Passport Health Plan by Molina Healthcare	303,146	312,781	307,322	308,565	325,490	333,594	10.04%
United Healthcare Community Plan					146,002	79,746	-54.62%
WellCare of Kentucky	441,187	449,519	437,962	446,327	473,746	488,329	10.68%
Total	**1,250,226**	**1,265,663**	**1,233,724**	**1,258,970**	**1,516,328**	**1,494,068**	**+19.50%**

2.1 Evolution of Medicaid Managed Care in Kentucky

In December 1995, the Commonwealth of Kentucky received approval from CMS under Section 1115 waiver authority[7] to establish a statewide Medicaid Managed Care (MMC) program. In the fall of 2000, following the withdrawal of a key healthcare partner from the program, Kentucky Medicaid halted plans to implement a statewide risk-based managed care program. The partnership with University Health Care (doing business as Passport Health Plan) continued service in Region 3 (Jefferson and 15 surrounding counties) and the rest of Kentucky's Medicaid enrollees were enrolled in the fee-for-service (FFS) system.

In 2011, with increasing Medicaid health care expenditures and a growing eligible population, Kentucky once again turned to risk-based managed care as a solution. Following a careful procurement process, risk-based, state-wide, managed care was implemented. The Patient Protection and Affordable Care Act (ACA) allowed DMS to further expand Medicaid eligibility in 2014.

In January 2018, a five-year Section 1115 Demonstration was approved by CMS entitled Kentucky HEALTH (Helping to Engage and Achieve Long Term Health). The Demonstration also included a Substance Use Disorder (SUD) Demonstration implemented July 1, 2019. The Kentucky HEALTH program was not implemented due to legal decisions regarding components of the program and was rescinded by DMS in December 2019 while the other components of the

waiver remained. KY filed an amendment to the SUD 1115 in November 2020 include coverage of SUD services for justice-involved individuals while incarcerated. CMS is currently in the policy development phase regarding waivers involving justice-involved individuals and KY is hopeful the amendment will be approved in the 5-year extension of the Demonstration requested in September 2022.

Oversight and guidance are provided by the Medicaid Oversight and Advisory Committee (MAC) by statutory mandate that includes oversight on the implementation of Kentucky Medicaid, as well as access to services, utilization of services, quality of services, and cost containment.

Technical Advisory Committees (TACs) provide additional guidance to Kentucky Medicaid and are also statutorily created. Each committee represents a specific provider type or individuals representing beneficiaries. Most members of the TAC are appointed by the professional associations they represent.

3.0 The Kentucky Medicaid Quality Strategy

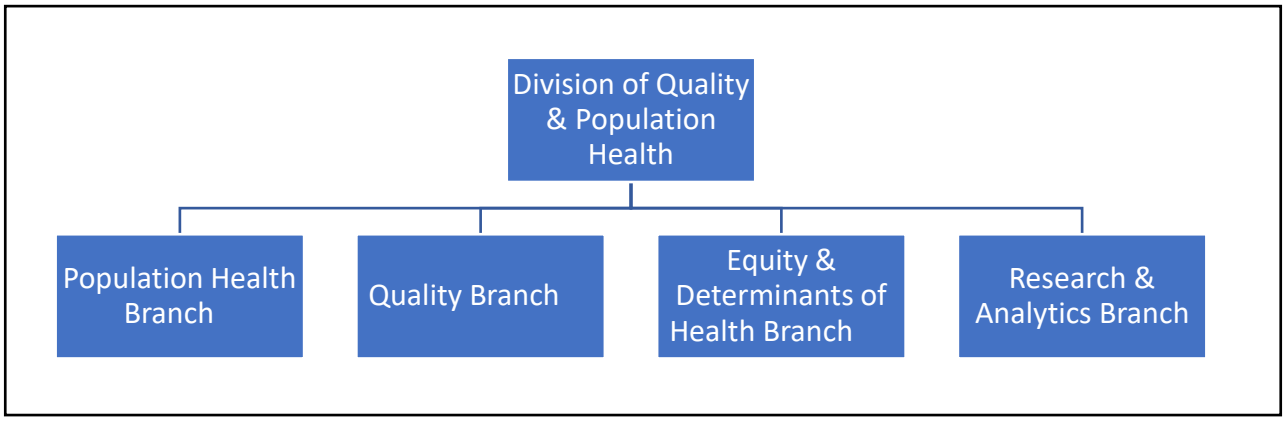
The current Quality Strategy is central to activities of DMS, MCOs, providers, and other stakeholders. The quality strategy proposed in this document represents a continuation and evolution of the existing strategy and has been developed, as recommended in the *Toolkit* with input, guidance, and information provided across stakeholder groups. In addition, the membership of MAC and TACs informed the development of the Quality Strategy via key informant interviews.

3.1 Reorganization of the Division of Quality and Population Health

In July 2022 DMS renamed the Division of Program Quality and Outcomes to the Division of Quality and Population Health to reflect the agency's goals in ensuring access to quality services and improving the health and outcomes of the entire population it serves. To meet these goals, DMS is creating the Equity and Determinants of Health Branch to focus on policies and programs that remove barriers to access and promote the overall health through population health management initiatives.

The creation of a Research and Analytics Branch will assist with ensuring that decisions are data-informed and that trends are identified and addressed. The Disease and Case Management Branch has been refashioned into the Population Health Branch and the Managed Care Oversight Quality Branch is renamed the Quality Branch. The Managed Care Oversight Contract Management Branch has been re-established under other more appropriate divisions. The new structure for the Division of Program Quality and Outcomes is depicted in Figure 1:

Figure 1: Organization of the Division of Quality and Population Health



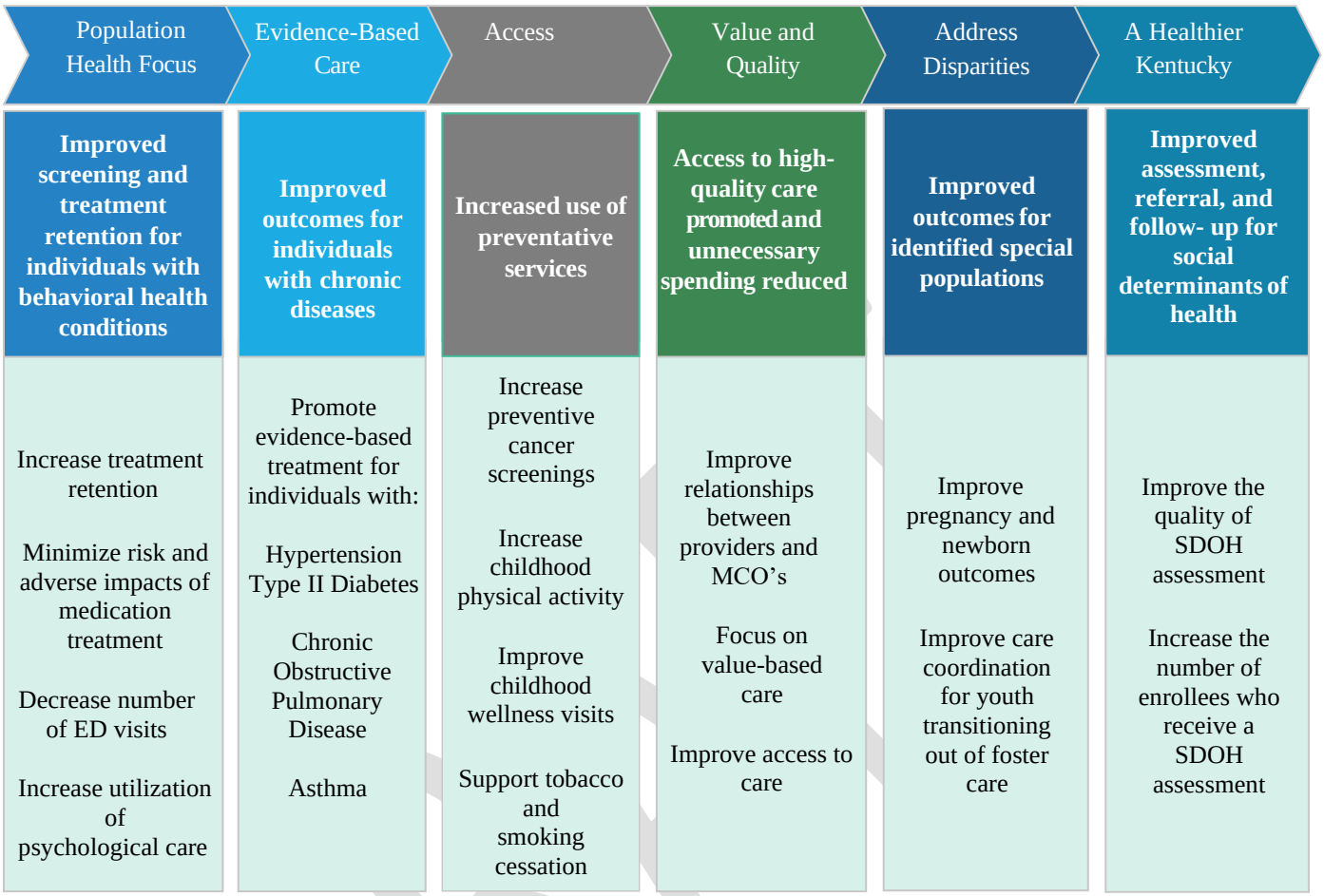
3.2 Delivery System Reforms

This Quality Strategy is also central to DMS system reforms. *These system reforms are designed to support the quality goal of improving care and care experiences, reducing costs, improving population health, and advancing health equity across the Commonwealth*. Figure 2 provides a summary of the Quality Strategy updated goals and objectives.

The goals and objectives represent a continued evolution from the 2019 Quality Strategy based upon EQR assessments, MCO performance reviews, stakeholder interviews, input from advisory and oversight committees, CMS guidance, and changes in the marketplace. Both PIP and Focused Studies conducted since the 2019 Strategy was implemented also informed and shaped the new strategy.

In the updated strategy, objectives are more targeted and are linked to Core Measures where possible. There is an increased emphasis on access, disparities, and the social determinants of health. Additional coordination and standardization of QAPI and value-based initiatives as well as their linkage to the Quality Strategy are also included. Finally, the updated strategy has a larger framework for review and continuous improvement.

Figure 2: Updated Quality Strategy Goals and Objectives Supporting System Reform



A summary of updates to the strategy includes the following.

- *The goal from the 2019 Quality Strategy focused on SUD has been broadened to a behavioral health-focused quality goal*, with SUD then being included within the larger objectives. This approach exemplifies a more general population health approach, with its objectives and measures aimed at care coordination and integrated care.
- *There are now fewer total objectives*. Although mitigated by COVID-19, performance lagged expectations relative to the chronic disease management objectives in the 2019 Quality Strategy. Reducing the number of objectives should foster greater focus and resources on these objectives, thus enhancing the ability to meet improvement targets.
- *The objectives in preventative care category have been reduced* from the earlier strategy in order to allocate more resources to higher priority issues: cancer screenings, adolescent wellness, and tobacco/nicotine cessation. The objectives for the latter create state-wide standardization and coordination of cessation programs for DMS of Public Health and all MCOs. There is wide-spread agreement that preventive care continues to be an area needing improvement in Kentucky.
- As an updated requirement, *DMS will require that all strategy measures be captured, stratified, and reported on a population health/demographic basis* in order to better

understand barriers to access, which will in turn support health equity initiatives. Access to care was identified as the highest priority in key informant interviews. Stratification should provide insight into the relationship between the Quality Strategy and on-going health disparities.

- *The updated quality strategy initiates the capture of metrics, characteristics, and performance of value-based contracting by all MCOs on a standardized basis.* Paying for the quality of care is key priority across all stakeholders. Generally, these initiatives consist of contracting that capture the metrics, demonstrate the characteristics, and enhancement to performance to maximize the IHI Triple Aim such as value-based contracting. Such value-based care for Medicaid in Kentucky is fragmented, primarily consisting of one-off contracting. This new strategy provides a foundation for policies, education, and initiatives for value-based care.
- In the updated Quality Strategy, *the special populations of pregnant persons and newborns are targeted with specific objectives and outcomes*. A second target population of "aging out" foster children is also identified. Relative to the 2019 Strategy, fewer objectives associated with special populations are included, with the expectation that focusing resources will achieve outcome targets.
- The final update includes *a specific goal related to the social determinants of health*. Across-cutting issue for the Quality Strategy, the objectives and measurement are based upon a successful and well-received PIP that is in process.

3.3 Health Disparity Initiatives

Health equity is listed as the first of five priorities for the Kentucky Cabinet for Health and Family Services (CHFS) Strategic Plan. The operationalization of equity initiatives within the CHFS includes advancing equity in hiring and procurement, utilization of racial equity tools to evaluate program design and impact, disaggregating data to uncover disparities in outcomes, and targeting campaigns to underserved populations to promote equitable access to services.

The updated quality strategy treats health disparities as a cross-cutting issue. All measurements for the objectives will now be reported on a sub-population basis by race, gender, age, ethnicity, and geography. A specific goal on the SDOH has been added to the strategy based upon a successful PIP introduced under the 2019 Quality Strategy. In addition, a Focus Study on Health Equity was completed in June 2022 and is being used to inform the updating of the Quality Strategy. MCO contracts will be updated to reflect the ongoing changes and increased focus on health equity, requiring that they be included in the MCO population health and quality programs.

In the Departments of Public Health (DPH), Behavioral Health, Developmental and Intellectual Disabilities (BHDID), and DMS within CHFS, there are several programs, committees, and workgroups focused on disparity initiatives including the Racial Equity Community of Practice initiative. This initiative is championed by a racial equity representative from each department and division of the cabinet. One of the main objectives of the Racial Equity Community of Practice is creating a Racial Equity Action Plan across all departments. The plan includes goals and objectives from each division that are aimed at expanding the racial equity lens from both a micro and macro level to expose racial disparities and create accountability for improving racial equity for all Kentuckians. In updating the Quality Strategy, representatives from these

aforementioned departments served on the Interdisciplinary Team and assisted in coordinating CHFS activities with other stakeholders, including MCOs and providers.

The MCOs have individual initiatives and programs focused on disparities, particularly the issue of equitable access. An increase in the number of community health workers and other similar employee types in the MCOs speak to a greater emphasis on the factors underlying disparities, including social determinants. Coordination of these activities with the Quality Strategy should be driven by insights provided by new objectives and more refined population health measurements.

Health equity initiatives will continue to be a high priority across DMS and stakeholders. DMS will begin participation in a state cohort learning collaborative through Medicaid Innovation Collaborative (MIC) in October. The focus of this collaborative will be social determinants of health and closing the gap on health disparities in KY. Currently, the Racial Equity Community of Practice Team is working to train all divisions about the use of the Government Alliance on Racial Equity (GARE) racial equity tool with the goal of implementing the GARE tool across DMS by end of year 2022. Likewise, CHFS is also implementing use of the tool for accountability purposes and to improve racial equity. The various oversight and advisory groups plus the Interdisciplinary Team will be used to integrate these initiatives and others within the Quality Strategy.

4.0 Review and Evaluation of the Current Strategy

Through oversight and direction by the Division of Quality and Population Health, DMS seeks to accelerate quality, value, and population health improvement in Kentucky by leveraging relationships with MCOs, health care provider organizations, Medicaid enrollees, families, and community partners. The Quality Strategy is central to this process.

The MCOs are required to maintain National Committee for Quality Assurance (NCQA) accreditation. NCQA provides a framework for essential quality improvement and measurement. The MCOs are also required to submit a full set of HEDIS and CAHPS data annually. DMS contracts with Island Peer Review Organization (IPRO) as its External Quality Review Organization (EQRO). All contracts entered into with DMS (MCO's and EQRO) incorporate the requirements and language imposed under 42 CFR 438.

The current quality strategy is focused on delivery system reforms, including efforts related to SUD, chronic disease management, and general managed care. QAPI programs currently in effect or recently completed indicate a continued evolving partnership among MCOs, DMS, providers, and other stakeholders. Since the implementation of the 2019 Quality Strategy, these initiatives include PIPs and focused studies in the following areas:

- Neonatal Abstinence Syndrome (now Neonatal Opioid Withdrawal Syndrome)
- Diabetes - Access to PCPs, Specialists, and Self-Management Education and Support
- Colorectal Cancer Screening
- Social Determinants of Health
- COVID-19 Hospital Encounters, Mortality, and Access to Telehealth Services among Kentucky MCO Enrollees
- Health Equity

The current strategy and various initiatives associated with it form as the foundation for the proposed strategy in this document. A review and evaluation of the current strategy is provided in the following sections. The methodology used to review the current Quality Strategy consists of the following:

- The EQRO Technical and Comprehensive Reports for 2019 through 2021
- Review of Kentucky's performance for CORE Measures
- Comparison to national benchmarks and peer states
- Interdisciplinary Team review of current strategy and suggestions for improvement
- Semi-structured interviews of key informants
- Review of MCO contracts

4.1 Summary Findings of Evaluation of the Quality Strategy

The goals, aims, and measures for the current strategy are listed in Table 4.

