External Quality Review Annual Technical Report

State Fiscal Year 2021

Review Period: July 1, 2020–June 30, 2021

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KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES

Department of Medicaid Services

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Table of Contents

I. Executive Summary I-5

Purpose of Report I-5
Scope of External Quality Review Activities Conducted I-5
High-Level Program Findings and Recommendations I-6

II. Kentucky Medicaid Managed Care Program II-9

Managed Care in Kentucky II-9
IPRO's Assessment of the Kentucky Medicaid Quality Strategy II-9
Recommendations to DMS II-10

III. Validation of Performance Improvement Projects III-11

Objectives III-11
Technical Methods of Data Collection and Analysis III-11
Description of Data Obtained III-12
Conclusions and Comparative Findings III-15

IV. Review of Compliance with Medicaid and CHIP Managed Care Regulations IV-19

Objectives IV-19
Technical Methods of Data Collection and Analysis IV-19
Description of Data Obtained IV-20
Conclusions and Comparative Findings IV-20

V. Validation of Performance Measures V-23

Objectives V-23
Technical Methods of Data Collection and Analysis V-23
Description of Data Obtained V-24
Conclusions and Comparative Findings V-25

VI. Administration or Validation of Quality of Care Surveys – CAHPS Member Experience Survey VI-32

Objectives VI-32
Technical Methods of Data Collection and Analysis VI-32
Description of Data Obtained VI-32
Conclusions and Comparative Findings VI-33

VII. Focus Studies VII-35

Focus Study: COVID-19 Hospital Encounters, Mortality and Access to Telehealth Services Among Kentucky Medicaid Managed Care Enrollees VII-35
Focus Study: Access to Colorectal Cancer (CRC) Screening and Care Management for Kentucky Medicaid Managed Care Enrollees, May 2021 ..... VII-35

VIII. Validation of Network Adequacy VIII-37

Provider Network Submissions and Web-Based Directory Audits VIII-37
Provider Access and Availability Survey VIII-38

IX. MCO Quality Ratings IX-40

Objectives IX-40
Technical Methods of Data Collection and Analysis IX-40
Description of Data Obtained IX-40
Conclusions and Comparative Findings IX-41

X. NCQA Accreditation X-42

Objectives....X-42
Technical Methods of Data Collection and Analysis....X-42
Description of Data Obtained....X-44
Conclusions and Comparative Findings....X-44

XI. MCO Responses to the Previous EQR Recommendations....XI-46

Aetna Response to Previous EQR Recommendations....XI-46
Anthem Response to Previous EQR Recommendations....XI-51
Humana Response to Previous EQR Recommendations....XI-55
Passport/Molina Response to Previous EQR Recommendations....XI-62
WellCare Response to Previous EQR Recommendations....XI-66

XII. MCO Strengths and Opportunities for Improvement, and EQR Recommendations....XII-68

Aetna Strengths and Opportunities for Improvement, and EQR Recommendations....XII-68
Anthem Strengths and Opportunities for Improvement, and EQR Recommendations....XII-70
Humana Strengths and Opportunities for Improvement, and EQR Recommendations....XII-71
Passport/Molina Strengths and Opportunities for Improvement, and EQR Recommendations....XII-73
WellCare Strengths and Opportunities for Improvement, and EQR Recommendations....XII-74

XIII. References....XIII-77

XIV. Appendix A....XIV-78

MCO – Level Compliance Findings for State Fiscal Year 2021....XIV-78

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List of Tables

Table 1: Statewide Summary – Strengths, Opportunities for Improvement, and EQR Recommendations I-7
Table 2: MCO PIP Topics III-11
Table 3: PIP Validation Scoring and Compliance Levels III-12
Table 4: MCO PIP Validation Results – Improving Diabetes Management – Baseline, 2020 .... III-15
Table 5: MCO PIP Performance Indicator Results – Improving Diabetes Management III-16
Table 6: Additional PIP Performance Indicator Results – Improving Diabetes Management: WellCare III-16
Table 7: MCO PIP Validation Results – Improving Assessment, Referral and Follow-up for Social Determinants of Health – Baseline, 2020 .... III-17
Table 8: MCO PIP Performance Indicator Results – Improving Assessment, Referral and Follow-up for Social Determinants of Health III-17
Table 9: Aetna PIP Validation Results – Improving Weight Assessment, Counseling for Nutrition and Physical Activity, and Referrals for Overweight and Obesity Management in Children and Adolescents in the Supporting Kentucky Youth (SKY) Program – Baseline 2020 .... III-18
Table 10: Aetna PIP Performance Indicator Results – Improving Weight Assessment, Counseling for Nutrition and Physical Activity, and Referrals for Overweight and Obesity Management in Children and Adolescents in the Supporting Kentucky Youth (SKY) Program III-18
Table 11: Kentucky Medicaid Managed Care Compliance Monitoring Standard Designations IV-20
Table 12: Overall Compliance Score – October 2021 Compliance Review IV-21
Table 13: MCO Compliance with Information System Standards – 2021 .... V-24
Table 14: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2020 Quality Compass National Percentiles V-24
Table 15: MCO HEDIS Performance Measures – Effectiveness of Care MY 2020 .... V-25
Table 16: MCO HEDIS Performance Measures – Access and Availability MY 2020 .... V-28
Table 17: HEDIS Performance Measures – Utilization and Risk Adjusted Utilization – MY 2020 .... V-30
Table 18: Color Key for CAHPS Rate Comparison to NCQA HEDIS MY 2020 Quality Compass National Percentiles VI-32
Table 19: CAHPS Performance – Adult and Child Members – MY 2020 .... VI-33
Table 20: Appointment Availability for Network PCPs, Behavioral Health, and Substance Use Disorder Providers, FY 2021 .... VIII-39
Table 21: MCO Quality Rating Scale IX-40
Table 22: MCO Quality Report Card IX-41
Table 23: NCQA Accreditation Status Levels and Point System X-42
Table 24: NCQA Health Plan Star Rating Scale X-43
Table 25: MCO Medicaid Accreditation Status – 2021 .... X-44
Table 26: MCO NCQA Ratings by Category, 2021 .... X-44
Table 27: Aetna Response to Previous EQR Recommendations XI-46
Table 28: Anthem Response to Previous EQR Recommendations XI-51
Table 29: Humana Response to Previous EQR Recommendations XI-55
Table 30: Molina Response to Previous EQR Recommendations XI-62
Table 31: WellCare Response to Previous EQR Recommendations XI-66
Table 32: Aetna Strengths and Opportunities for Improvement, and EQR Recommendations XII-68
Table 33: Anthem Strengths and Opportunities for Improvement, and EQR Recommendations XII-70
Table 34: Humana Strengths and Opportunities for Improvement, and EQR Recommendations XII-71
Table 35: Passport/Molina Strengths and Opportunities for Improvement, and EQR Recommendations XII-73
Table 36: WellCare Strengths and Opportunities for Improvement, and EQR Recommendations XII-74