Table 4: Goals, Aims, and Measures for 2019 Medicaid Quality Strategy

Goal	Core Measures
Goal 1. Reduce burden of SUD and engage enrollees to improve behavioral health outcomes **Aim 1.1** Reduce Opioid Use through access to addiction recovery services **Aim 1.2** Enhance Behavioral Health (BH) care through integrated primary care-BH care **Aim 1.3** Increase the number of screenings for OUD	**HEDIS Measures:** • Antidepressant Medication Management (AMM) (2 measures) • Initiation and Engagement of Alcohol and other Drug (IET) **Clinical Measures:** • Use of Opioids at High Dosage (NCQA proposed) • Screening for Clinical Depression and Follow Up Plan (NQF 418)
Goal 2. Reduce burden of and outcomes for chronic diseases **Aim 2.1** Promote evidence-based treatments for CAD, Hypertension, Diabetes, and Cancer	**HEDIS Measures:** • Controlling High Blood Pressure (CBP) • Comprehensive Diabetes Care (CDC) (6 measures) • Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) • Pharmacotherapy Management of COPD Exacerbation (PCE) (2 measures) • Appropriate Medications for People with Asthma (ASM) • Medication Management for People with Asthma (MMA) **Clinical Measures:** • Statin Therapy for Patients with Cardiovascular Disease (CMS 347v1 eCQM) • Diabetes Care: Hemoglobin (HbA1c) Poor Control (>9.0%) (NQF 59) • Controlling High Blood Pressure (Hypertension) (NQF 18) **(See also cancer screening measures below)**
Goal 3. Increase preventive service use **Aim 3.1** Increase screening **Aim 3.2** Reduce tobacco use **Aim 3.3** Promote physical activity **Aim 3.4** Enhance healthy child development	**HEDIS Measures:** • Adult BMI Assessment (ABA) • Cervical Cancer Screening (CCS) • Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC) (3 measures) • Childhood Immunization Status (CIS) (2 measures) • Breast Cancer Screening (BCS) • Cervical Cancer Screening (CCS) • Chlamydia Screening in Women (CHL) • Human Papillomavirus Vaccine for Female Adolescents (HPV) - NOW under IMA - Immunization for Adolescents • Annual Dental Visits (ADV)

	Clinical Measures: • Breast Cancer Screening (NQF 2372); • Colorectal Cancer Screening (NQF 32); • Tobacco Use: Screening and Cessation (NQF 28); • Body Mass Index (BMI) Screening and Follow-Up (NQF 42); • Childhood Immunization Status (NQF 38); • Well Child Visits, 3-6 years and first 15 months (NQF 1516); • Well Child Visits, first 15 months (NQF 1392)
Goal 4. Promote access to high-quality care and reduce unnecessary spending **Aim 4.1** Quality and performance monitoring **Aim 4.2** Enhance connections between community engagement, health behavior and health outcomes **Aim 4.3** Increase access to PCMH **Aim 4.4** Reduce inappropriate ED use	**HEDIS Measures:** • Follow-Up after Hospitalization (FUH) • Appropriate Testing for Children with Pharyngitis (CWP) • Appropriate Treatment for Children with Upper Respiratory Infection (URI) • Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis • Use of Imaging Studies for Low Back Pain (LBP) **Clinical Measures:** • Medication Reconciliation Post-Discharge (NQF 97) • 30 day All Cause Readmissions (NQF 1768)
Goal 5. Improve care and outcomes for children and adults, including special populations **Aim 5.1** ↑ care/outcomes for pregnant moms & newborns **Aim 5.2** ↑ care/outcomes for children transitioning out of foster care **Aim 5.3** Improve coordination of care for adults who are justice-involved and need health services related to substance use disorder or serious mental illness **Aim 5.4** Increase access and quality of community-based services for children and adults with SED and SMI	**HEDIS Measures:** • Follow-up Care for Children Prescribed ADHD Medication (ADD) (2 Measures) • Prenatal and Postpartum Care (PPC) (2 Measures) • Frequency of Ongoing Prenatal Care (FPC) **Clinical Measures:** • Childhood Immunization Status (NQF 38) • Well Child Visits, 3-6 years and First 15 months (NQF 1516) • Well Child Visits, first 15 months (NQF 1392)

The Fiscal Year 2022 Comprehensive Evaluation Summary, Commonwealth of Kentucky Strategy for Assessing and Improving the Quality of Managed Care Services, conducted by IPRO acting as the EQRO, reviewed the performance of the managed care plans relative to this strategy.[1] The summary of the measurement and review of performance is presented below:

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

[1] Available at https://chfs.ky.gov/agencies/dms/DMSMCOReports/2022TechReport.pdf

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.

The evaluation suggested a re-examination of the core measures used in the strategy due to limitations in the selected measures. A specific problem concerned the inclusion of clinical measures in tracking the program. The clinical measures had not been collected by the MCOs and were therefore unavailable for the analysis. When possible, HEDIS 2021 measures were used as proxies for the clinical measures. There were no HEDIS equivalents for three clinical measures, and the MCOs did not collect two of the designated HEDIS measures.

This updated quality strategy addresses these problems by focusing on HEDIS measures, and, where they are not appropriate or non-existent, getting MCO

agreement on new measures and their collection before the strategy is implemented.

As described in the EQRO Comprehensive Evaluation, performance on the target measures was mixed and impacted by COVID-19. While progress was made in some measures, overall, as described in the Population Health Section of this proposed strategy, there is substantial room for improvement in the health of Kentuckians, and particularly for Medicaid beneficiaries. The 2019 Quality Strategy did not specify specific targets or performance thresholds for the MCOs. This was addressed in the in the current year by a requirement that MCOs report a benchmark which increases the prior calendar year rate by a minimum of 2% in the same quarter in the current calendar year.

As recommended in the *Toolkit*, the strategy proposed in this document provides a performance target for the measures associated with the objectives.

4.2 Stakeholder Review of Existing Strategy and Input to Updated Strategy

In addition to a review by CMS, there were three primary sources of input to updating the Quality Strategy: the Interdisciplinary Team, semi-structured interviews of key informants, and public comments on the posted draft. The use of three different sources and methodologies provides for comprehensive perspectives.

The roster of the Interdisciplinary Team members is available in Appendix B. The Team met on a monthly basis. Sub-teams of subject-matter experts and volunteer members reviewed defined existing Quality Strategy Goals and Objectives and provided recommendations for the new strategy. The sub-teams met on a weekly or semi-weekly basis for 4 months. The work of these sub-teams, as reviewed and revised by the Interdisciplinary Team as a whole, are the basis for the goals, objectives, and measures for the proposed Quality Strategy.

The semi-structured interviews consisted of a formalized process. Key informants were identified across stakeholders, primarily from the Medicaid TAC, consumer advocates and beneficiaries. An analysis of these interviews of key informants is available in Appendix C.

As required by regulation, the draft Quality Strategy update was posted on the DMS web site for 30 days. Public comments will be reviewed and incorporated into the draft Quality Strategy submitted to DMS as appropriate.

4.2.1 Summary of Key Informant Interviews

A full analysis of the Key Informant interviews is provided in Appendix B. These interviews essentially reaffirmed the recommendations of the Interdisciplinary Team.

Key informants showed limited knowledge of the existing Quality Strategy but when reviewing the priority areas for this strategy concurred on their importance. Relative to the updated strategy, respondents agreed with the Interdisciplinary

Team in prioritizing goals involving behavioral health, substance misuse, chronic diseases, and preventive care. Cross-cutting issues involved social determinants of health and health equity. A consistent observation was the need to coordinate the many initiatives and programs targeting disparities which are in process across stakeholder organizations. Beneficiary engagement was identified as a priority area for both DMS and the MCOs.

The two areas of greatest discussion were access to care and system costs/reimbursement levels. Access issues concerned availability of providers accepting Medicaid and appointments, particularly for behavioral health care. Access to dentistry and optometry services were also identified as being acute issues. Network adequacy and geographic coverage in rural areas were also discussed by several key informants.

Reimbursement levels were discussed relative to system costs. The administrative burden of prior authorizations was a major issue highlighted, as well as the complexity of dealing with multiple MCOs. The level of reimbursement and limitations on individual encounter complexity billing levels were identified as important barriers to access by discouraging provider participation.

There was overall agreement that payment and delivery reform are needed to drive Medicaid modernization in Kentucky. Value-based contracting and other outcome-based approaches were positively discussed.

There was also a general discussion of the limitations of HEDIS measures, but participants agreed that there are few alternatives at this point.

4.2.2 Summary of Public Comments

Public Comments to this draft Quality Strategy were solicited during the period September 26 2022 to October 26, 2022. Only one comment was received during the comment period. This comment was from an MCO.[2] The comment consisted of the following:

- Errata correction to a HEDIS code abbreviation
- A suggested change to the calculation for the HbA1c targeted outcome
- Alignment of the categories of the Medicaid Managed Care Regulatory Report UM-06 to the Quality Strategy reporting requirements.

After the comment period, a comment was received from another MCO. This comment consisted of formatting and other editing related suggestions.

These comments and suggestions were incorporated into this draft as appropriate.

[2]Note that all MCO's are represented on the Interdisciplinary Team. This comment is additional formal input to that already provided through the Interdisciplinary Team process.

5.0 Quality Strategy Update

The strategies supporting delivery reform and continuous quality improvement for Medicaid Managed Care in Kentucky represented in this Quality Strategy were developed from multiple sources of information and policies. These include:

- Existing strategies in CHFS and DMS, including delivery reform
- The 2019 Quality Strategy goals and objectives
- 2019 performance measurement outcomes
- Kentucky's performance on the Core Set Measures compared to peers and national benchmarks
- External Quality Reports and Recommendations
- MCO QAPI programs
- Health disparity and health equity initiatives
- Enforcement activities, sanctions, and corrective plans for MCOs
- State demonstration and waiver programs
- State-directed payment data
- Stakeholder input

There are six specific areas in the new updated Quality Strategy:

1. Behavioral Health
2. Chronic Disease Management
3. Preventive Care
4. Delivery System Reform
5. Health Disparities
6. Social Determinants

A summary of the goals, objectives, and measures for these strategy areas is provided in Table 5. An analysis and discussion for each is provided in the sections that follow.

The 3-year target improvement is based upon an assumption that each measure shows annual improvement from the 2020 Measurement Year baseline. This assumes an increase of 3 percent for year 1; 4 percent for year 2 (using year 1 as its baseline); and 5 percent for year 3 (using year 2 as its baseline). Measures 1.1(a) and 1.1(b) have their target levels reduced based upon the process and complex nature of the activities required for improvement. Measures 1.2(b), 1.2(c), 2.2(b), 4.2(b), and 5.1(a) had the target measure reduced based upon their relatively high initial baseline measures.

Table 5: Summary of the Proposed Updated Quality Strategy including Performance Targets

Objective	Objective Description	Quality Measure [All Quality Measures will be reported by sub-populations for the purposes of ascertaining disparities, equity, and access]	Statewide Performance Baseline (2020 MY)	Statewide Performance Target for Objective 2026 MY (Annual 3/4/5% increase)[3]
Goal 1: - Improving enrollee health outcomes through improved screening, recognition, and treatment retention for individuals with behavioral health conditions.				
1.1	Increase treatment retention for those diagnosed with behavioral health disorders	1.1a) Anti-Depressant Medication Management (AMM) Effective Acute Phase Treatment Effective Continuation Phase Treatment	 53.65% 37.49%	 60.34% 41.49%
		1.1b) Adherence to Antipsychotic Medication for Persons with Schizophrenia (SAA)	58.01%	61.01%
		1.1c) Pharmacotherapy for Opioid Use Disorder (POD)	34.13%	38.39%
1.2	Improve the overall health outcomes of those with serious mental illness by minimizing risk and adverse impacts of medication treatment and increasing health screening	1.2a) Metabolic Monitoring for Children and Adolescents on Antipsychotic (APM)	28.58%	32.15%
		1.2b) Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SSD)	80.35%	83.35%
		1.2c) Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia (SMC)	73.13%	80.0%
		1.2d) Diabetes Monitoring for Persons with Diabetes and Schizophrenia (SMD)	67.35%	75.75%

[3] See assumption description in Section 5.0 above

1.3	Decrease number of emergency department visits for persons with OUD	1.3a) Emergency Department Utilization (EDU) Persons with a primary diagnosis of OUD who have any ED visit Persons who have more than one ED visit for a primary diagnosis of OUD	To Be Aggregated	To Be Determined
1.4	Increase utilization of psychosocial care for children on antipsychotics	1.4) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	63.04%	70.90%
Goal 2: Improve outcomes associated with people with the chronic diseases of diabetes mellitus, hypertension, COPD, and asthma.				
2.1	Promote evidence-based treatment for hypertension and type 2 diabetes and related complications	2.1a) HBD- Good control (HbA1c<8) BPD- Blood Pressure EED- Eye Exam KED- Kidney	42.53% 60.43% 48.70% 21.52%	46.83% 67.97% 54.78% 24.20%
		2.1b) Blood Pressure Control Measures (CBP)	54.67%	61.49%
		2.1c) Readmission rate (State Specifications-PCR)[4]	To Be Aggregated	To Be Determined
2.2	Promote evidence-based treatment for COPD and related complications	2.2a) Spirometry Testing in Assessment and Diagnosis of COPD (SPR)	23.31%	26.22%
		2.2b) Pharmacotherapy Management of COPD Exacerbation (PCE) Systemic Corticosteroid Bronchodilator	 64.88% 76.60%	 72.97% 81.1%
2.3	Promote evidence-based treatment for asthma in adolescent and COPD in the adult population	2.3a) PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD) PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Asthma in Older Adults Admission Rate (PQI05-AD)	To Be Aggregated	To Be Determined

[4] This is a state specific measure, the baseline measure needs to be aggregated from the MCOs for establishment

Goal 3: Increase use of preventative services				
3.1	Increase preventative cancer screenings among adults	3.1a) Colon Cancer Screening (COL)	16.45%[5]	18.50%
		3.1b) Cervical Cancer Screening (CCS)	55.70%	62.65%
		3.1c) Breast Cancer Screening (BCS)	46.90%	52.75%
3.2	Increase childhood physical activity and counseling	3.2 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) Counseling for Nutrition Total Counseling for Physical Activity Total BMI Percentile Total	 52.30% 50.08% 67.93%	 58.82% 56.33% 76.40%
3.3	Improve wellness visits to support healthy child development	3.3a) Well-Child Visits in the first 30 months (W30) 0-15 months ≥ 6 visits (W15) 16- 30 months	 57.87% 68.54%	 65.09% 77.09%
		3.3b) Child and Adolescent Well Care Visits 3-21 years of age (WCV)[6] 3-11 years 12-17 years 18-21 years Sum of stratifications (total)	 46.11% 38.53% 18.72% 39.48%	 51.86% 43.34% 21.06% 44.41%
		3.3c) Childhood Immunization Status (CIS Combo 10)	32.37%	36.41%
		3.3d) Immunization for Adolescents (IMA Combo 2)	30.79%	34.63%
3.4	Tobacco/Smoking Cessation	3.4a) Kentucky Smoker Quitline (DPH) and MCO program coordination on measures[7] Members who use tobacco registered Members who use tobacco engaged Members who use tobacco complete program Members' who use tobacco success rate	To Be Aggregated	To Be Determined

[5] Colon Cancer measure taken from PIP Evaluation, *Focus Study: Access to Colorectal Cancer Screening and Care Management for Kentucky Medicaid Managed Care Enrollees*, available at https://chfs.ky.gov/agencies/dms/DMSMCOReports/ColonCancerScreening2021.pdf.

[6] Benchmark category with new stratifications

[7] This measure will be aggregated in partnership between the DPH and the MCOs

Goal 4: Promote Access to high-quality care and reduce unnecessary spending				
4.1	Achieve collaborative relationships between providers & MCOs to provide care strategies such as Value Based Care	4.1a) MCO Value Based Care Data: Percent of providers under VBC Percent of members attributed to providers under VBC Percent of state identified quality metrics covered under VBC arrangements Percent improvement of quality score	To Be Aggregated[8]	To Be Determined
		4.1b) Core measures for following cohorts: VBC providers Non-VBC providers Total membership	To Be Aggregated[9]	To Be Determined
4.2	Access	4.2a) Analyze state performance for all core measures based upon sub-populations of gender, race, age, and geography.	To Be Aggregated[10]	To Be Determined
		4.2b) Covered lives with annual PCP visit Adults' Access to Preventive/Ambulatory Health Services (AAP)	79.99%	83%
		4.3c) Tele-Health Measures (New) Number of Telehealth Visits Number of Telehealth Visits by Modality (Video, Audio)	To Be Aggregated[11]	To Be Determined
Goal 5: Improve outcomes for identified special populations				
5.1	Improve outcomes for pregnant moms and newborns	5.1a) Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care Postpartum Care	 83.80% 75.18%	 86.80% 81.53%
		5.1c) Reduce Caesarian Section Rate Primary C-section (CPT Code 59510) Repeat C-section (CPT Code 59618)	To Be Aggregated[12]	To Be Determined

[8] New proposed measure with the baseline to be aggregated and reported by the MCOs
[9] New proposed measure with the baseline to be aggregated and reported by the MCOs
[10] Sub-population breakouts to support CHFS health equity initiatives
[11] New proposed measure with the baseline to be aggregated and reported by the MCOs
[12] New proposed measure with the baseline to be aggregated and reported by the MCOs

5.2	Improve care coordination for children transitioning out of foster care (aging-out)	5.2a) Well Child Visits 18-21 (WCV)	To Be Aggregated[13]	To Be Determined
		5.2b) Annual Dental Visit 2-20 years of age (ADV)	To Be Aggregated[14]	To Be Determined
Goal 6: Improve assessment, referral, and follow-up for SDOH among the Medicaid members in KY				
6.1	Improve the quality of enrollee SDOH assessment by incorporating two assessment questions to the Health Risk Assessment (HRA) to address social connectivity/isolation	6.1a) Percentage of new enrollees with a completed SDOH-Enhanced Health Risk Assessment (with at least two standardized questions to address the Social Connectivity/ Isolation Domain)	To be reporting from PIP[15]	
6.2	Improve the rate of enrollee receipt of SDOH assessments	6.2a) Percentage of enrollees enrolled in case management with a CNA that assesses SDOH Domains of Social Connectivity/Isolation, as well as housing, food insecurity, other financial problems (e.g., clothing, phone, medication) and transportation.	To be Reported [16]from PIP	

[13] New proposed measure with the baseline to be aggregated and reported by the MCOs
[14] New proposed measure with the baseline to be aggregated and reported by the MCOs
[15] This measure will be reported in a forthcoming focus study by the EQRO
[16] This measure will be reported in a forthcoming focus study by the EQRO

5.1 Individuals with Behavioral Health Conditions

The 2019 Quality Strategy focused specifically on issues of substance use disorder within the domain of behavioral health. This proposed updated strategy broadens the behavioral health related goals beyond SUD to include objectives targeting treatment retention and care coordination for individuals with serious mental illness (SMI) and the utilization of psycho-social treatments for adolescents on antipsychotic drugs. There is an overlap between the SUD and SMI populations, allowing for a potential positive interaction between the SMI and SUD objectives and their respective interventions.