I. Executive Summary

Purpose of Report

The Balanced Budget Act (BBA) of 1997 established that state agencies contracting with managed care organizations (MCOs) provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCO. *Title 42 Code of Federal Regulations (CFR) Section (§) 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review (EQR) of contracted MCOs. States are required to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCO. The states must further ensure that the EQRO has sufficient information to carry out this review, that the information be obtained from EQR-related activities, and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services (CMS). Quality, as it pertains to an EQR, is defined in *Title 42 CFR § 438.320 Definitions* as "the degree to which an MCO, PIHP,[1] PAHP,[2] or PCCM[3] entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that is consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement."

Title 42 CFR § 438.364 External review results (*a)* through *(d)* requires that the annual EQR be summarized in a detailed technical report that aggregates, analyzes, and evaluates information on the quality of, timeliness of, and access to health care services that MCOs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCOs regarding health care quality, timeliness, and access, as well as make recommendations for improvement.

To comply with *Title 42 CFR Section § 438.364 External review results* (*a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*, the Kentucky Department of Medicaid Services (DMS) contracted with IPRO, an EQRO, to conduct the state fiscal year (SFY) 2021 EQR activities for five MCOs contracted to furnish Medicaid services in the state. During the period under review, SFY 2021 (July 1, 2020–June 30, 2021), DMS's MCOs included Aetna Better Health of Kentucky (Aetna), Anthem Blue Cross Blue Shield (Anthem), Humana Healthy Horizons in Kentucky (Humana), Passport Health Plan (Passport) and WellCare of Kentucky (WellCare). Midway through the state fiscal year, Molina Healthcare took over operation of Passport and contracted with the Kentucky Medicaid Managed Care (MMC) Program as Molina Healthcare of Kentucky (Molina) as of January 1, 2021. UnitedHealthcare Community Plan (United) contracted with the Kentucky MMC Program for the first time as of January 1, 2021 and did not submit performance data for measurement year (MY) 2020. United and Molina submitted PIP baseline reports and also participated in a compliance review in October 2021.

Scope of External Quality Review Activities Conducted

This EQR technical report focuses on the four mandatory and three optional EQR activities that were conducted. It should be noted that validation of network adequacy and assistance with the quality rating of MCOs was conducted at the state's discretion as activity protocols were not included in the CMS *External Quality Review (EQR) Protocols* published in October 2019. These updated protocols did state that an "Information Systems Capabilities Assessment (ISCA) is a mandatory component of the EQR as part of Protocols 1, 2, 3, and 4." As set forth in *Title 42 CFR Section § 438.358 Activities related to external quality review* (b)(1), these activities are:

(i) ***CMS Mandatory Protocol 1*: Validation[4] of Performance Improvement Projects (PIPs) –** This activity validates that MCO performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.

(ii) ***CMS Mandatory Protocol 2:* Validation of Performance Measures –** This activity assesses the accuracy of performance measures reported by each MCO and determined the extent to which the rates calculated by the MCO follow state specifications and reporting requirements.

(iii) ***CMS Mandatory Protocol 3:* Review of Compliance with Medicaid Managed Care Regulations –** This activity determines MCO compliance with its contract and with state and federal regulations.

(iv) ***CMS Mandatory Protocol 4:* Validation of Network Adequacy –** This activity assesses MCO adherence to state standards for distance for specific provider types, as well as the MCO's ability to provide an adequate provider network to its Medicaid population. (CMS has not published an official protocol for this activity.)

(v) ***CMS Optional Protocol 6:* Administration or Validation of Quality of Care Surveys –** This activity uses a member survey to measure satisfaction with care received, providers, and health plan operations.

(vi) ***CMS Optional Protocol 9:* Conducting Focus Studies of Health Care Quality –** This activity conducts focus studies to assess quality of care at a point in time.

(vii) ***CMS Optional Protocol 10:* Assist with the Quality Rating of Medicaid MCOs –** This activity summarizes MCO performance in a manner that allows beneficiaries to easily make comparisons and to identify strengths and weaknesses in high priority areas. (CMS has not published an official protocol for this activity.)

While the *CMS External Quality Review (EQR) Protocols* published in October 2019 stated that an ISCA is a required component of the mandatory EQR activities, CMS later clarified that the systems reviews that are conducted as part of the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit™ may be substituted for an ISCA. Findings from IPRO's review of the MCOs' HEDIS final audit reports (FARs) are in the **Validation of Performance Measures** section of this report.

The results of these EQR activities are presented in individual activity sections of this report. Each of the activity sections includes information on:

- data collection and analysis methodologies;
- comparative findings; and
- MCO performance strengths and opportunities for improvement, where applicable.

High-Level Program Findings and Recommendations

IPRO used the analyses and evaluations of 2020–2021 EQR activity findings to assess the performance of Kentucky Medicaid MCOs in providing **quality**, **timely**, and **accessible** healthcare services to Medicaid members. The individual MCOs were evaluated against state and national benchmarks for measures related to the **quality**, **access**, and **timeliness** domains, and results were compared to previous years for trending when possible.

The following provides a high-level summary of these findings for the Kentucky MMC Program. The overall findings for MCOs were also compared and analyzed to develop overarching conclusions and recommendations for each MCO. These plan-level findings are discussed in each EQR activity section, as well as in the **MCO Strengths and Opportunities for Improvement, and EQR Recommendations** section.

Strengths and Opportunities for Improvement Related to Quality, Timeliness and Access

The EQR activities conducted in SFY 2021 demonstrated that DMS and the MCOs share a commitment to improvement in providing high-quality, timely, and accessible care for members. Program strengths and opportunities for improvement are displayed in **Table 1.**

Table 1: Statewide Summary – Strengths, Opportunities for Improvement, and EQR Recommendations

Statewide Summary – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	Strengths	Opportunities for Improvement
Compliance Review	One quality-related compliance domain, Practice Guidelines, received 100% overall determinations for each of the six Kentucky MCOs in the 2021 Compliance Review.	There were a total of 23 quality-related elements that received Not Met determinations: 12 for United; 7 for Molina; 3 for Aetna and 1 for Anthem.
HEDIS Performance Measures of Quality	There were 17 HEDIS MY 2020 Effectiveness of Care measures (30%) with weighted statewide rates equal to or better than the national 50th percentile out of a total of 57 measures. Five of these measures were equal to or better than the 75th national percentile, but less than the national 90th percentile.	Weighted statewide average rates for 12 out of the 57 HEDIS MY 2020 Effectiveness of Care measures (21%) were below the national 25th percentile, including 5 measures in the Prevention and Screening domain and another 5 measures in the Overuse/Appropriateness domain.
Consumer Satisfaction	Kentucky showed overall strong performance in weighted statewide average rates of consumer satisfaction with 9 of the 13 adult CAHPS measures (69%) and all of the 10 child CAHPS measures (100%), meeting or exceeding the national 50th percentile. Two adult measures were at or above the national 90th percentile.	Opportunities for improvement are evident statewide for the three Smoking and Tobacco Use Cessation measures.
PIP Validation	• All Kentucky MMC MCOs submitted baseline reports for two statewide PIPs: Improving Diabetes Management; and Improving Assessment, Referral and Follow-up for Social Determinants of Health (SDoH). • For both PIPs, the validation elements for Topic/Rationale and Methodology were fully addressed by all MCOs.	For both statewide PIPs, all MCOs partially addressed the Barrier Analysis element.
MCO Quality Ratings	• The EQRO prepared an annual quality ratings report card to help members compare MCO performance and assist members in choosing an MCO during the open enrollment period. IPRO updates the MCO report cards annually prior to the open enrollment period. • For the 2022 report, there were 2 out of the 5 domains with high performance ratings: Getting Care - WellCare (5 stars) and Aetna, Anthem and Humana (4 stars); and Satisfaction with MCO Services – Humana and WellCare (5 stars) and Aetna, Anthem and Molina (4 stars).	There are opportunities for all Kentucky MCOs to improve ratings for measures receiving 2 stars out of 5, indicating low performance, especially for the Children and Adolescent Wellness domain.
NCQA Accreditation	Aetna, Anthem, Humana and WellCare all have NCQA accreditation. NCQA accreditation ratings in 2021, indicated that Aetna, Anthem and WellCare each had an overall performance rating of 3.5 stars out of 5 and Humana and Passport each had an overall rating of 3 stars out of 5.	The two new MCOs, Molina and United, have opportunity to achieve accreditation in two years starting 1/1/2021.
Access/Timeliness of Care	Strengths	Opportunities for Improvement
Compliance Review	All Kentucky MCOs had compliance ratings of 100% for the two access-related compliance	There are no opportunities for improvement evident.

Statewide Summary – Strengths, Opportunities for Improvement, and EQR Recommendations		
	domains: Availability of Service; and Assurances of Adequate Capacity and Services.	
HEDIS Performance Measures of Access/Timeliness	Weighted statewide average rates for 7 of the 10 measures (70%) of HEDIS MY 2020 access and availability measures were equal to or greater than the national 50th percentile. One measure, IET: Engagement of AOD Treatment: Total, continues to have rates at or above the national 90th percentile statewide and for all five MCOs.	Three weighted statewide average rates of HEDIS MY 2020 access and availability measures were below the national 50th percentile: Annual Dental Visit; PPC Timeliness of Prenatal Care and PPC: Postpartum Care.
Network Adequacy	Of the total providers surveyed for the Access and Availability survey, 74.7% were able to be contacted.	Of the total providers surveyed for the Access and Availability survey: • Rates of appointments made within the time standards were low: 34.9% for routine appointments and 19.5% for urgent appointments. • 48.5% were compliant with after-hours standards.
Focus Studies	The EQRO completed two focus studies: • COVID-19 Hospital Encounters, Mortality and Access to Telehealth Services among Kentucky Medicaid Managed Care Enrollees; and • Access to Colorectal Cancer Screening and Care Management for Kentucky Medicaid Managed Care Enrollees.	Results of the focus studies provide information for the state and MCOs to use in implementing interventions to improve access to telehealth services and access to colorectal cancer screening.

How the State Can Target Goals and Objectives in the **Quality Strategy**

- Kentucky's 2019 Quality Strategy goals address the burden of substance use disorder and behavioral health; chronic disease management; screening and preventive care; access to high quality care/reduction of unnecessary spending; and improved care/outcomes for children and adults. The numerous quality and access/timeliness objectives appear to be consistent with this report's EQR findings by including a focus on HEDIS measures identified as needing improvement compared to national benchmarks.
- The Quality Strategy further promotes MCO standards supporting quality of care including many of the quality of care and access/timeliness domains annually reviewed by the EQRO such as availability of services; assurances of adequate capacity and services; provider selection; subcontracts and delegation; practice guidelines (quality improvement plans); coordination and continuity of care; provision of covered services; health information systems; confidentiality; grievances and appeals; and quality measurement and improvement.
- Results of the survey of PCP, behavioral health and substance use disorder providers and findings from the focus studies regarding access to telehealth services and colorectal cancer screening indicate priority areas for improvement statewide. Partnering with the MCOs and the EQRO, DMS should target state efforts to raise provider awareness of access and availability contractual expectations.
- With each annual EQR report, the state is encouraged to review the Quality Strategy's goals and objectives in light of the compliance review findings, aggregation and analysis of quality and access/timeliness data; and validation of PIPs and make adjustments and updates to the strategy as needed.