As highlighted in the population health section of this document, the continued impact of substance abuse across Kentucky is clear. An analysis of 2020 Medicaid claims data indicated that 2.5% of the Medicaid population received outpatient services for SUD and there were over 7,000 newly initiated SUD diagnoses among beneficiaries each month. The proposed Quality Strategy has targeted measures on pharmacotherapy for opioid use disorder and emergency department utilization.

The SUD Medicaid population is also being addressed by an 1115 Demonstration Waiver. This waiver targets improving access to care, increasing the use of evidence-based treatment for SUD/OUD, increasing provider capacity, and improving transitions in care. The term of this waiver is through September 2023. DMS has applied to extend the waiver through 2028. This waiver demonstration complements the Quality Strategy.

Four of the behavioral health measures focus on care coordination though the monitoring and screening for individuals with SMI and on children prescribed antipsychotic drugs. Increasing the use of first-line psychosocial care for children and adolescents on antipsychotics is also a targeted quality measure from the current baseline of 62%.

The behavioral health services are recovery and resiliency focused. The MCOs work collaboratively with DMS and the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to assure that enrollees receive quality behavioral services. The MCOs and their providers use the most current version of DSM classification. They incorporate the core values that enrollees have the right to retain the fullest control possible over their behavior health treatment; that behavioral health services shall be responsive, organized and accessible to those who require behavioral healthcare; that he most normative care in the least restrictive setting will be provided in the community to the greatest extent possible. They will measure enrollee satisfaction with services.

The MCOs maintain an emergency and crisis Behavioral Health Services Hotline that is staffed by trained personnel 24 hours a day throughout the Commonwealth. Face-to-face emergency services are also available 24 hours a day, including the new 988 crisis line.

MCOs provide training to network PCPs on how to screen for and identify behavioral health disorders, the referral process for Behavioral Health Services, and clinical coordination requirements for those services.

5.2 Improve Outcomes Associated with Chronic Diseases

Kentucky continues to face major public health challenges in dealing with chronic diseases. In both the prevalence and treatment of diseases, Kentucky ranks near the bottom when compared to national benchmarks and other states. For example, Kentucky ranks 49th in the percentage of adults with three or more chronic diseases, , 49th in chronic pulmonary disorder (COPD), 48th in cardiovascular disease, 47th in asthma, 46th in hypertension, 45th in obesity, and 42nd in diabetes.

The proposed Quality Strategy builds upon the chronic diseases targeted in the 2019 Strategy. The focus has been sharpened to type 2 diabetes, hypertension, and COPD for adults, and admission rates for asthma-related diagnoses for children, for Kentucky's relative performance in promoting evidence-based treatment of these conditions lags benchmark states.

There are multiple ongoing activities and programs addressing chronic diseases in the Commonwealth. They are priorities for the Kentucky Department of Public Health (DPH), MCOs, and the federal government. The EQRO conducted a 2020 focus study on diabetes access to primary care and self-management education and support. The study included an assessment of individual MCO performance, along with recommendations to implement the QAPI work plan, which includes enhanced case management, PCP education on evidence-based care, integration of behavioral health with diabetic interventions, and improved understanding of coding practices.

DMS will assist in the coordination of the variety of activities underway. Planned quarterly meetings of the Interdisciplinary Team, which includes all MCOs and various CHFS departments (such as DPH), will review and guide the coordination of the various programs and initiatives.

5.3 Increase the Use of Preventative Services

Paralleling the goal of improving outcomes for chronic diseases is the goal of increasing preventative care. The proposed Strategy focuses on four areas: cancer screening, childhood activity levels, adolescent wellness visits, and tobacco cessation. This focus stems from the 2019 Quality Strategy, but emphasizes fewer objectives and outcomes, with the intent of marshalling and coordinating resources to advance in these specific areas.

The suggested cancer screening measures are for breast, cervical, and colon cancer. Each of these measures is a carry-forward from the current strategy. Statewide performance in breast and cervical cancer is well below benchmarks; however, NCQA benchmarks for colon cancer have not been established. But a recently completed PIP focused on colon cancer screening. The interventions and measures used in the PIP anticipated the NCQA colon cancer measures.

Given the reported health and physical activities for children in Kentucky, the proposed Quality Strategy carries forward measures for counseling and wellness visits from the current Strategy with a renewed and coordinated vigor.

Each of the MCOs has a unique tobacco/nicotine cessation program. As well, through DPH, Kentucky has a statewide program for tobacco/nicotine cessation, the Kentucky Smoker Quit line. The Quality Strategy will align these tobacco/nicotine cessation activities and require that the MCOs each report similar data and that their data parallel those collected in the state program.

In general, preventive care is directed by contract requirements for the MCOs. MCOs have programs and processes in place to address preventive healthcare needs of its population. MCOs conduct health screening assessments, including mental health and SUD screenings of new enrollees for the purpose of meeting the enrollees' health care needs within ninety days of enrollment. Collected information includes demographics, and current health and behavioral health status, which are used to determine enrollees' need for care management, disease management, behavioral health services, and any other health or community services.

5.4 Promote Access to High Quality Care and Reduce Unnecessary Spending

To meet the goals of promoting access to high quality care and reduce unnecessary spending delivery, reform is required. Key informant interviews identified access to services as the major issue and priority for beneficiaries. Access to care is closely linked to disparities and health equity. As such, beyond the objectives in this strategy, access is being addressed by larger activities, including a dedicated Equity & Determinants Branch within the Division of Quality & Population Health.

Access to care is addressed in the proposed Quality Strategy through a refinement of reporting requirements. All Core measures will now be reported by subpopulations. This will allow for a more nuanced analysis of barriers to access as well as of the characteristics of disparities. These data will provide cross-cutting utility across the quality goals and better inform Medicaid policies.

Additional access measures include tracking telehealth use and the number of beneficiaries with a primary care provider encounter.

Similarly, all stakeholders identified migration to quality-based reimbursement, such as value-based care, as critical to the evolution of Medicaid services. The current state of value-based care for Medicaid is fragmented. MCOs are contractually required to offer value-based contracts, but their characteristics, including risk-based components, are negotiated individually between the MCO and the provider organization. The quality strategy measures for the goal of reducing unnecessary spending through the use of payment reforms is focused on establishing baselines for the number, type (e.g., risk characteristics), and outcomes for Medicaid value-based contracting.

In addition, DMS will continue to work with MCOs to develop innovative value-based model(s) aimed at transitioning from a reimbursement model that rewards providers based on volume to a model that aligns payment incentives with quality, performance, and outcomes. Further, DMS will pursue additional managed care system reforms aimed at improving the efficiency and responsiveness of the current managed care delivery system.

5.5 Improve Outcomes for Identified Special Populations

Individuals with Special Health Care Needs (ISHCN) are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional conditions and who may require a broad range of primary, specialized medical, behavioral health, or related services. ISCHN have an increased need for healthcare or related services due to their conditions. As per the requirement of 42 C.F.R. 438.208, DMS has defined the following categories of individuals as ISHCN:

- Children in or receiving Foster Care or adoption assistance,

- Blind/Disabled Children under age 19 and Related Populations eligible for SSI,
- Adults over the age of 65,
- Homeless (upon identification),
- Individuals with chronic physical health illnesses,
- Individuals with chronic behavioral health illnesses,
- Children receiving Early Periodic Screening, Diagnostic, and Treatment Services,
- Children receiving services in a Pediatric Prescribed Extended Care facility or unit.

MCOs have written policies and procedures in place, which govern how enrollees with these multiple and complex physical and behavioral health care needs are screened, identified, treated, and supported. They assess each identified ISHCN enrollee in order to ascertain any ongoing special conditions that require a course of treatment or regular care monitoring. MCOs develop information and materials specific to the needs of the enrollee and distribute them to ISHCN enrollees, caregivers, parents or legal guardians, as appropriate. This information includes health educational material as appropriate to assist ISHCN or caregivers in understanding the chronic condition. MCOs produce a treatment plan for enrollees with special health care needs who have been determined to need a course of treatment or regular care monitoring.

MCOs develop practice guidelines and other criteria that consider that needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population. In addition, because DMS covers more than half of all births in Kentucky, DMS, in partnership with MCOs and other Cabinet Departments, has several programs aimed at improving outcomes for pregnant mothers, infants, and children. The DPH-operated Kentucky Health Access Nurturing Development Services (HANDS) program is a voluntary home visitation program that supports families through pregnancy and the first two years of life. DMS and MCOs also help support children and families through Early and Periodic Screening, Diagnostic and Treatment (EPSDT). In Kentucky, EPSDT is divided into two components: EPSDT Screenings and EPSDT Special Services. The EPSDT Screening Program provides routine physicals or well-child check-ups for eligible children at specified ages. Children are checked early for medical problems, through preventive check-ups; growth and development assessments; vision, hearing, and tooth exams; immunizations; and laboratory tests. If conditions are discovered via screening, additional services and supports may be available.

The Supporting Kentucky Youth (SKY) program is the Commonwealth's Medicaid risk-based managed care delivery program for Foster Care Enrollees and Dually Committed Youth (DCBS and DJJ) through a single MCO, Aetna Better Health of Kentucky . Former Foster Care Youth Enrollees, Adoption Assistance Enrollees, and DJJ Youth may opt to participate as well. A care coordination team is assigned to each SKY beneficiary who ensures access to primary care, behavioral health services, dental care, specialty care, wraparound services, and social support services, with level-of-care management tailored to meet individual needs.

Led by DBHDID, with support from DMS and MCOs, the Kentucky Opioid Response Effort (KORE) is designed to be a comprehensive targeted response to Kentucky's opioid crisis by expanding access to a full continuum of high quality, evidence-based opioid prevention, treatment, recovery, and harm reduction services and supports in high-risk geographic regions of the state. KORE's target populations include persons who have survived an opioid-related

overdose, those pregnant or parenting, justice-involved individuals, children, transition-age youth, and families.

Objectives targeting specific special populations are included in the proposed quality strategy. The greatest concerns are for improving outcomes for pregnancy and newborns and for improving care coordination for children transitioning out of foster care.

Kentucky lags national benchmarks in pre-natal and post-partum care, therefore these basic services have been targeted for improvement. Kentucky also ranks in the bottom quartile in the number of Cesarean births. While not supported by a HEDIS measure, the Quality Strategy begins tracking C-section births by MCO based upon CPT codes. This is designed to support recent CMS initiatives aimed at low-risk Cesarean delivery to improve outcomes and reduce disparities.

Improving care coordination for children transitioning out of foster care is also an objective for special populations. While aging-out of foster care, adolescents risk falling out of Medicaid coverage or potentially experiencing care discontinuities. The measures focus on tracking and improving well-child visits and annual dental visits for this cohort.

Consideration was also given to including objectives and measures for behavioral health services to justice-involved individuals. The expectation is that Kentucky's request for an amendment to the 1115 Waiver SUD Demonstration focused on justice-involved individuals will be approved and in place before this Quality Strategy is implemented and would result in overlapping objectives and measurements. Therefore, the consideration was tabled.

5.6 Improve Assessment Referral and Follow-up for SDOH for Beneficiaries

DMS recognizes the cross-cutting importance of social determinants to the quality of service and outcomes for Medicaid beneficiaries. This is evidenced by the July 2022 reorganization of DMS to include an Equity and Determinants of Health Branch within the Division of Quality & Population Health. In addition, DMS and the MCOs are in the final year of a PIP focused on social determinants, *Improving Assessment, Referral, and Follow-up for Social Determinants of Health.* This PIP is the basis for the objectives and measures included in this Quality Strategy. Essentially, it is a continuation of two of the three objectives for the PIP that have been found to be measurable and inferential.

The two objectives focus on baseline assessment of beneficiaries for connectivity/isolation risk measures and increasing the number of new enrollees and beneficiaries enrolled in case management that receives an assessment for social determinants. The measure that is not carried-forward from the PIP required clinical measures and are not ascertainable by data available to MCOs.

6.0 Cross Cutting-Considerations and the Quality Strategy

6.1 Quality Measure Alignment with Child and Adult Core Set Measures

Kentucky's performance on the Child and Adult Core set measures was used in developing the Quality Strategy in two ways. The first was to identify areas of focus and improvement through results and comparisons to national benchmarks and other states. The second was to align the Quality Strategy measures as closely as possible to Core measures. The EQRO Comprehensive Report 2019 included clinical measures as indicators for some of the goals. This complicated data collection, interpretations, benchmarking, and comparisons.

In the updated Quality Strategy, HEDIS measures are not fully useful. The goals of increasing value-based care, tobacco/nicotine cessation activities, and the use of telehealth are not directly related to HEDIS outcome measures . However, they have been deemed important activities in the Commonwealth and their measurement is central to the alignment and coordination of activities. As such, data will be collected to determine relative benchmarks in Kentucky.

In other cases, HEDIS measures are not available. The SDOH and colon cancer screening goals carry forward measurements from PIPs. The colon cancer PIP anticipated and is in alignment with the forthcoming NCQA colon cancer screening measure. C-Section rate measures use CPT codes, which are captured in claims data and will be comparable to other federal initiatives targeting this area.

Kentucky's overall Core Set Performance comparing 2018 to 2020 was inadequate. While impacted by the COVID-19 pandemic and associated challenges, some performance measures declined, such as annual dental visit (12%), while others, such as initiation of alcohol and other drug abuse treatment increased (8.5%). According to the EQR Comprehensive Report[viii]:

> Excluding the 6 measures that should not be trended according to NCQA, 19 of the remaining 35 measures (54%) showed improvement in rates between HEDIS 2018 and HEDIS 2020, while the other 16 trendable measures (46%) did not show improvement. Compared to national benchmarks, rates for 8 of the 41 measures (20%) met or exceeded the national 50th percentile, while 19 measure rates (46%) met or exceeded the national 25th percentile, but were below the national 50th percentile, and another 14 measure rates (34%) were below the national 25th percentile.

As indicated by the Core Measure performance, there is opportunity for improvement. As noted, the updated Quality Strategy is taking the approach of targeting fewer goals and allocated more focused resources to them. The approach to PIPs is similar. DMS and the various stakeholder oversight initiatives will continue to track performance on the targeted quality measures as well as Kentucky's overall performance in the Core Measure set.

6.2 Alignment with Other Managed Care Tools

The Medicaid Managed Care Quality Strategy provides a central organizing tenet for DMS. As described in this document, this includes driving an alignment within a range of managed care

tools including population-health-focused delivery models, risk and value-based payment models, interventions including PIPs and QAPI programs, coordination with public health and other initiatives within CHFS, and oversight activities.

6.3 Quality Assurance and Performance Improvement Activities

QAPI activities by the MCOs are monitored and reviewed for compliance with state and federal regulations by the EQRO. All MCOs scored as full or substantial performance relative to QAPIs for access, utilization management, measurement and improvement, health information systems, credentialing, and delegated services. MCOs are required to submit a quarterly report concerning quality related QAPI activities. All the areas and reported measures are derived from the current Quality Strategy. This assures a high degree of coordination between DMS and the MCOs driven by the Quality Strategy.

6.3.1 Performance Improvement Project (PIPs) and PIP Interventions

Performance Improvement Projects (PIPs) are a primary vehicle for assessing and improving the processes and outcomes of healthcare provided by an MCO. During the period 2019 – 2022, four PIPs were completed or initiated. These PIPs are summarized in Table 6. All PIPs are subject to review by the EQRO in the annual technical report and are assessed for:

1. Assessment of the study methodology
2. Verification of the PIP study findings
3. Evaluation of the overall validity and reliability of study results.

Two of the PIPs undertaken under the 2019 Quality Strategy have been used as objectives and measures for the proposed Quality Strategy.

6.3.2 Quality of Care Focused Studies

In coordination with DMS and the EQRO the MCOs are engaged in quality focus reports. These reports allow for the comparison of activities and performance across the MCOs, inform Medicaid policies, and identify the potential for managed care interventions to improve access, utilization, and quality of care. Table 7 provides a summary of focused studies since the implementation of the 2019 Quality Strategy

These studies were used to inform and develop the proposed Quality Strategy including the objectives and measures. Two of the focused studies resulted in follow-on PIPs, Colon Cancer Screening, and Social Determinants of Health, both of which used measures originally used in the study for the Quality Strategy.