MCO: managed care organization; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; CAHPS: Consumer Assessment of Healthcare Providers and Systems; PIP: performance improvement project; MMC: Medicaid managed care; EQRO: external quality review organization; NCQA: National Committee for Quality Assurance; IET: Initiation and Engagement of Alcohol and Other Drug (AOD) Use Treatment; PPC: Prenatal and Postpartum Care; COVID-19: 2019 novel coronavirus; EQR: external quality review; PCP: primary care provider; DMS: Department of Medicaid Services.

II. Kentucky Medicaid Managed Care Program

Managed Care in Kentucky

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

Kentucky Medicaid Quality Strategy

According to federal regulation (42 CFR§438.340 et seq.)[5], all states that contract with an MCO or a PIHP are required to have a written strategy for assessing and improving the quality of managed care services provided to Medicaid enrollees. Kentucky's first quality strategy was published in September 2012 and included the program descriptions as were then required by federal regulation.

With the advent of the Final Rule, new guidelines for state quality strategies were outlined by CMS in the Federal Register. DMS drafted an updated strategy entitled *Strategy for Assessing and Improving the Quality of Medicaid Managed Care Services*, dated July 2019. Posted on the DMS website, Kentucky's 2019 Quality Strategy identifies five program goals:

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

IPRO's Assessment of the Kentucky Medicaid Quality Strategy

The state of Kentucky contracts with IPRO to conduct an annual comprehensive evaluation and progress summary of the accountability strategy, monitoring mechanisms and compliance assessment system of the Kentucky MMC Program. Using annually updated information, reports, and interviews conducted during the most recent contract period, this report evaluates the state's progress in achieving the goals of Kentucky's quality strategy. A summary of program strengths and opportunities for improvement are identified and recommendations are proposed.

The updated quality strategy entitled, *Strategy for Assessing and Improving the Quality of Medicaid Managed Care Services,* provides a well-constructed framework to enhance quality monitoring and improvement as Kentucky's MMC Program seeks to achieve its five program goals and selected Core Measure objectives. Of the 35 HEDIS 2020 Core Measures aligned with the quality strategy goals that could be trended, 19 measures (54%) showed improvement in rates between HEDIS 2018 and HEDIS 2020, and 16 (46%) of the 35 trendable HEDIS measures listed in the 2019 Quality Strategy did not improve between HEDIS 2018 and HEDIS 2020. Opportunities for improvement were identified for HEDIS 2020 statewide average rates that were below the national 50th percentile, including 19 Core Measure rates that met or exceeded the national 25th percentile, but were below the national 50th percentile, and another 14 measure rates that were below the national 25th percentile.

Recommendations to DMS

The following recommendations were made to DMS:

- DMS should consider establishing state-level baselines for all reported Core Measures and setting state-level performance thresholds for each Core Measure in order to better evaluate the effectiveness of the MMC program in achieving the goals set forth in the quality strategy. Thresholds should be quantifiable, actionable, and able to be sustained over time. Benchmarks targeting national Medicaid performance, such as NCQA's national Quality Compass®, as well as incremental improvement over baseline rates offer potential sources for future evaluation.
- DMS should continue to engage the MCOs in discussions related to contract reporting requirements in order to determine what needs to be monitored through MCO reporting and how best to obtain this information on a regular basis. Considerations to lessen the reporting and review burden could include reducing the frequency of report submissions and/or using other state administrative sources for some of the requested data.
- DMS, in collaboration with the EQRO, may want to consider taking a more proactive role in initiatives to promote quality improvement such as providing feedback to the MCOs regarding HEDIS rate improvement, including face-to-face or remote video conferences and trainings based on lessons learned from focus studies and PIPs. Reaching out to other states and engaging them in webinars to share their quality improvement initiatives could also be informative. Using the DMS website to share quality performance data results as well as publish EQR report findings can also be a valuable initiative to support data transparency and promote quality improvement.

III. Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.330(d) establishes that state agencies require contracted MCOs to conduct PIPs that focus on both clinical and non-clinical areas. According to CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO.

The goal of the PIP is to achieve significant and sustainable improvement in clinical and non-clinical areas. *Title 42 CFR § 438.356(a)(1)* and *42 CFR § 438.358(b)(1)* establish that state agencies must contract with an EQRO to perform the annual validation of PIPs. A mandatory activity of the EQRO under the BBA is to review the PIP for methodological soundness of design, conduct and report to ensure real improvement in care and confidence in the reported improvements. To meet these federal regulations, DMS contracted with IPRO to validate the PIPs that were underway in 2020–2021.

Each Kentucky Medicaid MCO was required to submit two statewide baseline proposals. In addition, Aetna also submitted one plan-specific PIP. Specific MCO PIP topics are displayed in **Table 2**.

Table 2: MCO PIP Topics

MCO	PIP Topic(s)[1]	Time Period
Statewide – all Medicaid MCOs	Improving Diabetes Management	January 1, 2020 to December 31, 2022
	Improving Assessment, Referral and Follow-up for Social Determinants of Health (SDoH)	January 1, 2020 to December 31, 2022
Aetna	Improving Weight Assessment, Counseling for Nutrition and Physical Activity, and Referrals for Overweight and Obesity Management in Children and Adolescents in the Supporting Kentucky Youth (SKY) Program	January 1, 2020 to December 31, 2022

[1] Includes performance improvement projects (PIPs) that started, are ongoing, and/or were completed in the review year.
MCO: managed care organization.

Technical Methods of Data Collection and Analysis

IPRO's validation process begins at the PIP proposal phase and continues through the life of the PIP. During the conduct of the PIPs, IPRO provides technical assistance to each MCO.

CMS's *Protocol 1. Validation of Performance Improvement Projects*[6] was used as the framework to assess the quality of each PIP, as well as to score the compliance of each PIP with both federal and state requirements. IPRO's assessment involves the following 10 elements:

1. Review of the selected study topic(s) for relevance of focus and for relevance to the MCO's enrollment.
2. Review of the study question(s) for clarity of statement.
3. Review of the identified study population to ensure it is representative of the MCO's enrollment and generalizable to the MCO's total population.
4. Review of selected study indicator(s), which should be objective, clear, unambiguous, and meaningful to the focus of the PIP.
5. Review of sampling methods (if sampling used) for validity and proper technique.
6. Review of the data collection procedures to ensure complete and accurate data were collected.
7. Review of the data analysis and interpretation of study results.
8. Assessment of the improvement strategies for appropriateness.

9. Assessment of the likelihood that reported improvement is "real" improvement.
10. Assessment of whether the MCO achieved sustained improvement.

IPRO provided PIP report templates to each MCO for the submission of project proposals, baseline and interim updates, and results. All data needed to conduct the validation were obtained through these report submissions. The validation protocol begins with an assessment of the methodology for conducting the PIP, which is evaluated for each MCO's baseline proposal. Baseline PIP validation findings are assessed as:

- Addressed – all items reviewed for the element are deemed to be acceptable.
- Partially Addressed – one or more of the items reviewed for the element are not acceptable and require revisions.
- Not Addressed – all of the items reviewed for the element were not acceptable and each needs to be revised.

The EQRO reviews PIPs for compliance at interim and final remeasurement. For all final reports, the interim PIP score is re-evaluated based upon the extent to which the MCO addressed the interim PIP review comments. Additional points are earned for sustained improvement, as well as a corresponding interpretation of which goals were/were not met, lessons learned and follow-up activities. There are three levels of compliance for final reports as shown in **Table 3.**

Table 3: PIP Validation Scoring and Compliance Levels

Validation Level	Compliance Score Range 0–100 points	Interpretation
Level 1	93–100 points	Requirements met with comments and no recommendations.
Level 2	60–92 points	Requirements met with recommendations.
Level 3	0–59 points	Requirements not met with a CAP required.

PIP: performance improvement project; CAP: corrective action plan.

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

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

Description of Data Obtained

Information obtained from the MCOs throughout the reporting period include project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, and final), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

Statewide PIP: Improving Diabetes Management (January 1, 2020 – December 31, 2022)

Goal: Improve diabetic control among adult Kentucky MMC enrollees and reduce the prevalence of type 1 diabetic ketoacidosis among children.

The following key interventions were required to be implemented by all MCOs:

- Enhance case management and care coordination for enrollee outreach, diabetes education about nutrition and exercise, and engagement and referral to Diabetes Self-Management Education and Support (DSMES).
- Enhance case management and care coordination interventions for endocrinologist referrals.
- Educate primary care providers (PCPs) on evidence-based hemoglobin A1c (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.

There are three study indicators for this PIP:

- Indicator 1: The percentage of adult enrollees with diabetes (type 1 and type 2) who had an HbA1c test during the measurement year (HEDIS Comprehensive Diabetes Care).
- Indicator 2: The percentage of adult enrollees with diabetes (type 1 and type 2) with poor HbA1c control (> 9.0%) (HEDIS Comprehensive Diabetes Care).
- Indicator 3: The percentage of enrollees < 20 years of age with a diagnosis of type 1 diabetes mellitus with ketoacidosis (E10.10, 10.11).

Baseline validation findings are presented in **Table 4** and indicator results for Kentucky MCOs' baseline reports are shown in **Table 5**.

WellCare added three additional study indicators to their Improving Diabetes Management PIP:

- Indicator 4: The percentage of adult enrollees with diabetes mellitus (type 1 or type 2) referred to Good Measures DSMES program and enrolled in their DSMES program.
- Indicator 5: The percentage of enrollees < 20 years of age with diabetes mellitus (type 1 or type 2) referred to Good Measures and enrolled in their DSMES program.
- Indicator 6: The percentage of enrollees < 18 years of age with a diagnosis of T1DM.
- Indicator 6a: The percentage of enrollees < 18 years of age with a diagnosis of T1DM with ketoacidosis.

Results for these additional indicators are presented in **Table 6.**

Statewide PIP: Improving Assessment, Referral and Follow-up for Social Determinants of Health (SDoH) (January 1, 2020 – December 31, 2022)

Goal: Improve the quality of enrollee SDoH assessment, improve the rate of enrollee receipt of SDoH assessment and improve the rate of enrollee receipt of SDoH referral, follow-up and care coordination with the enrollee, PCPs and community mental health providers.

The following key interventions were required to be implemented by all MCOs:

- Incorporate the two social connectivity/isolation assessment questions from a validated SDoH tool (e.g., Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences [PRAPARE] and Accountable Health Communities Health-Related Social Needs Screening [AHC HRSN]) into the health risk assessment (HRA) to create an SDoH-enhanced HRA.
- Implement new procedures for obtaining alternate enrollee telephone numbers to improve the percent of new enrollees with a completed SDoH-enhanced HRA.
- Implement use of a validated SDoH assessment tool (e.g., PRAPARE and AHC HRSN) that assesses social connectivity/isolation as part of the comprehensive needs assessment (CNA) process to improve the percent of enrollees enrolled in case management with an SDoH assessment.

- Initiate a new procedure to incorporate goals to address social connectivity/isolation issues into the care plan in order to increase the percentage of enrollees enrolled in case management with a care plan that monitors SDoH issues (including social connectivity/isolation).
- Use findings of social connectivity/isolation issues identified by the SDoH-enhanced HRA and CNA to inform case management 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.
- Educate PCPs on SDoH assessment using a validated tool (i.e., PRAPARE) and SDoH coding.
- The MCO case management and/or utilization management (UM) discharge planner collaborates with the hospital discharge planner to facilitate an enhanced discharge planning process for each member that integrates SDoH assessment into the discharge planning procedure.