Table 6: Performance Improvement Projects (PIP) and PIP Interventions

PIP: Social Determinants of Health (SDOH)	
PIP AIM	**PIP Intervention**
Improve the quality of enrollee SDOH assessment by incorporating assessment questions to address the SDOH domain of social connectivity/isolation.	• Adding two additional questions to the Health Risk Assessment
Improve the rate of enrollee receipt of SDOH assessment	• Enhancing Health Risk Assessment (HRA) outreach, contact and engagement processes for new enrollees • Incorporating a standardized SDOH assessment tool, such as PRAPARE, into the Comprehensive Needs Assessment (CNA) for enrollees eligible for case management. • Standardized tools include validated measures of SDOH issues, so provide an evidence-based means to identify reliable and valid indicators of SDOH issues. • Educating and engaging PCPs in SDOH assessment and coding.
Improve the rate of enrollee receipt of SDOH referral, follow-up and care coordination with the enrollee, PCPs and community mental health providers	• Using findings of social connectivity/isolation issues identified by the SDOH-enhanced H.R.A. and C.N.A. to inform CM determinations of unmet social connectivity need and referrals to PCPs for depression screening, health plan mental health crisis hotline, and community resources for emotional support. • Incorporating SDOH goals and outcomes into the plan of care, with referrals and follow-up for enrollees in case management. • Conducting discharge planning with hospital discharge planners to include SDOH assessment and referral, for enrollees with a psychiatric hospitalization, i.e., i.e., mental health disorder diagnosis and/or substance use disorder diagnosis (drug or alcohol abuse/dependence).
PIP: Improving Diabetes Management	
PIP AIM	**PIP Intervention**
Reduce the percent of enrollees with poorly controlled diabetes	• Increase The Diabetes Self-Management Education and Support (DSMES) enrollee engagement rate among enrollees newly diagnosed with T2DM • Increase the proportion of enrollees with poorly controlled diabetes with an endocrinologist visit
Reduce the prevalence of type 1 diabetic ketoacidosis among children	• Educate pediatric primary care providers (PCPs) and parents about warning signs of T1DM
Enhance case management and care coordination for enrollee outreach, diabetes education about nutrition and exercise, and engagement and referral to DSMES	• ITM to monitor quarterly progress of care coordination interventions for DSMES referrals. • The percentage of enrollees 18-75 years of age diagnosed with T2DM (i.e., ICD-10 code E11) and who were screened for pre-diabetes/diabetes (i.e.,

	Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes 82947 or 82950 or 82951 or 83036, or ICD-10 code Z13.1) during the 12 months prior to the first diagnosis of T2DM [denominator] and who had a claim for DSMES (i.e., HCPCS/CPT codes G0108 and G0109) during the six months after diagnosis [numerator]. • Of note, the presence of screening codes during the 12 months prior to the first T2DM diagnosis is an indicator of a new diabetes diagnosis.
Enhance case management and care coordination interventions for endocrinologist referrals	• ITM to monitor quarterly progress of care coordination interventions for endocrinologist referrals: The percentage of adults enrolled in diabetes case management and/or disease management program and who have poor HbA1c control, as indicated by the adverse lab result alert [denominator] who had an endocrinologist visit within three months of the adverse lab result alert [numerator].
Educate PCPs on evidence-based HbA1c testing, patient communication, indications for referral to endocrinologists and DSMES, as well as diagnosis of type 1 diabetes mellitus in children and adolescents, i.e., early signs and symptoms	• ITM to monitor quarterly progress of education intervention for PCPs and parents on T1DM early warning signs: The percentage of pediatric PCPs who received Provider Relations or Quality Practice Advisor education about incorporating assessment of signs and symptoms of T1DM into well child visits with parent education
PIP: Weight Management	
PIP AIM	**PIP Intervention**
Improve the rate for counseling for nutrition among the total SKY population aged 3-18 years.	• Improve the rate of receipt of counseling for nutrition and counseling for physical activity among the total SKY population by creating member care gap reports for PCPs and DCBS staff that identify all SKY enrollees without nutrition counseling and/or physical activity counseling codes. The MCO CM shares these gap reports with DCBS staff and PCPs and conducts education and care coordination to close these gaps.
Improve the rate for counseling for physical activity among the total SKY population aged 3-18 years.	• Develop a Plan of Care (POC) for each enrollee in the SKY population with overweight status or obesity. The POC should be developed in collaboration with the child and foster parent/caregiver, DCBS social worker and PCP. The POC should include goals and interventions in accordance with the Bright Futures algorithm for Stage 1 Prevention Plus, Stage 2 Structured Weight Management, Stage 3 Comprehensive Multi-disciplinary Intervention, and Stage 4 Tertiary Care Intervention (AAP, 2015). • Educate all foster parents/guardians/caregivers using parent education resources such as the “Five-Two-One-Almost None” suggestions and tips for healthier eating and physical activity (Nemours Health & Prevention Services, 2010).

Improve the evidence-based management and treatment of overweight and obesity among the SKY population aged 3-18 years.	• Educate PCPs who treat children and adolescents about the evidence-based guidelines for weight management • Collaborate with external collaborators to facilitate referrals from PCPs to Stage 2 Structured Weight Management, Stage 3 Comprehensive Multi-disciplinary Intervention, and Stage 4 Tertiary Care Intervention (AAP, 2015).
PIP: Colorectal Cancer Screening	
PIP AIM	**PIP Intervention**
Improve the rate of early screening for colorectal cancer among eligible enrollees aged 45-50 years	• Home Test Intervention for Early CRC Screening: Identify enrollees aged 45-49 years who have not been screened for colorectal cancer by creating a member gap report and conducting direct member outreach with education and offer for mailed FIT or gFOBT home test, as well as addressing any concerns about out-of-pocket costs, with corresponding provider education. • Organize the "Enrollees Aged 45-49 years Eligible for Early Screening" member gap report by Care Manager/ Care Coordinator/Community Health Outreach Worker (CM/CC/CHOW). • Conduct direct member outreach with education and offer for mailed FIT or gFOBT home test • Organize the "Enrollees Aged 45-49 years Eligible for Early Screening" member gap report by PCP for distribution to PCPs. • Conduct direct provider outreach with education about ACS and USPSTF recommendations for CRC screening starting at 45 years of age, as well as the mailed FIT or gFOBT home test benefit.

Table 7: Quality of Care Focused Studies

Focus Study	Date Completed	Objectives
Diabetes Access to PCPs, Specialists, and Self-Management Education and Support	2020	• Quantify the total number of members with a diagnosis of T1DM (International Classification of Diseases, Tenth Revision [ICD-10] code E10) and T2DM (ICD-10 code E11) for members with continuous enrollment during the12-month measurement year, by adult and child age groups, and by MCO. • Quantify the proportion with at least one endocrinologist visit, without an endocrinologist visit but with a PCP visit, and with neither an endocrinologist nor PCP visit. • Identify the top five most prevalent short-term complication diagnoses and the top five most prevalent long-term complication diagnoses (earliest occurring primary or principal diagnosis during the measurement period), and stratify prevalence by demographic, clinical, and health care utilization characteristics. • Quantify the proportion of members with newly diagnosed T2DM who have a claim for DSMES (i.e., HCPCS/CPT codes G0108 and G0109) during the 6 months after diagnosis. • Stratify DSMES receipt and non-receipt by demographic, clinical, and health care utilization characteristics. • Identify risk factors for non-receipt of DSMES. • Identify trends/opportunities for improving member receipt of evidence-based care.
Social Determinants of Health, Hospital Readmissions and Multiple ED Visits	2020	• Quantify SDOH prevalence by type using ICD-10 codes for SDOH-related problems (Table 1), including the domains of social connection/isolation, housing issues and income/financial resource strain, as well as possible adverse childhood experiences, as indicated by ICD-10 codes for problems related to upbringing, and frailty conditions pertinent to SDOH. • Profile enrollee demographics (e.g., age group, race/ethnicity, area of residence); clinical factors (i.e., adults with multiple high-risk chronic conditions, as specified in the value sets listed in the Healthcare Effectiveness Data and Information Set [HEDIS®] 2019 • Follow-up After Emergency Visit for People with Multiple High-Risk Chronic Conditions [FMC] measure [e.g., chronic obstructive pulmonary disease, asthma, Alzheimer's disease, dementia, chronic kidney disease, depression, heart failure, acute myocardial infarction, atrial fibrillation, stroke and transient ischemic attack], serious mental illness [HEDIS Value Sets for depression, schizophrenia, an bipolar disorder], substance abuse/dependence [HEDIS Value Sets for detoxification, drug abuse, other drug disorder, other drug abuse and dependence, alcohol abuse and dependence]); and health-care-access–related

		factors (e.g., primary care practitioner [PCP] visits, MCO, one or more 30-day hospital readmissions, six or more ED visits during a 12-month period • Utilize administrative/claims data among total enrollees with any hospital encounter(s) to identify disparities by enrollee subsets by quantifying the proportions of enrollees who are high utilizers by demographic, clinical, SDOH domains and health-care-access–related subsets. • Conduct a chart review of a random sample of Kentucky MMC enrollees for the most recent 12-month timeframe comprising two subsamples. • Review MCO care management charts to assess enrollee receipt of SDOH assessment (e.g., conducted utilizing PRAPARE or other standardized SDOH assessment tools) and interventions to address SDOH (e.g., referrals to a resource listing, warm hand-off to a resource provider, engage in care management by scheduling the appointment with the resource provider, and follow-up with the enrollee and PCP). • Identify missed opportunities for MCO care managers to identify SDOH-related enrollee needs, as well as missed opportunities to address these needs.
Access to Colorectal Cancer Screening and Care Management for Kentucky Medicaid Managed Care Enrollees	2021	• Evaluate disparities in access to CRC screening overall among enrollees aged 45–75 years during the study period from July 1, 2018 to June 30, 2020. • Evaluate disparities in access to timely initial CRC screening among enrollees aged 45–50 years, i.e., within 12 months of reaching the age of eligibility for the first CRC screening (starting at age 45 per the ACS recommendation and age 50 per the USPSTF recommendation). • Assess receipt of care coordination to facilitate CRC screening for enrollees aged 45–50 years of age who are eligible for the initial CRC screening. • Assess receipt of care coordination and case management for enrollees with a CRC diagnosis.
COVID19 Hospital Encounters, Mortality and Access to Telehealth Services	2021	• Profile the outcomes of COVID-19 prevalence (i.e., ICD-10 code U07.1, COVID-19 confirmed diagnosis), hospitalization for COVID-19, and hospital discharge status of expired to identify associations between demographic, clinical, SDoH, and healthcare system access-related factors and hospitalization for COVID-19; and hospital discharge status of expired among enrollees with a COVID-19-related hospitalization. • Quantify risk factors for hospitalization for COVID-19; and hospital discharge status of expired among enrollees with a COVID-19-related hospitalization. • Profile non-receipt of telehealth services among KY MMC enrollees who utilized ambulatory care services. • Identify associations between demographic, clinical, SDoH and healthcare system access-related factors and non-receipt of telehealth among KY MMC enrollees with ambulatory care encounters; and among KY MMC enrollees with

		ambulatory care encounters and signs and symptoms of COVID-19 diagnosed at the ambulatory care encounter. • Quantify risk factors for non-receipt of telehealth services among KY MMC enrollees with ambulatory care utilization; and among KY MMC enrollees with ambulatory care utilization and COVID-19 signs/symptoms.
Health Equity Focus Study: Racial/Ethnic and Geographic Disparities in Availability, Access to, and Quality of Health	2022	• Identify racial/ethnic and geographic disparities in effectiveness of care, access and availability of care and utilization. • Conduct analysis of disproportionate under-representation by HEDIS race/ethnicity combined categories. • Map Kentucky MMC geographic performance indicator rates by county of member residence.
Perspectives on Kentucky's Medicaid Managed Care Organizations: Key Findings from Interviews with Primary Care Providers	2022	• The objective was to elicit direct feedback from PCPs on their experiences with Kentucky MCOs' care management and quality improvement efforts. • This qualitative research study conducted semi-structured interviews with high-volume PCPs who provide care to MMC enrollees.

6.4 Annual EQR Technical Reports

Kentucky requires the contracted EQRO to perform the mandatory and optional EQR activities utilizing the nine protocol documents. Annually, the EQRO will review MCO 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 is available on the DMS website.

The EQRO provides monitoring of contracted MCOs. Specifically, the EQRO conducts on-site MCO annual compliance reviews, access and availability, validation of performance measures, validation of performance improvement projects, and NCQA HEDIS compliance audits. An annual Technical Report is submitted to DMS, outlining review focus and findings as well as recommendations to each MCO on opportunities to improve DMS enrollee healthcare quality for the coming year.

The most recent Technical Report was completed and submitted in April 2022. 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 optional quality-focused activities. Report results provide information regarding the effectiveness of the managed care organizations program, identify strengths, and weaknesses and provide information about problems or opportunities for improvement. This information is incorporated into the Quality Strategy and used to initiate and develop quality improvement projects.

6.5 State Directed Payments

The May 2016 Managed Care Final Rule allowed Kentucky to make directed payments, which could either take the form of uniform payment increases or value-based purchasing for a class of providers. They allow Kentucky to make enhanced payments to providers to advance the goals of the Medicaid program. In general, directed payments are:

1. Based on the utilization and delivery of services.
2. Designed to advance at least one goal of the State Medicaid program's quality strategy with appropriate oversight to evaluate progress on the goals.
3. Evaluated at the end of each program year to measure progress on achieving outlined goals.
4. Submitted to CMS for approval annually.

DMS provides directed payments, as approved by CMS, to support provider payment initiatives which support both delivery reform and the Quality Strategy. The directed payments consist of a combination of uniform payment increases and value-based purchasing. These directed payments support three programs, a hospital rate improvement program, an ambulance provider assessment program, and university programs. These programs are evaluated annually and require annual CMS approval.

The hospital rate improvement program increases the funding available to hospitals to increase payments to advance the quality of care for Medicaid members and provide a stable based for hospitals that extend beyond the COVID-19 pandemic. The value-based funding portion of the program consists of 10% of the pool. The Quality Strategy goals addressed are improved access to care, lower hospital readmissions, and two opioid related metrics.

The ambulance provider assistance program provides enhanced payments to ground ambulance service providers. The program addresses the quality goals of increasing access to care, increasing the number of qualified ambulance providers, and reducing unnecessary spending. Associated quality goals are reducing ambulance response times and increasing the number of certified EMS practitioners.

Supplemental payments for university programs include increased operating expenses for pediatric teaching hospitals, a state-designated urban trauma center, state university teaching hospital faculty (medicine and dentistry), and a designated psychiatric hospital. These allowances preserve the ability of these entities to provide essential services to Kentucky residents.

Additional state-directed payments associated with the updated Quality Strategy will be considered as appropriate in consultation with stakeholders and advisory groups.

6.6 Long Term Services and Supports (LTSS) Performance

Under Kentucky Revised Statute §907 KAR 17:020, LTSS are not contracted for under managed care plans. They are managed by Fee for Service (Traditional) Medicaid.

6.7 Disparity Initiatives

Please see Section 3.3 for a description of the DMS disparity initiatives.

6.8 Contract Violations, Breach, or Non-performance

DMS may conduct performance reviews at its discretion at any time that relate to any MCO responsibility for timely and responsive performance of Contract requirements. Based on such performance reviews or as determined through other means, upon the discovery of an MCO's or Subcontractor's violation, breach, or non-performance of the terms, conditions, or requirements of the MCO Contract, DMS shall assign the violation, breach, or non-performance into one of the following categories of risk:

A. **Category 1:** Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of Enrollee(s); reduces Enrollees' access to care; and/or jeopardize the integrity or viability of Kentucky's Medicaid Managed Care program;

B. **Category 2:** Action(s) or inaction(s) that jeopardize the viability or integrity of Kentucky's Medicaid Managed Care program, but do(es) not necessarily jeopardize Enrollee(s') health, safety, and welfare or reduce access to care; or

C. **Category 3:** Action(s) or inaction(s) that diminish the efficient operation and effective oversight and administration of the Kentucky Medicaid Managed Care program.

6.8.1 Requirement of Corrective Action

DMS will consider some or all the following factors in determining need to impose remedial action(s), intermediate sanction(s), penalty(ies), and/or liquidated damages against the MCO:

1. Risk category assignment based on the nature, severity, and duration of the violation, breach, or non-performance;
2. The type of harm suffered (e.g., impact to quality of care, access to care, Program Integrity);
3. Whether the violation (or one that is substantially similar) has previously occurred;
4. The timeliness in which the MCO self-reports a violation;
5. The MCO's history of compliance;
6. The good faith exercised by the MCO in attempting to stay in compliance (including self-reporting by the MCO); and
7. Any other factor DMS deems relevant based on the nature of the violation, breach, or non-performance.

Should DMS determine that the MCO or any Subcontractor is in violation or is at risk of violation of any requirement of the MCO Contract, DMS shall issue a "Letter of Concern." The MCO shall contact DMS's representative within two (2) Business Days of receipt of the Letter of Concern and shall indicate how such concern is unfounded or how it will be addressed. If the MCO fails to timely contact the designated representative regarding a Letter of Concern, DMS shall proceed to the additional enforcement contained in the MCO Contract.

DMS may impose additional remedial actions, intermediate sanctions, penalties, or liquidated damages or elevate the violation to a higher Category of Risk if the non-compliance continues, or if the MCO fails to comply with the originally imposed action.

6.8.2 Corrective Action Plan

Should DMS determine that the MCO or any Subcontractor of the MCO is not in substantial compliance with any material provision of the MCO Contract, DMS shall issue a Written Deficiency Notice to the MCO specifying the deficiency and requesting a corrective action plan be filed by the MCO within ten Business Days following the date of the notice. DMS reserves the right to require a more accelerated timeframe if the deficiency warrants a more immediate response.

A corrective action plan shall delineate the following information at a minimum:

1. The names of the individuals who are responsible for implementing the corrective action plan.
2. A description of the deficiency(ies) and the cause of the deficiency(ies) that resulted in need for corrective action.
3. A detailed approach for addressing the existing deficiency(ies) and prevention of the repeated and/or similar deficiency(ies) in the future.
4. The timeline for implementation, establishment of major milestones and correspondence dates to DMS, and notification of completion of corrective actions.

The corrective action plan shall be subject to approval by DMS, which may accept the plan as submitted, may accept the plan with specified modifications, or may reject the plan within ten Business Days of receipt. DMS may reduce the time allowed for corrective action depending upon the nature of the deficiency.

6.8.3 Notice of MCO Breach

A MCO shall be considered in breach if the MCO is not in substantial compliance with any material provision of the MCO Contract that cannot be cured, if the MCO fails to cure a default in accordance with a plan of correction under Section 39.3 "Requirement of Corrective Action" after issuance of a Sanction, or comply with Sections 1932, 1903(m), and 1905(t) of the Social Security Act, or 42 C.F.R. 438. Upon determination of MCO breach, FAC shall issue a timely written notice to the MCO, explaining any Appeal rights provided to the MCO, indicating the nature of the default, and advising the MCO that failure to cure the default within a defined time period to the satisfaction of DMS, may lead to the imposition of any sanction or combination of sanctions provided by the terms of the MCO Contract, or otherwise provided by law, including but not limited to all of the following:

A. Suspension of receipt of further Enrollment for a defined time period after the date the Secretary or the Commonwealth notifies the MCO of a determination of a violation of any requirement under Sections 1903(m) or 1932 of the Social Security Act;
B. Suspension of Capitation Payments for Enrollees after the effective date of the sanction and until CMS or DMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;
C. Suspension or recoupment of the Capitation Rate paid for any month for any Enrollee who was denied the full extent of Covered Services meeting the standards set by the MCO Contract, or who received or is receiving substandard services;
D. A claim against MCO's Performance Bond;
E. Appoint temporary management;
F. Grant Enrollees the right to disenroll without cause and notifying the affected Enrollees of their right to disenroll; and
G. Termination of the contract.