There are three study indicators for this PIP:
- Indicator 1: Percentage of new enrollees with a completed SDoH-enhanced HRA (at least two standardized questions to address the social connectivity/ isolation domain).
- Indicator 2: 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, and medication) and transportation.
- Indicator 3: Percentage of enrollees enrolled in case management with a plan of care (PoC) that includes SDoH goals developed in collaboration with the enrollee, with ongoing monitoring and follow-up to address outcomes.

Baseline validation findings are presented in **Table 7** and indicator results for KY MCOs baseline reports are shown in **Table 8**.

Aetna PIP: Improving Weight Assessment, Counseling for Nutrition and Physical Activity, and Referrals for Overweight and Obesity Management in Children and Adolescents in the Supporting Kentucky Youth (SKY) Program (January 1, 2020 to December 31, 2022)

Goals: Improve the rate for body mass index (BMI) percentile documentation among the high-risk SKY population aged 3–17 years, i.e., diagnosed with abnormal weight gain, overweight or obesity, prediabetes or type 2 diabetes; improve the rate for counseling for nutrition and counseling for physical activity among the total SKY population aged 3–17 years; and improve the evidence-based management and treatment of overweight and obesity among the SKY population aged 3–17 years.

The following key interventions were proposed to be implemented by Aetna:
- Develop Department for Community Based Services (DCBS) care gap reports for high-risk and for non–high-risk SKY population for distribution to/education of DCBS case workers regarding BMI percentile documentation, nutrition and physical activity counseling.
- Develop PCP care gap reports for high risk and for non-high risk SKY population for distribution to/education of PCP regarding BMI percentile documentation, nutrition and physical activity counseling.
- Plan of Care with weight goals in accordance with Bright Futures algorithm for the SKY population with any of the International Statistical Classification of Diseases, 10th Revision (ICD-10) codes in Table A for overweight status and for obesity.
- Provider education for motivational interviewing.
- Enhance care coordination to facilitate referrals to Pediatric Weight Management Clinic/multi-disciplinary team in accordance with Bright Futures algorithm for children who are overweight or obese.
- Establish collaborative partnership with local residential facility to pilot a provider and enrollee education and wellness program to address high risk area of obesity and overweight enrollees.

- Educate 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). Education includes cultural considerations.
- Adapt and edit Aetna's current Health Runs Deep Program to appeal to an audience of families with children of different ages.

There are six study indicators for this PIP:
- Indicator 1a: The percentage of high-risk SKY enrollees aged 3–11 years with BMI percentile documentation.
- Indicator 1b: The percentage of high-risk SKY enrollees aged 12–17 years with BMI percentile documentation.
- Indicator 2a: The percentage of total SKY enrollees aged 3–11 years with documentation of counseling for nutrition.
- Indicator 2b: The percentage of total SKY enrollees aged 12–17 years with documentation of counseling for nutrition.
- Indicator 3a: The percentage of total SKY enrollees aged 3–11 years with documentation of counseling for physical activity.
- Indicator 3b: The percentage of total SKY enrollees aged 12–17 years with documentation of counseling for physical activity.

Baseline validation findings are presented in **Table 9** and indicator results for Aetna's baseline report are shown in **Table 10.**

Conclusions and Comparative Findings

All Kentucky MCOs submitted baseline reports for two statewide PIPs: Improving Diabetes Management and Improving Assessment, Referral and Follow-up for Social Determinants of Health (SDoH). Aetna also submitted an additional baseline report for one plan-specific PIP entitled, Improving Weight Assessment, Counseling for Nutrition and Physical Activity, and Referrals for Overweight and Obesity Management in Children and Adolescents in the Supporting Kentucky Youth (SKY) Program (January 1, 2020 to December 31, 2022) . The following tables (**Tables 4–10)** display baseline validation results and performance indicator results for the two statewide PIPs conducted by Kentucky Medicaid MCOs during FY 2021, along with FY 2021 baseline results for Aetna's plan-specific PIP. As baseline reports, the data submitted included performance indicator target rates and actual baseline data for January 1, 2020 to December 31, 2020. IPRO will prepare validation compliance scores for the interim and final report results.

Table 4: MCO PIP Validation Results – Improving Diabetes Management – Baseline, 2020

	MCO PIP Validation Findings[1,2]					
PIP Validation Elements	Aetna	Anthem	Humana	Molina	United	WellCare
Topic/Rationale	Addressed	Addressed	Addressed	Addressed	Addressed	Addressed
Aim	Partial	Partial	Addressed	Addressed	Addressed	Addressed
Methodology	Addressed	Addressed	Addressed	Addressed	Addressed	Addressed
Barrier Analysis	Partial	Partial	Partial	Partial	Partial	Partial
Interventions	Partial	Partial	Partial	Partial	Addressed	Addressed
Results	Partial	Partial	Addressed	Addressed	Partial	Addressed
Discussion (Final Report)	-	-	-	-	-	-

[1] There are three levels of validation findings: addressed; partial (partially addressed); and NA: not addressed.
[2] Grey shaded cells indicate data were not available for these measurement periods.
MCO: managed care organization; PIP: performance improvement project.

Table 5: MCO PIP Performance Indicator Results – Improving Diabetes Management

MCO PIP Performance Indicator Results – Improving Diabetes Management						
Target/MY	Aetna	Anthem	Humana	Molina	United	WellCare
Indicator 1: The percentage of adult enrollees with diabetes who had an HbA1c test during the MY						
Target Rate	91.49%	86.86%	86.17%	88.79%	85.95%	87.96%
1/20–12/20	80.29%	84.18%	82.54%	83.45%	62.35%	82.96%
1/21–12/21	-	-	-	-	-	-
1/22–12/22	-	-	-	-	-	-
Indicator 2: The percentage of adult enrollees with diabetes (type 1 and type 2) with poor HbA1c control (> 9.0%)[1]						
Target Rate	28.75%	37.35%	55.46%	37.47%	45.96%	18.08%
1/20–12/20	38.44%	40.63%	59.62%	44.77%	85.08%	28.08%
1/21–12/21	-	-	-	-	-	-
1/22–12/22	-	-	-	-	-	-
Indicator 3: The percentage of enrollees < 20 years of age with a diagnosis of type 1 diabetes mellitus with ketoacidosis[1]						
Target Rate	N: 48[2]	10.00%[3]	0.035%	0.041%	<0.05%	0.004%
1/20–12/20	N: 53[2]	0.031%	0.050%	0.048%	0.05%	0.01%
1/21–12/21	-	-	-	-	-	-
1/22–12/22	-	-	-	-	-	-
Validation Compliance Scores						
Interim	-	-	-	-	-	-
Final	-	-	-	-	-	-