DMS shall impose mandatory temporary management when a MCO repeatedly fails to meet substantive requirements established in Sections 1903(m) or 1932 of the Social Security Act or 42 C.F.R. 438. It shall not delay the imposition of temporary management to provide a hearing and shall not terminate temporary management until it determines that the MCO can ensure the sanctioned behavior will not reoccur. If DMS imposes temporary management, DMS shall notify affected Enrollees of their right to terminate enrollment without cause, pursuant to 42 C.F.R. 438.706(b).

Additionally, DMS may impose civil money penalties in the circumstances and amounts as required in 42 C.F.R. 438.700.

7.0 Performance Measures

7.1 Quality Measurement and Reporting

The MCOs incorporates outcomes measurement against relevant targets and benchmarks. DMS specifies performance and outcomes measures that MCOs must address, including HEDIS and Kentucky-specific measures. Please see section 7.2 below for additional detail on MCO claims-based quality reporting.

In addition to the analysis of claims data, DMS, MCOs, providers and other stakeholders will work collaboratively to develop the capacity to use clinical quality data for value-based performance improvement. Clinical quality measures will be aligned with DMS Managed Care Quality Aims. DMS and MCOs will work with selected health care providers to monitor and report quality measures for Medicaid enrollees. DMS will establish state-level baselines for all reported measures and set performance thresholds for each measure using baseline data. To support the transition to value-based care, providers need to meet or exceed the DMS performance thresholds for selected quality measures to be eligible for performance bonuses if applicable.

7.2 Quality Strategy Development, Review, and Revision

The Quality Strategy and the CMS Quality Strategy Toolkit is reviewed at least annually. DMS contracts with Island Peer Review Organization (IPRO) as its External Quality Review Organization (EQRO). All contracts entered into by DMS incorporate the requirements and language imposed under 42 CFR 438.

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

MCOs conduct an annual survey of enrollees' and providers' satisfaction with the quality of services provided and their degree of access to services. The enrollee satisfaction survey requirement is satisfied by the MCO 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. Annually, the MCO is required to assess the need for conducting special surveys to support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services. Additional sources of participant input include enrollee grievances, public forums.

Quality Strategy documents are posted on the DMS website for public comment. Each MCO establishes and maintains an ongoing Quality and Member Access Committee (QMAC) composed of enrollees, individuals from consumer advocacy groups or the community who represent the interests of the enrollee 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 the Medicaid Technical Advisory Committee's (TACs) with consumer representation. This enrollee 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.

The Interdisciplinary Team created to update this Quality Strategy will continue as a voluntary work group to meet at least quarterly and review the barriers and enablers of the quality strategy, measurement issues, performance, and issues of disparities and equity. This team can provide comments to DMS which would be subject to the processes of public comments described above.

7.3 Development and Implementation of the Quality Improvement Plan

MCOs use UM/QI data to profile provider practices, comparing them against experience and norms for comparable individuals. UM/QI data are also used to profile the utilization of providers and enrollees and compare them against experience and norms. The EQRO conducts an annual provider data validation survey. The purpose is to determine the accuracy of the provider data files and determine whether the providers are available and accessible to DMS enrollees. Credentialing and re-credentialing is performed in compliance with NCQA standards, KRS 205.560(12), 907 KAR 1:672 or other applicable state regulations and federal law.

The MCOs monitor provider actions to ensure they comply with the DMS policies which include:

- Maintaining continuity of the enrollee's health care
- Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within the MCO's network
- Maintaining a current medical record for the Enrollee, including documentation of all primary care providers (PCP) and specialty care services
- Discussing Advance Medical Directives with all Enrollees as appropriate
- Providing primary and preventative care, recommending or arranging for all necessary preventive health care, including EPSDT for persons under the age of 21 years
- Documenting all care rendered in a complete and accurate medical record that meets or exceeds DMS's specifications
- Arranging and referring enrollees when clinically appropriate, to behavioral health providers.

Providers will be terminated from participation if they (i) engage in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) have a license, certification, or accreditation terminated, revoked or suspended; (iii) have medical staff privileges at any hospital terminated, revoked or suspended; or (iv) engage in behavior that is a danger to the health, safety or welfare of enrollees. The MCO is to notify the DMS if this occurs. Likewise, the DMS will notify the MCO of any suspension, termination, and exclusion actions taken against Medicaid providers by the DMS.

The MCO, through the QAPI program, shall monitor and evaluate progress in improving the quality of health care and outcomes on an ongoing basis and provide updates to DMS on progress during quality meetings and at DMS's request on an ad hoc basis. Health care needs such as preventive care, acute or chronic physical or behavioral conditions, social determinants of health and high volume, high risk, and special health care needs populations shall be studied and prioritized for performance measurement, performance improvement and/or development of practice guidelines.

The MCO's Quality Management and performance improvement activities shall demonstrate the linkage of quality initiatives and projects to findings from multiple quality evaluations, such as the EQR annual evaluation, opportunities for improvement identified through performance metrics (e.g., annual HEDIS™ indicators), results of consumer and provider surveys, internal surveillance and monitoring, as well as any findings identified by DMS or an accreditation body.

The MCO shall use appropriate multidisciplinary teams to analyze and address data or systems issues. The MCO shall collaborate with existing provider Quality Improvement activities and, to the extent possible, align with those activities to reduce duplication and to maximize outcomes.

Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee. Areas identified for improvement shall be tracked and corrective actions taken as indicated. The effectiveness of corrective actions shall be monitored until problem resolution occurs. The MCO shall perform reevaluations to ensure that improvement is sustained.

The MCO shall annually review and evaluate the overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Enrollees. The MCO shall modify as necessary, the QAPI program, including Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols; utilization and access to Covered Services; and treatment outcomes to meet the needs of Enrollees. The MCO shall prepare a written report to DMS detailing the annual review and shall include a review of completed and continuing QI activities that address the quality of clinical care and service; trending of measures to assess performance in quality of clinical care and quality of service; any corrective actions implemented; corrective actions which are recommended or in progress; and any modifications to the program. There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive and behavioral health care, provided to Enrollees. The MCO shall submit this report as specified by DMS. DMS shall give the MCO advance notice of the due date of the annual QAPI report. DMS may require interim reports more frequently than annually to demonstrate MCO progress.

7.4 Role of Utilization Management

The MCO's UM program and processes are to be in accordance with 42 CFR 456, 42 CFR 431, 42 CFR 438 applicable state and federal laws and regulations, and NCQA standards. Timeframes for service review decisions will conform to those set forth in 42 CFR 456. The program identifies and describes the mechanisms to detect under-utilization as well as over-utilization of services.

The MCO's QI Plan contains methods for integrating the Quality Improvement activity with other management activities including utilization management. The MCOs analyze and report on trends in utilization, and any unusual patterns about which the MCO will take subsequent action. The utilization management/quality improvement (UM/QI) data is used to produce reports which focus on access, availability and continuity of services, quality of care, detection of over and underutilization of services, and the development of defined reporting criteria and standards.

The MCOs UM program also monitors and evaluates the appropriateness of care and services on an ongoing basis. Each MCO is required to establish an internal utilization management committee, including Kentucky-based provider representation, that focuses on oversight of clinical service delivery trends across its membership, including evaluating utilization, patterns of care, and key utilization indicators.

The MCO develops or adopts written medical necessity review criteria that are based on sound medical evidence or judgment. These criteria are reviewed at least annually and updated as needed by the MCO. DMS reviews and approves the criteria prior to use and requires adequate notification to the providers of any change in criteria. The MCO includes practicing physicians and other providers in the MCO's provider network in the review and adoption of medical necessity criteria. The MCO has in place mechanisms to check the consistency of the application of review criteria.

7.5 Quality and Performance Modeling of Individual Providers

MCOs use UM/QI data to profile provider practices, comparing them against experience and norms for comparable individuals. UM/QI data are also used to profile the utilization of providers and enrollees and compare them against experiences and norms. The EQRO conducts an annual provider data validation survey. The purpose is to determine the accuracy of the provider data files and determine whether the providers are available and accessible to DMS enrollees. Credentialing and re-credentialing is performed in compliance with NCQA standards, and applicable state regulations and federal law.

The MCOs monitor provider actions to ensure they comply with the DMS policies that include:

- Maintaining continuity of the enrollee's health care;
- Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within the MCO's network;
- Maintaining a current medical record for the Enrollee, including documentation of all primary care provider (PCP) and specialty care services;
- Discussing Advance Medical Directives with all Enrollees as appropriate;
- Providing primary and preventative care, recommending or arranging for all necessary preventive health care, including EPSDT for persons under the age of 21 years;
- Documenting all care rendered in a complete and accurate medical record that meets or exceeds DMS's specifications; and
- Arranging and referring enrollees when clinically appropriate, to behavioral health providers.

Providers will be terminated from participation if they (i) engage in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) have a license, certification, or accreditation terminated, revoked or suspended; (iii) have medical staff privileges at any hospital terminated, revoked or suspended; or (iv) engage in behavior that is a danger to the health, safety or welfare of enrollees. The MCO is to notify the DMS if this occurs. Likewise, the DMS will notify the MCO of any suspension, termination, and exclusion actions taken against Medicaid providers by the DMS.

7.6 Frequency of State Reviews and Effectiveness of the Quality Strategy

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 contracted EQRO

will perform an annual review of MCOs compliance with state and federal regulations. This activity includes documentation review and interviews with MCO staff.

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.

7.7 Significant Changes to the Quality Strategy

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 stakeholder 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 when significant changes are made.

8.0 MCO Standards

8.1 State-Defined Network Adequacy and Availability of Services

The MCO shall meet the Provider Network access and adequacy standards consistent with KRS 304.17A-515 and established by DMS as described in this section unless otherwise approved by the DMS in accordance with the requirements set forth in the MCO Contract. Any exceptions shall be justified and documented by the MCO in accordance with "Exceptions to Provider Network." Significant changes in the MCO's Network composition that reduce Enrollee access to services may be grounds for Contract termination.

DMS may amend these standards as deemed appropriate throughout the Contract Term. The MCO shall comply with modified standards as directed, but with no less than a ninety (90) Day prior notice unless another timing is required by federal or state regulation.

The MCO shall make available and accessible facilities, Service Locations, and personnel sufficient to provide Covered Services consistent with the requirements specified in this subsection.

Consistent with KRS 304.17A-515, the MCO shall have a Provider Network that meets the following accessibility requirements:

A. For urban areas, a Provider Network that is available to all Enrollees within thirty (30) Miles or thirty (30) minutes of each Enrollee's place of residence or work, to the extent that services are available;

B. For areas other than urban areas, a Provider Network that makes available PCP and hospital services within thirty (30) minutes or thirty (30) Miles of each Enrollee's place of residence

or work, to the extent those services are available. All other providers shall be available to all Enrollees within fifty (50) minutes or fifty (50) Miles of each Enrollee's place of residence or work, to the extent those services are available.

In addition, the MCO shall meet the following as required by DMS:

A. Enrollee to PCPs ratios shall not exceed 1500:1 FTE Provider for children under twenty-one (21) and adults;

B. Specific to voluntary family planning, counseling and medical services as soon as possible within a maximum of thirty (30) Days. If not possible to provide complete medical services to Enrollees less than eighteen (18) years of age on short notice, counseling and a medical appointment as immediately as possible and within ten (10) Days;

C. Appointment and wait times shall not exceed thirty (30) Days from date of an Enrollee's request for routine and preventive services and forty-eight (48) hours for Urgent Care:

1. PCPs for both adults and pediatrics
2. Specialists designated by DMS including sufficient adult specialists to meet the needs of Enrollees twenty-one (21) years of age and older and pediatric specialists to meet the needs of Enrollees under age twenty-one (21)
3. General and pediatric dental services
4. General vision services
5. Laboratory and radiology services.

D. If either the MCO or a Provider (including Behavioral Health) requires a referral before making an appointment for Specialty Care, any such appointment shall be made within thirty (30) Days for routine care or forty-eight (48) hours for Urgent Care

E. Emergency Medical and Behavioral Health Services shall be made available and accessible to Enrollees twenty-four (24) hours a day, seven (7) Days a week. Urgent care services by any provider in the MCO's Network shall be made available and accessible within forty-eight (48) hours of request; and

F. Immediate treatment for any Emergency Medical or Behavioral Health Services by a health provider that is most suitable for the type of injury, illness, or condition, regardless of whether the facility is in the MCO's Network.

The MCO shall monitor the usage of Emergency Rooms in each Medicaid Region by Enrollees for non-emergent visits and provide sufficient alternate sites for twenty-four (24) hour care and appropriate incentives to Enrollees to reduce unnecessary Emergency Room visits.

The MCO shall develop and provide GeoAccess reports to DMS in accordance with the "Reporting Requirements and Reporting Deliverables" and as directed by DMS. The MCO shall utilize the most recent GeoAccess program versions available and update them periodically and on a timeline defined by DMS. The MCO shall use GeoCoder software along with the GeoAccess application package.

The MCO shall only include in its Geographic Access data reports those Providers that operate a Full-Time Provider location. For purposes of this requirement, a Full-Time Provider location is defined as a location operating for 16 or more hours in an office location each week. For

Providers who have more than one office, the MCO must indicate each location by a separate record in the Provider file and divide the capacity of the Provider by the number of locations. For example, if the Provider capacity is 150, and the Provider has two offices, each office would have a capacity of 75. The "individual capacity" option should be used when reporting PCPs.

For calculating distance, the MCO shall use the maximums for the amount of time it takes an enrollee, using usual travel means in a direct route, to travel from the place of residence or work to the provider's location. DMS recognizes that when using NEMT services, transportation may not always follow direct routes due to multiple passengers.

8.2 Enrollment and Disenrollment

DMS has the exclusive right to determine an individual's eligibility for the Medicaid Program and eligibility to become an Enrollee of the MCO. Such determination shall be final and is not subject to review or Appeal by MCOs. To be eligible for MCO enrollment, an individual must have qualified to receive medical assistance under one of the Medicaid assistance categories and be a resident of the MCO service area. MCOs provide for a continuous open enrollment period throughout the term of the Contract for newly eligible Enrollees. MCOs cannot discriminate against potential Enrollees on the basis of an individual's health status, need for health services, race, color, religion, gender, sexual orientation, gender identity, disability or national origin, and shall not use any policy or practice that has the effect of discriminating on the basis of an Enrollee's health status, need for health services, race, color, religion, gender, sexual orientation, gender identity, disability or national origin. Enrollment begins at 12:01 a.m. on the first day of the first calendar month for which eligibility is indicated on the eligibility file (HIPAA 834) transmitted to the MCO and shall remain until the Enrollee is disenrolled in accordance with Disenrollment provisions of the MCO Contract. Applicable state and federal law determine membership for newborns. Membership begins on day of application for Enrollees who are presumptive eligible. An Enrollee may request Disenrollment only with cause pursuant to 42 C.F.R. 438.56. MCOs will follow the Disenrollment for Cause process as defined by DMS. Only DMS may disenroll an enrollee from the plan.

8.3 Availability of Services

MCOs maintain and monitor a network of appropriate providers (including hospitals, home health providers, dentists, vision providers, hospice, pharmacy, prevention, primary care, and at least one provider of maternity care), 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. MCOs also comply with the following service availability requirements:

- All covered services are as accessible to enrollees as generally available to commercial insurance enrollees, and no incentive for providers to withhold medically necessary services;
- 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, coordinating appropriate payment and ensuring that the cost to the enrollee is no greater than it would be if provided in-network;

- Direct access of female enrollees to qualified women's health specialists is ensured within the network.
- Second opinions related to surgical procedures and the diagnosis and treatment of complex and/or chronic conditions will be provided within or outside the network;
- Providers may advise the beneficiary about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under Medicaid; and
- MCOs 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.

8.4 Assurances of Adequate Capacity and Services

MCOs offer an appropriate range of medically necessary preventive, primary care, specialty, and emergency services as required by federal and state regulations, guidelines, transmittals, and procedures. Medically necessary services are those considered by the DMS to be 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.

8.5 Provider Selection

MCOs have written policies and procedures regarding the selection and retention of their 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 a provider's licensure or certification. They must also comply with the Any Willing Provider provisions set forth in 907 KAR 1:672 and KRS 304.17A-270. MCO provider networks must offer sufficient types, numbers, and specialties in each county to assure quality and access to health care services.

All MCO network providers, including individuals and facilities, who will provide health care services must have a valid license or, where required, certified to provide health care services in the Commonwealth, including certification under CLIA, if applicable. They must also have a valid Drug Enforcement Agency ("DEA") registration number, if applicable. The following providers must be accountable to a formal governing body for review of credentials: physicians, dentists, advanced registered nurse practitioners, vision care and other licensed or certified practitioners. MCOs will be responsible for the ongoing review of provider performance and credentialing.

8.6 Subcontracts and Delegation

The MCO may, with the approval of DMS, enter into Subcontracts for the provision of various Covered Services to Enrollees or other services that involve risk-sharing, medical management, or otherwise interacting with an Enrollee or Provider, except the MCO shall not enter into any Subcontract with Subcontractors outside of or that would be providing any services outside the United States. All subcontractors shall have and maintain Kentucky specific expertise in each content area for which they are providing services.

Subcontractors must be eligible for participation in the Medicaid program, pursuant to federal and state regulations. The MCO shall evaluate each prospective Subcontractor's ability to perform the proposed delegated activities. The MCO shall execute a written contractual agreement (Subcontract) between the MCO and Subcontractor that is in a form and has content approved by DMS. Furthermore, the MCO shall submit any change in terms or scope of a Subcontract, notice of suspension or termination of a Subcontract to DMS for review and approval. The MCO shall submit for review to DMS a listing of Subcontractors who will support their Contract, a description and role of each Subcontractor, detail listing of services provided, all locations of operation including disclosure of any and all operations outside the United States, and a template agreement of each type of such Subcontract referenced herein.

DMS may approve, approve with modification, or reject the templates if they do not satisfy the requirements of the MCO Contract. In determining whether DMS will impose conditions or limitations on its approval of a Subcontract, DMS may consider such factors as it deems appropriate to protect the Commonwealth and Enrollees, including but not limited to, the proposed Subcontractor's past performance. In the event DMS has not approved a Subcontract referenced herein prior to its scheduled effective date, the MCO agrees to execute said Subcontract contingent upon receiving DMS's approval. No Subcontract shall in any way relieve the MCO of any responsibility for the performance of its duties pursuant to the MCO Contract including the processing of Claims. Likewise, any DMS Subcontract approval does not in any way relieve the MCO of any responsibility or liability for the performance of its duties pursuant to the MCO Contract. The Contractor shall submit a summary of the services for which the Subcontractor is responsible with the Subcontract.