[1] A lower rate is better.
[2] To be determined: Due to the disparity in the numerator/denominator sizes (54/119,201 =0.000453) for this indicator, Aetna has proposed a 10% reduction in the overall number of enrollees < 20 years of age with a diagnosis of type 1 diabetes mellitus with ketoacidosis (for a rate of 0.000444627).
[3] Anthem was advised by IPRO to revise the denominator to include all children rather than restrict to children with diabetes in order to measure the overall pediatric prevalence of ketoacidosis, an indicator of possible missed diabetes diagnosis and treatment.
Grey shaded cells indicate data were not available for these measurement periods.
MCO: managed care organization; PIP: performance improvement project; HbA1c: hemoglobin A1c; MY: measurement year.

Table 6: Additional PIP Performance Indicator Results – Improving Diabetes Management: WellCare

Additional PIP Results – Improving Diabetes Management: WellCare				
	Measurement Year Rates			
Indicator	Target Rate	1/20–12/20	1/21–12/21	1/22–12/22
4: The percentage of adult enrollees with diabetes mellitus (type 1 or type 2) referred to Good Measures DSMES program and enrolled in their DSMES program	50.00%	14.80%	-	-
5: The percentage of enrollees < 20 years of age with diabetes mellitus (type 1 or type 2) referred to Good Measures and enrolled in their DSMES program	TBD	0.00%	-	-
6a: The percentage of enrollees < 18 years of age with a diagnosis of T1DM[1]	0.10%	0.11%	-	-
6b: The percentage of enrollees < 18 years of age with a diagnosis of T1DM with ketoacidosis[1]	0.004%	0.01%	-	-
Validation Compliance Scores				
Interim	-	-	-	-
Final	-	-	-	-

[1] A lower rate is better.
Grey shaded cells indicate data were not available for these measurement periods.
PIP: performance improvement project; DSMES: Diabetes Self-Management Education and Support; TBD: to be determined; T1DM: type 1 diabetes mellitus.

Table 7: MCO PIP Validation Results – Improving Assessment, Referral and Follow-up for Social Determinants of Health – Baseline, 2020

	MCO PIP Validation Findings – Improving Assessment, Referral and Follow-up for Social Determinants of Health [1,2]					
PIP Validation Elements	Aetna	Anthem	Humana	Molina	United	WellCare
Topic/Rationale	Addressed	Addressed	Addressed	Addressed	Addressed	Addressed
Aim	Addressed	Addressed	Addressed	Addressed	Addressed	Partial
Methodology	Addressed	Addressed	Addressed	Addressed	Addressed	Addressed
Barrier Analysis	Partial	Partial	Partial	Partial	Partial	Partial
Interventions	Partial	Partial	Partial	Partial	Addressed	Partial
Results	Addressed	Partial	Addressed	Addressed	Addressed	Partial
Discussion (Final Report)	-	-	-	-	-	-

[1] There are three levels of validation findings: addressed; partial (partially addressed); and NA: not addressed.

[2] Grey shaded cells indicate data were not available for these measurement periods.

MCO: managed care organization; PIP: performance improvement project.

Table 8: MCO PIP Performance Indicator Results – Improving Assessment, Referral and Follow-up for Social Determinants of Health

MCO PIP Performance Indicator Results – Improving Assessment, Referral and Follow-up for Social Determinants of Health						
Target/MY	Aetna	Anthem	Humana	Molina	United[1]	WellCare
Indicator 1: Percentage of new enrollees with a completed SDoH-Enhanced Health Risk Assessment						
Target Rate	68.62%	25.00%	20.00%	20.00%	2.09% -3.00%[2]	56.5%
1/20–12/20	28.08%	0.00%	0.00%	0.00%	0.09% - 1%	0.00%
1/21–12/21	-	-	-	-	-	-
1/22–12/22	-	-	-	-	-	-
Indicator 2: Percentage of enrollees enrolled in case management with a Comprehensive Needs Assessment that assesses SDoH Domains of Social Connectivity/Isolation, as well as housing, food insecurity, other financial problems and transportation						
Target Rate	84.72%	50.00%	20.00%	60.00%	20.66%[2]	TBD
1/20–12/20	79.35%	10.10%	0.00%	13.10%	18.66%	0.00%
1/21–12/21	-	-	-	-	-	-
1/22–12/22	-	-	-	-	-	-
Indicator 3: Percentage of enrollees enrolled in case management with a Plan of Care that includes SDoH goals developed in collaboration with the enrollee, with ongoing monitoring and follow-up to address outcomes.						
Target Rate	93.80%	50.00%	20.00%	50.00%	96.87%[2]	25.00%
1/20–12/20	90.80%	22.30%	0.00%	39.50%	94.87%	20.20%
1/21–12/21	-	-	-	-	-	-
1/22–12/22	-	-	-	-	-	-
Validation Compliance Scores						
Interim	-	-	-	-	-	-
Final	-	-	-	-	-	-

[1] United has two rates for Indicator 1 representing 2 population subcategories: presumptive eligible and fully eligible.

[2] Target rate to be determined annually, based on the previous year's rate for an annual increase of 2 percentage point improvement.

Grey shaded cells indicate data were not available for these measurement periods.

MCO: managed care organization; PIP: performance improvement project; MY: measurement year; SDoH: social determinants of health.