8.7 Practice Guidelines

MCOs maintain an overall Quality Improvement Plan (QIP) with practice guidelines or standards against which clinical care is compared, based on the most recent published evidence. MCOs are encouraged to use state and national practice guidelines and assess suitability with appropriate health care professionals. Prior to implementation and upon renewal, each practice guideline is reviewed for consistency with utilization management criteria, medical education, available benefits and disease management programs materials. Specific guidelines are adopted for treatment of enrollees with special health care needs and complex, chronic conditions. Practice guidelines are disseminated to the MCO's Network, and to enrollees, upon request.

MCOs annually review, evaluate and modify as necessary, their QIPs, including clinical care standards, practice guidelines, and patient protocols. Each year, they prepare an annual report to the DMS, detailing their review, completed activities, corrective actions (including recommended and in progress), and results of all clinical, administrative, provider and enrollee satisfaction surveys conducted during the immediately preceding year.

8.8 Coordination and Continuity of Care

8.8.1 Primary Care Provider (PCP)

MCOs ensure that each enrollee has an ongoing source of primary care through a PCP. 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, have 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 an enrollee 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. MCOs have procedures for serving enrollees from the enrollment date, regardless of whether they have selected a PCP.

MCOs are required to send enrollees a written explanation of the PCP selection process within five business days of enrollment to include: time frame for PCP selection, explanation of the PCP selection/assignment process, and where to call for assistance. MCOs are responsible for explaining and facilitating the selection of or change in Primary Care Provider through telephone or face-to-face contact where appropriate. They assist enrollees in making the most appropriate PCP selection based on previous or current PCP relationship, providers of other family enrollees, medical history, language needs, provider location or any other factors that are important to the enrollee.

8.8.2 Coordination of All Services that Enrollees Receive

MCOs establish referral relationships with various human service agencies whose services are outside the scope of covered services, but important to the health of enrollees. Case Management is provided by the MCO to enrollees, as appropriate, and specialized Case Management services is provided for enrollees with complex and/or chronic conditions. Through information sharing and monitoring, PCPs are responsible for coordinating assessment and treatment, and following enrollees as they use multiple providers, services sites, and levels of care.

8.8.3 Prevention of Duplication of Services for Individuals with Special Health Care Needs

DMS for Community Based Services (DCBS) and DMS for Aging and Independent Living (DAIL) will complete a service plan for all clients who receive services from DCBS and DAIL who are newly enrolled in an MCO. This service plan will be forwarded to the MCO before enrollment and will be used by DCBS, DAIL, and the MCO to determine enrollee medical needs and the potential need for specialized case management, coordinate care, and avoid duplication of services. The DCBS population includes Adult Guardianship Clients, Children in Foster Care, and Children Receiving Adoption Assistance. Dual Eligible Enrollees will be identified by the management information system.

MCOs also assure and facilitate direct access to specialty physicians for 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.

8.9 State Transition of Care Policy

Upon receipt of an indication that a Member is transferring from one MCO to another MCO, the former MCO shall be responsible to contact the new MCO, the recipient and the recipient's providers in order to transition existing care. A Prior Authorization (PA) shall be honored by the new MCO for 90 Days or until the recipient or provider is contacted by the new MCO regarding

the PA. If the recipient and provider are not contacted by the new MCO, the existing Medicaid PA shall be honored until expired.

- **Inpatient Hospital Admission Prior to the Member's Transition.**

If the Member is an in-patient in an acute care hospital, critical care hospital, acute rehabilitation facility, psychiatric hospital or long term acute care facility at the time of transition, the entity responsible for the Member's care at the time of admission shall continue to provide coverage for the Member at that facility, including all Professional Services, until the recipient is discharged from the facility for the current admission. An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a "current admission." The "same diagnosis" is defined as the first five digits of a diagnosis code.

- **Outpatient Facility Services and Non-Facility Services**

Effective on the Member's Transition date, the new MCO will be responsible for outpatient services both facility and non-facility. Outpatient reimbursement includes outpatient hospital, ambulatory surgery centers, and renal dialysis centers.

- **Nursing Homes**

Eligibility for Long Term Care in a Nursing Facility (NF) includes some financial requirements not needed for basic Medicaid eligibility. When an eligible member enters an NF the facility must receive a Level of Care (LOC) determination to ensure the member meets medical criteria for Nursing Facility. That LOC is passed electronically to the DCBS eligibility worker, triggering the eligibility determination for this additional benefit. That determination can generally be completed within thirty Days. *Once LTC eligible, worker entries exempt the member from managed care effective with the next feasible month.* If the worker action is completed prior to cut off (eight Business Days before the end of the month), managed care ends at the last day of current month. If the action is after cut off, managed care ends the last day of the following month. During this transition, the MCO will be responsible for ancillary, physician and pharmaceuticals charges and the Department will reimburse for those services billed by Nursing Facility. Once exempt from Managed Care, DMS will be responsible for all eligible services associated with this recipient.

- **Waiver Participation**

1915(c) Home and Community Based Services Waiver programs are simply added benefits for eligible members; however, the action that exempts those members from being subject to Managed Care resides with the DCBS eligibility worker. These services require a Level of Care (LOC). The LOC is passed electronically to the DCBS eligibility worker; receipt of the LOC triggers the eligibility worker to complete entries within the eligibility system. Those entries exempt the member from managed care effective the next feasible month. If the worker action is completed prior to cut off (eight Business Days before the end of the month), managed care ends at the last day of current month. If the action is after cut off, managed care ends the last day of the following month. During this transition, the MCO will be responsible for all services except the additional Waiver benefits. The Waiver Services will be paid by DMS as fee for service. Coding in the

billing system allows the Wavier Service to be processed during the transition period, once the eligibility worker has completed the necessary entries. Once exempt from Managed Care, DMS will be responsible for all services associated with this recipient.

- **Transplants**

Follow up care provided on or after the Member's Transition that is billed outside the Global Charges, will be the responsibility of the new MCO.

- **Eligibility Issues**

For a Member who loses eligibility during an inpatient stay, an MCO is responsible for the care through discharge if the hospital is compensated under a DRG methodology or through the day of ineligibility if the hospital is compensated under a per diem methodology.

8.10 Coverage and Authorization of Services

MCOs provide or arrange for the provision of covered services to all enrollees in accordance with DMS policies and procedures applicable to each category of covered services. MCO is also required to maintain a comprehensive Utilization Management (UM) program that reviews services for medical necessity and evaluates the appropriateness of care and services. Written clinical criteria and protocols will include a mechanism for obtaining all necessary information, including pertinent clinical information, and a consultation with the attending physician or other health care provider as appropriate. The MCO 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 must be made by qualified medical professionals.

8.11 Identifying Special Populations

Individuals needing long term services and supports (LTSS) are beneficiaries of all ages who have functional limitations or chronic illness and require services and supports whose primary purpose is to support the enrollee's ability to live or work in the setting of their choice. These settings may include enrollee home, worksite, provider-owned or controlled residential setting, nursing facility, or other institutional setting. Under Kentucky statutes, LTSS beneficiaries are covered under the fee-for-service program, not managed care.

Individuals with Special Health Care Needs (ISHCN) are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional conditions 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 condition(s). The primary purpose of the definition is to identify these individuals so that MCOs can facilitate access to appropriate services. DMS has defined the following categories of individuals who shall be identified as ISHCN.

- Children in or receiving Foster Care or adoption assistance;
- Blind/Disabled Children under age 19 and Related Populations eligible for SSI;
- Adults over the age of 65;
- Homeless (upon identification);

- Individuals with chronic physical health illnesses; and
- Individuals with chronic behavioral health illnesses.

To identify these special populations, MCOs will be responsible for the following:

- Have written policies and procedures in place, which govern how enrollees with these multiple and complex care needs are further identified.
- Request all enrollees complete an initial Health Risk Assessment (HRA) within 90 days of enrollment. Information to be collected will include demographic, socioeconomic, current health status, and behavioral risk questions and be inclusive enough to determine the enrollee'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 enrollees and provide the basis for the health education program
- Maintain internal operational processes to target enrollees for screening and identification.
- Assess each enrollee identified to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment process uses appropriate health professionals.

8.12 Health Information Systems

MCOs maintain a Management Information System (MIS) that provides support for all aspects of a managed care operation and includes the following subsystems: enrollee, third party liability, provider, reference, encounter/claims processing, financial utilization data, quality improvement and surveillance utilization review. The *enrollee subsystem* maintains an accurate record of demographic information for current and historical MCO enrollees. The *provider subsystem* includes demographic data, provider type, specialty codes, licensing, credentialing, and re-credentialing information, PCP enrollment capacity, and provider payment information. The *financial subsystem* tracks all financial transactions, including claim payments, adjustments and recoupments, and accounts receivable. This subsystem ensures that all funds are appropriately disbursed, and all post-payment transactions are applied accurately. As a final step, this system produces remittance advice statements/explanations of benefits and financial reports. The *utilization/quality improvement subsystem* is used to profile providers, monitor primary care and specialty referral patterns, and examine the use of specific services (e.g., EPSDT, out-of-network), assess care treatment and medication use patterns across settings (comparing to established standards), and conduct adverse event reporting, including adverse incidents and complications. The *Surveillance Utilization Review Subsystem (SURS)* is used to identify potential fraud and/or abuse by providers or enrollees. SURS supports profiling, random sampling, groupers (for example Episode Treatment Grouper), ad hoc, and targeted queries.

Additional requirements include.

- MCOs must ensure that all medical information is kept confidential through appropriate security and privacy protocols.
- MCOs must ensure that data received from providers is accurate and complete by collecting service information in standardized formats whenever feasible and appropriate, verifying the accuracy and timeliness of reported data (through audits and edits consistent

with NCCI), screening data for completeness, logic and consistency, and storing all claims and encounter data in a data warehouse.

- MCOs must make all collected data available to the DMS and provide additional data and reports as requested by the DMS. At a minimum, MCOs must electronically provide encounter data to DMS monthly. Encounter data must follow the format, data elements, and method of transmission specified by the DMS. If the MCO knowingly fails to submit 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 contract, the DMS may assess penalties.
- Encounter data is 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 contracted EQRO will perform encounter data validation to determine the accuracy and adequacy of claims submitted by the MCO.
- MCOs, and their subcontractors, must make all of their books, documents, papers, provider records, medical records, data, surveys and computer databases 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.

8.13 Confidentiality

MCOs have the responsibility to protect enrollee information from unauthorized disclosure for any reason. MCOs maintain that confidentiality through written policies and procedures designed to protect the rights of enrollees including, but not limited to, the right to respect, dignity, privacy, confidentiality, and nondiscrimination. MCOs agree 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. Confidentiality of all enrollee information is mandatory, and a breach of confidentiality is considered as a basis for immediate revocation of the MCO Contract.

8.14 Grievances and Appeals

Any enrollee has a right to file a grievance with the MCO or the DMS if they are dissatisfied with anything related to the MCO and may file an appeal related to actions or decisions made by the MCO related to covered services or services provided. MCOs maintain a timely and organized Grievance System for resolving oral and written grievances filed by enrollees. The MCOs Grievance Systems offer a grievance process, an appeal process, and access for enrollees to the State's fair hearing system.

Every grievance received will be documented in an MCO’s management information system. MCOs maintain written policies and procedures for the receipt, handling and disposition of grievances that comply with 42 CFR 438 Subpart F and 42 CFR 431. These policies and procedures include a process for evaluating patterns of grievances for impact on formulation of

policy and procedures, access, and utilization. They also outline procedures for maintaining grievance records separate from medical case records to protect the confidentiality of enrollees who file a grievance or appeal.

MCOs submit quarterly reports of all enrollee grievances and appeals and their disposition to DMS and their QMAC. These reports include 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.

DMS staff review quarterly MCO reports and share with the EQRO, which reviews and annually reports on all services denied by the MCO or its subcontractors and related appeals. Minor discrepancies are brought to the attention of MCOs through regularly scheduled meetings, and in writing for more grievous errors. Significant deficiencies result in an MCO corrective action.

9.0 Quality Measurement & Improvement Standards

The DMS, as well as the MCOs, are responsible for monitoring targeted quality and health outcomes measures, collaboratively developing annual benchmark goals. The DMS reserves the right to assess an MCO's achievement of goals, and if it is determined that goals have not been achieved, DMS will initiate a corrective action plan to be performed by the MCO. MCOs implement steps targeted at either improving the actual outcomes or the underlying processes that affect those outcomes. Additionally, a mechanism to update standards and guidelines and disseminate revised information to practitioners is required.

The EQRO conducts 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 EQRO also conducts 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. Finally, the EQRO annually reviews MCO compliance with state and federal standards and state MCO contract requirements. The EQRO produces a report that describes the manner by 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.

Each MCO establishes and maintains an ongoing Quality Member Advisory Committee (QMAC) composed of enrollees, individuals from consumer advocacy groups, the community, who represents the interests of the enrollee population, and public health representatives. Enrollees of the committee are consistent with the composition of the enrollee population, including such factors as aid category, gender, geographic distribution, parents, as well as adult enrollees, and representation of racial and ethnic minority groups. Responsibilities of the committee include (summarizing from among other required items): providing review and comment on the quality and access standards; providing review and comment on the grievance and appeals process as well as policy modifications needed based on a review of aggregate grievance and appeals data; review, and provide comments on Enrollee Handbooks; reviewing enrollee education materials prepared by the MCO; recommending community outreach

activities, and providing reviews of and comments on MCO and DMS policies that affect enrollees.

9.1 Assessment of quality and appropriateness for enrollees with special needs

The MCO regularly reports data and other summary reports to assess the quality and appropriateness of care and services supplied under the MCO Contract to all enrollees, including those populations previously identified in this document as special populations

Quarterly and annually, the MCO submits 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. Also included is 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.

9.2 Mandatory External Quality Review (EQR)

DMS maintains a contract with an External Quality Review Organization (EQRO) to perform external quality review functions. The EQRO performs 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 an MCO or their subcontractors furnish to Medicaid enrollees. 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 are 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,
- the validation of performance improvement projects.

DMS 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 is 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. The DMS has contracted with a single EQRO to perform the mandatory and optional EQR activities.

Quarterly Reports containing a summary of EQR activities for the quarter and are provided to DMS on a quarterly schedule. An Annual Report is provided containing a detailed technical report describing the manner by 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 each 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 as requested.

9.3 Health Equity

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

The Kentucky Department for Public Health, Office of Health Equity (OHE) was established in September 2008 to address health disparities among racial and ethnic minorities, and rural Appalachian populations. Grant support has been received from the U.S. Department of Health and Human Services, Office of Minority Health (OMH) since 2010. OHE supports goals and evidence-based strategies from the National Partnership for Action to End Health Disparities (NPA) to mobilize a statewide, comprehensive, community-driven, and sustained approach to combating health disparities and to move Kentucky toward achieving health equity. OHE also supports a wide variety of activities and services through partnerships with health departments, universities, nonprofit organizations, and private health systems. The Kentucky OHE has five focus areas and goals:

- Education and Awareness – Increase awareness of the significance of health disparities, their impact on the state, and the actions necessary to improve the health outcomes for racial and ethnic minorities, rural, and low-income populations of Kentucky.
- Cultural Competency – Improve the health and health care outcomes for racial and ethnic minority and underserved communities through evidence-based tailored approaches that account for differences in culture and language.
- Research – Improve the coordination and utilization of research to advance health equity for racial and ethnic minorities and underserved communities.
- Evaluation – Improve the coordination and utilization of evaluation outcomes to advance health equity for racial and ethnic minority and underserved communities.
- Strengthening Partnerships – Strengthen and broaden leadership in Kentucky for addressing health disparities at all levels.

Health equity initiatives will continue to be a high priority across DMS and stakeholders. DMS will begin participation in a state cohort learning collaborative through Medicaid Innovation Collaborative (MIC) in October. The focus of this collaborative will be social determinants of health and closing the gap on health disparities in KY. Currently, the Racial Equity Community of Practice Team is working to train all divisions about the use of the Government Alliance on Racial Equity (GARE) racial equity tool with the goal of implementing the GARE tool across DMS by end of year 2022. Likewise, CHFS is also implementing use of the tool for accountability purposes and to improve racial equity. The various oversight and advisory groups plus the Interdisciplinary Team will be used to integrate these initiatives and others within the Quality Strategy.

Please refer to Section 3.3 for a description of specific disparities initiatives associated with this Quality Strategy.

Appendix A: List of Acronyms

ACA	Affordable Care Act
AHRQ	Agency for Healthcare Research and Quality
AMM	Antidepressant Medication Management
AOD	Abuse and Dependence Treatment
BHDID	Developmental and Intellectual Disabilities
CAD	Coronary Artery Disease
CAHP	Consumer Assessment of Healthcare Providers & Systems
C.N.A.	Comprehensive Needs Assessment
CDC	Centers for Disease Control and Prevention
CHFS	Cabinet for Health & Family Services
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CPT	Current Procedural Terminology
DAIL	Department for Aging and Independent Living
DBHDID	Department for Behavioral Health, Developmental and Intellectual Disabilities
DCBS	Department for Community Based Services
DEA	United States Drug Enforcement Administration
DJJ	Department of Juvenile Justice
DMS	Department for Medicaid Services
DPH	Departments of Public Health
DRG	Design and development of the Diagnosis Related Group
ED	Emergency Department
EMS	Emergency Medical Services
EPSDT	Early and Periodic Screening, Diagnostic and Treatment services
EQR	External Quality Review
EQRO	External Quality Review Organization
FFS	Fee-for-service
HANDS	Health Access Nurturing Development Services
HDO	Health Delivery Organization
HEDIS	Healthcare Effectiveness Data and Information Set
HRA	Health Risk Assessment
IMD	Institutions for Mental Diseases
IPRO	Island Peer Review Organization
ISHCN	Individuals with Special Health Care Needs
KCHIP	The Kentucky Children's Health Insurance Program
KORE	Kentucky Opioid Response Effort
LOC	Level of Care

LTSS	Long Term Services & Supports
MAC	Medicaid Oversight and Advisory Committee
MC	Managed Care
MCO	Managed Care Organization
MIS	Management Information System
MMC	Medicaid Managed Care
NCQA	National Committee for Quality Assurance
NF	Nursing Facility
NPA	National Partnership for Action to End Health Disparities
OHE	The Office of Health Equity
OMH	The Office of Minority Health
OUD	Opioid Use Disorder
PA	Prior Authorization
PCCM	Pediatric Critical Care Medicine
PCMH	Patient-Centered Medical Home
PCP	Primary Care Provider
PIHP	Prepaid Inpatient Health Plan
PIP	Health Plan Performance Improvement Project
PMs	Performance Measures
QAPI	Quality Assessment and Performance Activities
QI	Quality Improvement
QMAC	Quality Member Advisory Committee
SDOH	Social Determinants of Health
SKY	Supporting Kentucky Youth
SMI/SED	Serious Mental Illness/Serious Emotional Disturbance
SUD	Substance Use Disorder
SURS	The Surveillance Utilization Review Subsystem
TAC	Technical Advisory Committee

Appendix B: Roster of Interdisciplinary Team Members

Name	Organization
Andrew McNamara MD	Aetna Better Health of Kentucky
Jennifer Nachreiner	Aetna Better Health of Kentucky
Susan Vickers	Aetna Better Health of Kentucky
Greta Crutcher Collins	Anthem Blue Cross Blue Shield
Stuart Cox	Anthem Blue Cross Blue Shield
Andrea Dougherty	Anthem Blue Cross Blue Shield
Stephanie Kuntz	Anthem Blue Cross Blue Shield
Kate Miller	Anthem Blue Cross Blue Shield
Lisa Galloway MD	Humana Healthy Horizons in Kentucky
Kristan Mowder	Humana Healthy Horizons in Kentucky
Elizabeth Stearman	Humana Healthy Horizons in Kentucky
Sangil Tsai	Humana Healthy Horizons in Kentucky
Leslie Anderson	Passport Health Plan (Molina Healthcare)
Tom James MD	Passport Health Plan (Molina Healthcare)

Michelle Weikel	Passport Health Plan (Molina Healthcare)
Jodi Atwood	UnitedHealthcare Community Plan
Angela Bredenkamp	UnitedHealthcare Community Plan
Divya B Cantor MD	UnitedHealthcare Community Plan
Lisa Cook	UnitedHealthcare Community Plan
John Eric Davis MD	UnitedHealthcare Community Plan
Carri Featheringill	UnitedHealthcare Community Plan
Suzanne Lewis	UnitedHealthcare Community Plan
Charles Nails	UnitedHealthcare Community Plan
Robin Laaser Chandler	WellCare of Kentucky
Sharon Hall	WellCare of Kentucky
Carolyn Gallagher	Island Peer Review Organization (IPRO)
Chuck Merlino	Island Peer Review Organization (IPRO)
Allen Brenzel MD	Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), Cabinet for Health and Family Services
Leslie Hoffman	Department for Medicaid Services

Ann Hollen	Department for Medicaid Services
Carolyn Kerr	Quality Branch, Department for Medicaid Services, Cabinet for Health and Family Services
William Lohr MD	Department of Community Based Services, Cabinet for Health and Family Services
Angela W. Parker	Division of Quality & Population Health, Department for Medicaid Services, Cabinet for Health and Family Services
Stephanie Patchen	Quality Branch, Department for Medicaid Services, Cabinet for Health and Family Services
Catheranne Terry	Quality Branch, Department for Medicaid Services, Cabinet for Health and Family Services
Judy Theriot MD	Department for Medicaid Services
Troy Sutherland	Quality Branch, Department for Medicaid Services, Cabinet for Health and Family Services
Connie White MD	Department for Public Health, Cabinet for Health and Family Services
Joveria Baloch	Northern Kentucky University
Gary Ozanich	Northern Kentucky University
Lousette Rodney	Northern Kentucky University
Valerie Hardcastle	Northern Kentucky University

Appendix C: Key Informant Interviews Analysis

Kentucky Medicaid Quality Strategy

Analysis of Key Informant Interviews

Northern Kentucky University
Institute for Health Innovation
July 7, 2022

TABLE OF CONTENTS

EXECUTIVE SUMMARY

In accordance with Federal Regulations states are required to establish and update a quality strategy to assess and improve the quality of healthcare services provided by managed care plans. CMS has provided guidance on the steps and suggested outcomes for this process. Kentucky is following this guidance in updating its current quality strategy which became effective in 2019. As part of this process, 20 key informants were identified and interviewed using a semi-structured instrument focused on key elements and strategic questions involving Medicaid in Kentucky. This document provides a summary of these interviews.

Key informants showed limited knowledge of the existing Quality Strategy but when reviewing the priority areas for this strategy concurred on their importance. Relative to the updated strategy, respondents agreed with the Interdisciplinary Team in prioritizing goals involving behavioral health, substance abuse, chronic diseases, and preventive care. Cross-cutting issues involved social determinants and health equity. A consistent observation was the need to coordinate the many initiatives and programs targeting disparities that are in process across stakeholder organizations. Beneficiary engagement was identified as a priority area for both DMS and the MCOs.

The two areas of greatest discussion were access to care and system costs/reimbursement levels. Access issues concerned availability of providers accepting Medicaid and appointments particularly for behavioral health care. Access to dentistry and optometry services were identified as being an acute issue. Network adequacy and geographic coverage in rural areas were also discussed by several key informants.

Reimbursement levels were discussed relative to system costs. The administrative burden of prior authorizations was a major issue highlighted as well as the complexity of dealing with multiple MCOs. The level of reimbursement and limitations on individual encounter complexity billing levels were identified as important barriers to access by discouraging provider participation.

There was overall agreement that payment and delivery reform are needed to drive Medicaid modernization in Kentucky. Value-based contracting and other outcome-based approaches were positively discussed. Concerning the measurement of the success of the Quality Strategy, there was a general discussion of the limitations of HEDIS measures, but agreement that there are few alternatives at this point.

This report contains a Hierarchy Map of the concepts and related domains discussed by the key informants as well as detailed summaries of the interviews.

Figure 1: Word Cloud for All Domains and Interviews

PURPOSE

The Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Toolkit (Toolkit) is prescriptive in recommending how states develop their strategy to assess and improve the quality of healthcare services provided by managed care organizations (MCOs). This includes recommending the nine-step process depicted in Figure 1. Kentucky is following these steps in developing its quality strategy.

Figure 2: CMS Recommended Process to Develop a Quality Strategy

The *Toolkit* also identifies cross-cutting considerations for the state to consider when developing the strategy. To augment and inform the activities of the interdisciplinary team (step 1) and to address cross-cutting issues, formal interviews of key informants were added to the information-gathering process (step 3). This document provides a summary of the interview process and outcomes.

METHODOLOGY

A semi-structured interview instrument was developed by NKU and reviewed by the Kentucky Department of Medicaid Services (DMS) quality team. This instrument is available in the appendix. The instrument was organized based upon the following:

- Knowledge and experience with the current Medicaid Quality Strategy
- Considerations of the areas and domains established by the Interdisciplinary Team as priorities for goals and objectives
- Potential measures to assess the quality of Medicaid services
- Discussion and insights concerning disparities, health equity, and social determinants
- Barriers and facilitators of access to care
- Payment reform initiatives including value-based care

A purposive sample combined with the snowball technique (i.e., using study participants recommendations for other individuals to include) was used to identify key informants. Informants were primarily drawn from the Kentucky Medicaid Technical Advisory Committee (TAC). In total, 22 individuals were identified as key informants, and 20 agreed to be interviewed. Interviews lasted for approximately 60 minutes and were conducted over Zoom. Interviews were recorded, transcribed, and coded using NVivo qualitative analysis software to facilitate thematic analysis. A list of interviewees, their affiliation, and date of interview is provided in Table 1.

Payer organizations were not included in the key informant interviews because all six managed care organizations already had multiple representatives on the Interdisciplinary Team and the focus-area sub-teams. Thus, the Interdisciplinary Team is the principal means of input from the MCOs at this initial stage of the strategy development, and the key informant interviews were used to access input from other significant healthcare stakeholders across the Commonwealth. All stakeholders will have additional opportunities for comment in response to the initial draft of the strategy and during the public comment period.

Table 1: Key Informants Interviewed

Quality Strategy Interviews		
Name	**Affiliation**	**Date of interview**
Jerry Roberts, DPM	Podiatrist MAC Member Represents KY Board of Podiatry	March 2 2022
Sheila Schuster, PH.D.	Psychologist Behavioral Health TAC Chair	March 2 2022
Peggy Roark	Advocate MAC Member Medical Assistant Recipient	March 2 2022
Steve Compton, OD	Optometrist MAC Member Represents KY Optometric Association Optometric TAC Member	March 7 2022
Garth Bobrowski, DMD	General Practitioner/Dentist MAC Member Represents KY Dental Association Dental TAC Chair	March 7 2022
Ashima Gupta, MD	Pediatric Ophthalmologist MAC Member Represents KY Medical Association Physicians TAC Member	March 8 2022
Terry Skaggs	Chief Financial Officer, Wells Health Systems, Owensboro, KY Nursing Home Care TAC Chair	March 10 2022
Steve Shannon	Executive Director, KARP Association	March 10 2022

	Persons Returning to Society from Incarceration TAC Chair Behavioral Health TAC Member	
Matthew Burchett, O.D.	KY Optometric Association, Optometric TAC Chair	March 10 2022
Charles Thornbury, MD	Medical Director, Multi-Specialty Clinic, Glasgow, KY Physicians TAC Chair	March 10 2022
Annlyn Purdon, MBA, MACC	Home Health Home Health TAC Chair	March 15 2022
Beth Ennis, PT, EdD	Pediatric Physical Therapist Therapy TAC Chair KY Physical Therapy Association	March 16 2022
Ron Poole, R.Ph	Pharmacist Pharmacy TAC Chair	March 17 2022
Beth Partin, APRN	Nurse Practitioner MAC Member Represents KY Nurses Association	March 21 2022
Mahak Kalra, MPH	Kentucky youth advocate Children's Health TAC Chair	March 25 2022
Beverly Williams-Coleman, DNP, APRN	Advocate Nursing Services TAC Chair	March 25 2022
Emily Beauregard, MPH	Director, Kentucky Voices for Health Consumer Rights and Client Need TAC Chair	March 25 2022
Russ Ranallo, M.S.	Hospital Finance Hospital Care TAC Chair	March 30 2022
Melanie Landrum, CPC & team	Kentucky Hospital Association	March 30 2022
Pat Purcell, MD	Office for Children with Special Health Care Needs (OCHSN)	April 22 2022

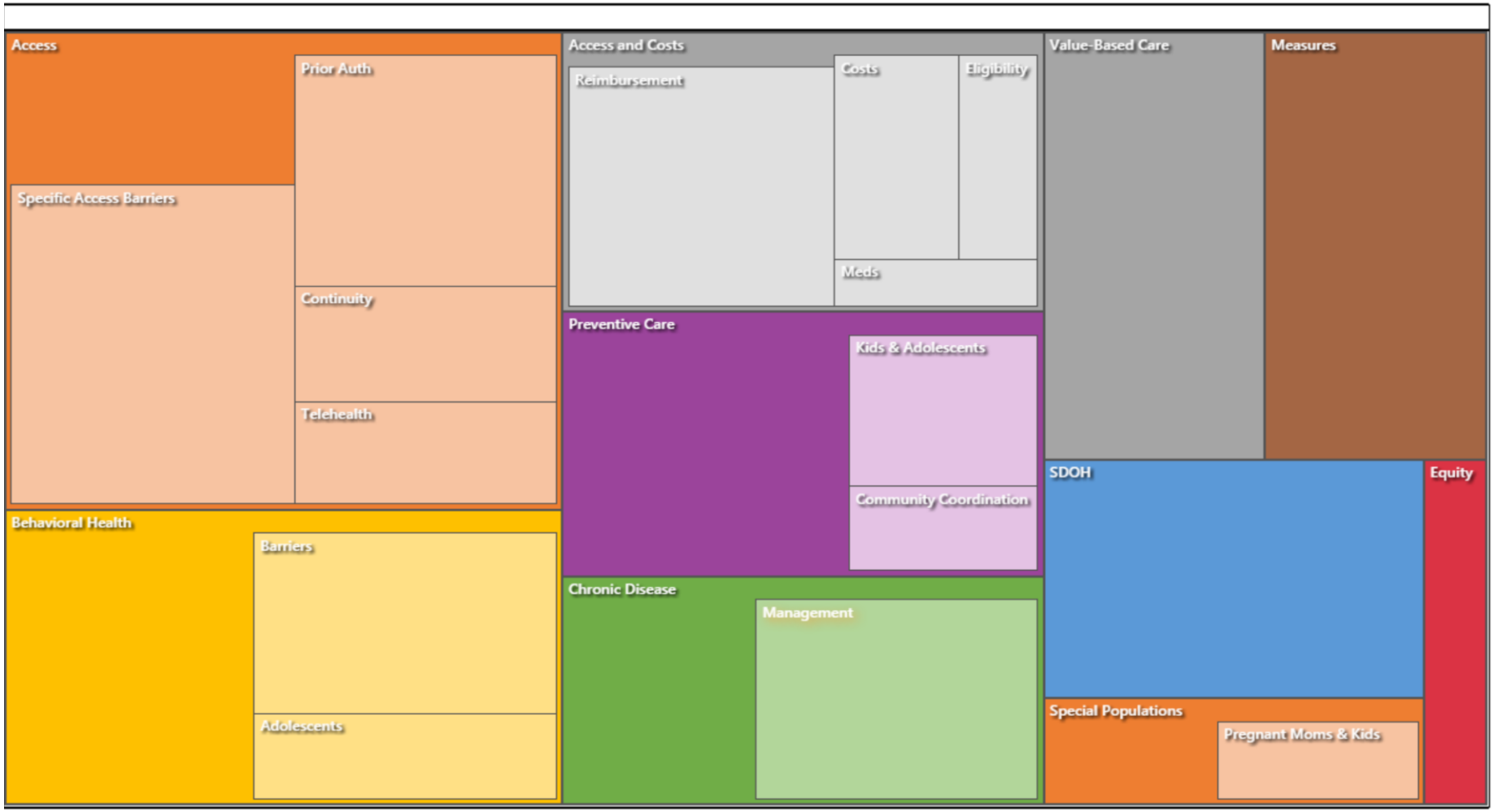
FINDINGS

This section first describes an overall review and summary of the responses by the key informants. The second section provides a more thorough assessment for each of the identified principal domains and factors, and the final section summarizes the discussion of cross-cutting and priority issues.

Hierarchy Map

There was considerable consistency by the key informants in the identification of challenges needed to be addressed in the Kentucky Medicaid Quality Strategy. Figure 1 provides a hierarchy map for the relative count for the factors identified and their key sub-elements. These factors are based on the draft goals and objectives identified by the Interdisciplinary Team. In addition, interviewees suggested new factors beyond those from the draft goals and objectives and these are included in the Map as well.

Figure 3: Hierarchy Map for Key Informant Responses



This tree map represents the relative coding of content for each concept node. The rectangles should be considered in relation to each other and are scaled for a best fit. The greater the overlap of shared comments, the more proximal the positioning between the concepts (e.g., closer). The amount of content coded may reflect complexity rather than importance. For example, more complex issues such as access to care may have had a more detailed discussion than preventive care and therefore have more coded elements and be represented by a larger rectangle.

Summary of Responses

Key informants showed limited knowledge of the existing Quality Strategy. Only two respondents indicated that they were very familiar with the strategy. While generally aware of the existence of the External Quality Reviews (EQR), few respondents indicated a familiarity with their findings.[17] Relative to meeting the targets for the existing Quality Strategy, respondents reflected a general need for substantial improvement across all priority areas.

However, one priority area in which respondents indicated they perceived improvement was the prioritization of substance abuse disorder. While acknowledging continuing severe problems with access to care, the general view was that stakeholders have prioritized activities designed to address Kentucky's substance abuse crisis; one respondent described it as a "great push."

The two areas of greatest discussion were access to care and system costs/reimbursement rates. Both were cross-cutting issues. Access issues primarily concerned network adequacy, including appointment availability, lack of service in rural areas, behavioral health and substance abuse care availability, and the number of providers accepting Medicaid patients. Access to dentistry and optometry services were identified as particular problems that are sometimes overlooked. Given the experiences with the expansion of telehealth during the pandemic, key informants were consistently positive about the potential for its use to ameliorate some degree of the issues with access in the future.

Reimbursement was discussed within the context of system costs. Low reimbursement rates were identified as potentially creating Medicaid as a loss leader for health systems and individual providers. This affects access by potentially limiting the number of available appointment due to the need to optimize the reimbursement-type mix. The second area of reimbursement concerned the administrative time and effort required in the prior authorization (e.g., pre-certification) process, including varying policies across DMS and MCOs, and the complexity of dealing with up to six MCOs.

In identifying priority areas for targeting., key informants agreed with the Interdisciplinary Team regarding prioritizing goals that involve behavioral health, substance abuse, chronic diseases, and preventive care. No additional priority areas were recommended. Challenges and barriers to achieving objectives related to goals in these areas were identified, particularly as they relate to the complexity of caring for underserved and special populations.

Health disparities, health equity, and social determinants were discussed as issues cross-cutting all potential strategy goals and objectives. Beneficiary engagement was identified as the key barrier in

[17] Payer organizations engaged through the Interdisciplinary Team have greater knowledge of both the Quality Strategy and EQR reports.

dealing with both the Department for Medicaid Services and the MCOs. This challenge included web site navigation and beneficiaries' understanding of the system and processes. Key informants universally welcomed the increased emphasis on disparities and equity in the Quality Strategy.

Among the key informants, providers reflected a general appreciation of the need for delivery and payment reform efforts. Value-based contracting (VBC) was the approach most discussed, with respondents indicating confusion about the various approaches to VBC across the six MCO organizations and concern about contracts that include the possibility of penalties, as opposed to contracts that are based only on the sharing of cost-savings.

Interviewees were asked to discuss potential measures that can be used to track the goals and objectives of the Quality Strategy. The importance of evidence based and standardized HEDIS measures were acknowledged. Providers have experience with these measures in other programs and exhibited a level of comfort with them. There was a general discussion of the limitations of administrative data. Clinical data were deemed burdensome to capture and unreliable across electronic health record systems.

Domain Review

This section provides an analysis of the responses by the key informants categorized by topic. Given the interrelationships between the challenges faced by Medicaid, there was substantial overlap in the priorities and issues identified. These are highlighted in the descriptions below and discussed in greater detail in the Cross-Cutting Issues section.

Access

Issues of access were part of the key informant discussions across all domains. For this analysis, we organize access into two domains. The first concerns more general issues of access and the second is access and cost or the financial/economic factors effecting access. The components are summarized in the figure below.

The most cited specific access issue was availability of providers and appointments for Medicaid beneficiaries. For example, one stakeholder observed the need to "make it more accessible. Make it more convenient. Make it easier. Incentivize providers to go into communities that are unstaffed, that don't have sufficient …. doctor(s), APRNs, I don't care who it is." A shortage of dentist and optometrists willing to serve Medicaid patients in all geographic settings was also identified.

Transportation was acknowledged as an ongoing specific problem. Most informants indicated that non-emergency medical transportation (NEMT) has improved and is generally available. Others indicated that NEMT is complex with inconsistent policies and coverage including the challenges with beneficiaries knowing about and using these services within their region continues. The problem with transportation overlaps with social determinant impacts.

Additional specific barriers to access discussed included the ability for providers to make appropriate referrals for pediatric patients without concerns for delays, the ability to prescribe the most appropriate medication without having to complete an excessive amount of paperwork, the ability of school

personnel to communicate with other service providers to students in order to improve continuity of care.

Nearly one-quarter of all comments about access to care involved the prior authorization process. Key informants cited the burden and costs from the time and effort required to receive pre-certification. One provider stated, “if you don’t get the pre-cert, you don’t do the visit. We often still do the visit and know it’s just for free.” Another provider stated, “it feels like they (MCOs) are constantly denying visits, and I know there is probably some good reason for that …, yet patients don’t seem to get the services that they need approved.”

Dealing with six different MCO organization for prior authorization and billing was also a commonly cited issue. A stakeholder provided this overview:

> There are some MCOs who don’t require prior authorization for the first 20 visits because that’s what’s allowed within the plan. Others require authorization after the evaluation. The ones that do require authorization may have different requirements for what you turn in as far as paperwork or how you submit that. Is it all electronic? Do you have to fix it? What’s required to do what’s called a ‘peer to peer’ where you actually talk to another professional of the same discipline to talk through what you want, why you want it? What triggers that? So, it’s just remembering seven (SIC) different processes and then monitoring each of those processes as they continually change moving through the year. So, if there could be some consistency, that would be wonderful.

The net effects of prior authorization were identified as increasing system costs, requiring additional administrators, distracting providers from caregiving, and creating disincentives for seeing Medicaid patients.

Continuity of care was also identified as a key barrier in access to care. The continuity of care concern was primarily around availability to specialists. For example, one provider stated, “When I make referrals, sometimes if it’s not an emergency, it’s three months before someone can be seen, and that is really not acceptable for any condition.” For behavioral health, stakeholders indicated there were often few or no providers to refer patients to.

Approximately 10% of the comments concerning general access to care concerned the potential for telehealth. Key informants pointed to what they perceived to be positive results associated with the expansion of telehealth in response to the Covid-19 pandemic.

Cost

The cost of providing Medicaid services and the level of reimbursement were areas of substantial discussion by the key informants. Similar to the prior authorization issue described above, providers indicated that the administrative burden combined with the level of Medicaid reimbursement and the challenges of engaging the Medicaid population create barriers to access. As one provider described the problem, “with the Medicaid reimbursement being what it is, being significantly lower than anything else out there, providers can't spend non-billable time dealing with all of the administrative burden to try and get somebody back in the door who may or may not show up for little money.”

System costs were discussed as a problem relative to the time and effort required to pre-authorize a patient visit and receive approval and reimbursement for activities during the encounter, which includes the complexity of dealing with multiple MCOs. Reimbursement levels were seen as often not meeting costs. Patients' cases are often complex, and providers are sometimes limited to billing at higher levels for only two annual visits. Some respondents also indicated a need for equivalent reimbursement for services regardless of provider credentials or type.

The principal issue identified was the level of reimbursement. As one interviewee indicated, "A lot of the folks [providers] that are taking Medicaid, they're the only ones in the area taking Medicaid, and so they get them all. And if half your patients don't show up and that's all you can get on your list, you can't keep your lights on with what they're being reimbursed."

Similarly, beneficiaries described challenges with understanding eligibility, finding in-network providers, scheduling appointments, and transportation. Providers and beneficiaries both indicated some challenges dealing with DMS as well as with MCO websites.

A final cost-related concern was changes to formularies. Providers, particularly those in behavioral health, were concerned when patients were shifted from an effective medication to new medicines based upon changes to formulary. One provider had the following observation:

> What the MCOs are doing is shaping the prescribing of those professionals that have prescriptive authority. Because what happens is it's so hard to really prescribe the particular drug that I think is going to be best for you as my patient because I know that I'm going to have to do X number of faxes and X number of appeals and so forth. And so, you shape my behavior because I have so many more patients to see and so forth. And so, I just take the path of least resistance and put somebody on a different medication that is not actually what I think they ought to be on.

In summary, barriers associated with access and cost included (1) administrative burdens connected to prior authorization (pre-certifications) for Medicaid beneficiaries, (2) low reimbursement levels, (3) the need for equivalent reimbursements regardless of type of practice, (4) inadequate networks, and (5) changing formularies.

<u>Behavioral Health</u>

Behavioral health was identified as a top priority for the quality strategy by all key informants. The primary points of discussion were the related issues of access and network adequacy. As described by one interviewee, "Mental health issues are coming more to the forefront. And so, we need to continue our efforts and wrap around as much [*sic*] services and support to families, and kids, in particular."

The most commonly cited problem was access to providers for both inpatient and outpatient services. Ability to access to inpatient services was described as particularly acute, but access to care cut across all settings, with the problem being greatest in rural settings. In an interview one beneficiary summed up the problem: "I've been trying to call and find me a counselor myself, and I haven't had any luck." Stigma was also cited as a barrier, with the stigma associated with walking into a local community mental health center preventing some adults from seeking behavioral health services.

The legal requirements also create a barrier to receiving MOUD. Kentucky requires APRNs to have a collaborative prescribing agreement with a physician to prescribe scheduled drugs. These agreements can be difficult to establish. As one APRN described the problem, "… [In] order to prescribe MAT, you have to have a collaborative prescribing agreement with the physician who also does MAT. And so, if you can find a physician who does it, then you have to find a physician who's willing to sign an agreement. And that's been difficult."

The general opinion was that children and adolescents have better access to behavioral health care than adults. Parents tend to be more willing to get mental health services for their children than for themselves, and there are resources available for youth within school systems.

Most of the issues identified are not under the direct influence by the MCOs. Two issues described as concerns were formulary changes and it's the impact on medication adherence and prior authorization. These were discussed above.

Chronic Disease Management

Chronic diseases as a population health problem were discussed across all informants. The poor performance relative to national benchmarks, as reported in *t* the *2021 External Quality Review Technical Report Review of MCO Contract Years 2018 to 2020*, was pointed out in several interviews. Chronic diseases and their management continue to be a priority in establishing goals and objectives for the strategy,. Typifying the responses was the statement from one provider interviewed:

> Social determinants of health, mental health, those kinds of things are truly critical, especially for the population that we're talking about. Diabetes management, all of those kinds of things are really important. Obviously, smoking has been an issue. Opioid management is an issue for this state that's really problematic. So, I think that the targets [in the previous Quality Strategy] were appropriate. I think we can probably do some more.

The main issues identified with chronic diseases and chronic disease management are (1) the need for better patient education, (2) better coverage to allow for proper chronic disease management, and (3) the effects of lifestyle choices on chronic diseases. The connection between mental health and chronic diseases was also discussed as a priority.

Relative to MCO performance and targets, respondents discussed issues of access, formulary, prior authorization, and general network adequacy. All these topics are discussed in previous sections. Regarding beneficiary engagement education, key informants identified a perceived need to better coordinate the engagement and education activities across MCOs and with initiatives by DMS.

In summary, the key informant interviews confirmed that the focus on chronic disease measures identified by the interdisciplinary team are priorities.

Preventative Care

The discussions concerning preventive care paralleled those for the earlier domains. However, there was relatively more discussion with greater overlap with the Social Determinant and Equity domains (data).

Comments centered on access to care, beneficiary engagement for preventive services, and the challenges getting individuals to use preventative care. For example, one informant stated, “Some people don’t know how to use it [healthcare]. And, if you’ve never had it, how would you know how to use it, you know, to go for an annual physical exam?”

Of interest, several discussions including the importance of coordination with community health workers and community organizations to bridge inequity and social determinants. This was also discussed as an area where there could be better coordination with the MCOs, such as: (1) engagement between MCO outreach activities and organizations active in the community and (2) a better understanding of the activities of the community health workers employed by the MCOs.

Preventive care for adolescents was also discussed. There, the focus was on nutrition and physical activity counseling as initiating a healthy lifestyle at an early age. Other observations centered on childhood immunizations as a priority, particularly given their fall-off during the Covid-19 pandemic.

Overall, there was consensus in the comments. The key informants universally agreed preventive care should be a priority goal in the Quality Strategy.

Social Determinants of Health

As described in the earlier sections, SDOH is a cross-cutting issue across all the Domains. Key informants universally recognized the importance of the issue in the Quality Strategy. Suggestions focused primarily upon engagement to attract the beneficiaries into care. One interviewee observed that “the vast majority of folks can have a Medicaid benefit now who need it, 100 percent of poverty. And for some unknown reason, we haven’t made a conscientious decision to ensure people [who] have access to health care are using it.” A similar description of the problem was provided in another comment, who connected the problem to access: “How do we look at groups who may be less likely to access services to their detriment? And how do we engage with those communities? Again, it comes back to that access issue.”

Once again, there was a discussion about how to coordinate the various activities in the area of social determinants across multiple organizations in the Commonwealth. As one key informant indicated, “We’re all collecting information of food insecurity and housing insecurity and transportation barriers.” The suggestion was this information, and the activities of various programs, need to be coordinated.

In summary, SDOH were identified as cross-cutting and of the highest priority in the state. When discussing social determinants of health, a common theme was the need to reduce the administrative burden associated with getting reimbursed for Medicaid patients; if this administrative burden were to be reduced, more providers may be willing to see these patients. Access was also a common theme. The importance of community programs was discussed, to have someone in the community develop relationships with people and help guide them on utilizing resources and accessing care. The need to address food and housing insecurities, as well as transportation barriers, was also discussed.

Health Equity

Like SDOH, health equity was a cross-cutting issue across all the domains. All key informants identified the area as central to developing the Quality Strategy. The range of comments were limited, with

similar observations across all informants. Thus, in the Hierarchy Map indicates a relatively small space for this topic, even though it clearly was one of primary importance.

Interviewees pointed to the increased focus on health equity by all stakeholders, including data collection by DMS, MCOs, and health systems. Kentucky is also creating a health equity TEP and an Equity Branch within CHFS. These activities were acknowledged as a starting point in what is a very challenging area.

Access was the area most discussed topic within health equity. A summary of the discussions is that equity should be addressed by ensuring beneficiaries know how to utilize their coverage and what services they should access and how often. An initial step would be to offer guidance to help them navigate the complex healthcare system. Health equity should be among the highest priorities of the state.

Special Populations

The discussions were directed toward what special populations should be prioritized and comments on the two areas proposed by the Interdisciplinary Team: pregnancy and newborns and foster children. The key informants agreed on prioritizing pregnancy and newborns, but they reflected limited knowledge of the situation for foster children. One special population discussed for potential inclusion was justice-involved individuals and the overlap with behavioral health and SUD.

Specifically, the discussion of special populations brought up concerns about (1) the need to provide necessary postpartum care prior to discharge, (2) prioritizing childhood immunizations, and (3) ensuring medical coverage for the duration of pregnancy to ensure appropriate prenatal care is received. Two main issues that were identified regarding newborns and youth were low birth weights and adolescent obesity.

The discussion suggests there is likely a need for CHFS to do greater education about this foster children as special population to stakeholders. For justice-involved individuals, several interviewees pointed to the anticipated 1115 Waiver for reimbursement and continuity of care for incarcerated individuals with an SUD diagnosis as a starting point for this special population.

Value-Based Care

Key informants were largely aware of value-based payment approaches to reimbursement. For obvious reasons, beneficiaries and some advocates had limited knowledge of these schemes. There was general support for the concept of value-based care and the need for this payment method to improve population health. As summarized by one provider, “I think value-based purchasing is the future. I think we have to figure that out. I think the challenge is what’s the value? What’s the outcome?”

One consumer advocate suggested, “If we could focus our attention on wellness, prevention and that value-based purchasing, and we all feel comfortable with what the value is and how it’s being purchased, we can move the Medicaid program.” As far as a direction forward, one provider suggested learning from best practices in other states stating, “I now see the growing trend of value-based care...it’s important to kind of engage in ongoing trends that are happening nationally and see what ways that we can plug in.”

One criticism of value-based care concerned the degree to which patient behavior is outside of the influence of the provider. One provider observed, “You don’t have any control over where the patients are going for their care… And so, you know, the providers are being judged by a patient being seen by other providers … So, it’s difficult for any provider to drill in there to see if the patient is getting the preventive care, the lab work that they need.” Other criticisms included the role of social determinants relative to interaction with the health system. For example, a provider stated, “It’s also not very helpful when you’re trying to look at the measures and if the providers are meeting the measures because the patients don’t have to come and see them [the providers], so you don’t have an opportunity to meet the measures.”

In sum, respondents with an understanding of value-based care agreed that it should be an integral part of Kentucky’s Medicaid Quality Strategy. However, there were few specific suggestions beyond a focus on prevention and management.

Measurement

Key informants had many opinions on outcome measurement. Controversy is not unique to Medicaid, and it also surrounds other national programs such as the MIPS (merit-based incentive payment system) and APMS (alternative payment models). A primary criticism as described by one interviewee was “ a lot of quality measures, … and the majority of HEDIS measures, are more squarely directed at primary care doctors.” Another stated, “It’s really hard to do those kinds of measurements on the behavioral health side, and I think that by default, in some ways, we end up focusing on them.”

Other providers indicated that they viewed measures as primarily an administrative task with little impact on care. A provider commented, “We’re providing the best care we can for our patients. And we did that before all these quality measures came out, and I don’t think any of us have changed the way we practice since the quality measures came out.” Another observed, “I don’t think [the quality measures] changed the way we practice so much as it’s forced us to take more time checking boxes on a health record.”

The discussions provided no specifics on alternative measurements. There was a recognition that HEDIS measures are evidence-based, supported by CMS, used in other programs (e.g., Medicare), and allow for comparisons across providers and states. While clinical measures would likely provide greater insight into processes and outcomes, they were viewed as too complicated to capture and a potential additional burden. Thus, administrative data, such as claims, need to be the basis for measurement.

In sum, the previous Quality Strategy focused on many critical issues for Medicaid beneficiaries in Kentucky, but key informants suggested there is a need for a stronger link to measures that support value-based care. There is a general support for HEDIS measure use, but it was discussed that there is a need for population-specific measures. However, some providers believe that measures do not influence how they practice; instead, they just create more tasks to check off boxes in a patient’s health record.

Cross-Cutting Issues

As apparent in the discussion of the individual domains, all the priority areas are interrelated and have cross-cutting implications. Chronic disease management, preventative care, behavioral health, and targeted care for special populations are clear priorities for Kentucky. Each of these are shaped by the cross-cutting issues of social determinants/ health equity, access to care, and system/payment reform. These issues are summarized below:

- Social Determinants/Health Equity – There are clear challenges of disparities in the population of Kentucky Medicaid beneficiaries and the access to care, especially as it relates to social factors and geography. This will be a priority in the Kentucky Medicaid Quality Strategy. Initial planned steps include capturing sub-population measures across all quality domains, SDOH measures being standardized and formally required, and an initiative to understand and coordinate all of the SDOH/disparities/health equity initiatives underway in Kentucky.

- Network Adequacy – This issue is complex and is more than descriptive statistics of providers and regional coverage. The Quality Strategy needs to wrestle with formidable barriers to access, including the number and type of providers and appointments available, administrative costs associated with prior authorization and billing, and relative reimbursement levels.

- System/Payment Reform – Related to cost as a barrier to access, all stakeholders agreed that Medicaid needs to move to a reimbursement model focused on quality of care and outcomes, such as value-based payments/contracting. This is a national trend and CMS requires the Quality Strategy to include this cross-cutting issue.

References

[1] U.S. Census Bureau (2022). *Explore Census Data*. https://data.census.gov/cedsci/

[2] United Health Foundation (2021). *Health of Women and and Children.* https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/food_insecurity_household/state/KY

[3] United Health Foundation (2022). *America's Health Rankings*. https://www.americashealthrankings.org/learn/reports/2021-annual-report

[4] Sanders, D.H., Illback, R.J., Crabree, et al. (2022). Statewide Trends (2012-2021) Related to Youth Substance Use, Mental Health, and School Safety. *Kentucky Incentives for Prevention (KIP).*

[5] Kentucky Department for Medicaid Services. (2022). *Monthly Membership Counts by County*. https://chfs.ky.gov/agencies/dms/stats/KYDWMMCC072022.pdf

[6] Kentucky Department for Medicaid Services. (2022). *Child Membership Count*. https://chfs.ky.gov/agencies/dms/stats/ChildMembersMarch22.pdf

7 *Fiscal Year 2021 Comprehensive Evaluation Summary Commonwealth of Kentucky Strategy for Assessing and Improving the Quality of Managed Care Services* p.6 Available at https://chfs.ky.gov/agencies/dms/DMSMCOReports/2022TechReport.pdf