Table 9: Aetna PIP Validation Results – Improving Weight Assessment, Counseling for Nutrition and Physical Activity, and Referrals for Overweight and Obesity Management in Children and Adolescents in the Supporting Kentucky Youth (SKY) Program – Baseline 2020

Aetna PIP Validation Findings[1,2]	
PIP Validation Elements	Findings
1. Topic/Rational	Addressed
2. Aim	Partial
3. Methodology	Addressed
4. Barrier Analysis	Addressed
5. Interventions	Partial
6. Results	Addressed
7. Discussion (Final Report)	-

[1] There are three levels of validation findings: addressed; partial (partially addressed); and NA: not addressed.

[2] Grey shaded cells indicate data were not available for these measurement periods.

MCO: managed care organization; PIP: performance improvement project.

Table 10: Aetna PIP Performance Indicator Results – Improving Weight Assessment, Counseling for Nutrition and Physical Activity, and Referrals for Overweight and Obesity Management in Children and Adolescents in the Supporting Kentucky Youth (SKY) Program

Aetna PIP Performance Indicator Results				
	Measurement Year Rates			
Indicator	Target Rate	1/20–12/20	1/21–12/21	1/22–12/22
1a: The percentage of high risk SKY enrollees aged 3–11 years with BMI percentile documentation	84.22%	80.22%	-	-
1b: The percentage of high risk SKY enrollees aged 12–17 years with BMI percentile documentation	70.92%	65.92%	-	-
2a: The percentage of total SKY enrollees aged 3–11 years with documentation of counseling for nutrition	35.22%	29.22%	-	-
2b: The percentage of total SKY enrollees aged 12–17 years with documentation of counseling for nutrition	32.62%	26.62%	-	-
3a: The percentage of total SKY enrollees aged 3–11 years with documentation of counseling for physical activity	32.86%	26.86%	-	-
3b: The percentage of total SKY enrollees aged 12–17 years with documentation of counseling for physical activity	32.41%	26.41%	-	-
Validation Compliance Scores				
Interim	-	-	-	-
Final	-	-	-	-

Grey shaded cells indicate data were not available for these measurement periods.

PIP: performance improvement project; BMI: body mass index.

IV. Review of Compliance with Medicaid and CHIP Managed Care Regulations

Objectives

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

Technical Methods of Data Collection and Analysis

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

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

- statement of federal, state, and MCO contract requirements and applicable state regulations;
- prior results and follow-up;
- NCQA deemable citation and NCQA determination;
- reviewer compliance determination;
- descriptive reviewer findings and recommendations related to the findings;
- overall compliance determinations and scoring grid; and
- suggested evidence.

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

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

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

Remote Activities – In light of the 2019 novel coronavirus (COVID-19) restrictions, the visit took the form of remote online meetings and offsite reviews. This part of the review commenced with an opening conference where staff was introduced and an overview of the purpose and process for the review and agenda are provided. Following this, IPRO may conducted a review of additional documentation provided, as well as the file reviews. Staff interviews were conducted to clarify and confirm findings. When appropriate, walkthroughs

or demonstrations of work processes were conducted. The remote review concluded with a closing conference, during which IPRO provided feedback regarding the preliminary findings, follow-up items needed and the next steps in the review process.

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

The standard designations and assigned points used are shown in **Table 11.**

Table 11: Kentucky Medicaid Managed Care Compliance Monitoring Standard Designations

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

[1] Elements determined to be non-applicable were not included in the overall determination calculation.
MCO: managed care organization.

Description of Data Obtained

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

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

Conclusions and Comparative Findings

Overall compliance scores for the October 2021 review are presented in **Table 12**.

Table 12: Overall Compliance Score – October 2021 Compliance Review

CFR Standard Name	CFR Citation	State Citation	Aetna	Anthem	Humana	Molina	United	WellCare
Overall compliance score								
Availability of services	**438.206**	28.0, 28.1, 28.2, 28.3	100%	100%	100%	100%	100%	100%
Assurances of adequate capacity and services	**438.207**	28.4, 28.5, 30.1, 30.2	100%	100%	100%	100%	100%	100%
Coordination and continuity of care	**438.208**	34.0, 34.1, 34.2, 34.3, 34.4, 34.5, 34.6, 35.0, 35.1, 35.2, 35.3, 35.4	98%	99%	99%	98%	86%	100%
Coverage and authorization of services	**438.210**	20.0, 20.1, 20.2, 20.3, 20.4, 20.5, 20.6, 20.7	100%	100%	100%	91%	94%	100%
Provider selection	**438.214**	27.7, 28.6, 28.7, 28.8, 28.10	100%	100%	100%	99%	100%	100%
Confidentiality	**438.224, 438.100, 438.10**	22.9, 22.1, 22.2, 20.3	98%	100%	100%	95%	100%	100%
Grievance and appeal systems	**438.228**	24.0, 24.1, 24.2, 24.3, 27.1	98%	100%	100%	100%	98%	100%
Subcontractual relationships and delegation	**438.230**	4.3, 6.0, 6.1, 6.2	100%	100%	100%	98%	88%	99%
Practice guidelines	**438.236**	20.3	100%	100%	100%	100%	100%	100%
Health information systems	**438.242**	16.1	97%	97%	100%	97%	100%	100%
QAPI	**438.330**	19.1, 19.2, 19.3, 19.4, 19.5, 19.6, 19.10, 21.2, 21.3, 21.4	99%	98%	100%	96%	93%	100%
Elements Reviewed			800	730	730	730	730	730
Elements Not Met (% of total)			3 (0.4%)	1 (0.1%)	None	7 (1.0%)	12 (1.6%)	None

CFR: Code of Federal Regulations; QAPI: quality assurance and performance improvement.

All six MCOs participated in the 2021 Compliance Review. Aetna had 800 elements reviewed while Anthem, Humana, Molina, United and WellCare each had 730 elements reviewed for a total of 4,450 elements reviewed overall (**Table 12**).

Kentucky MCOs showed strong performance in the 2021 Compliance Review. All six MCOs received 100% compliance for 3 of the 11 standard domains: availability of services; assurances of adequate capacity and services; and practice guidelines (**Table 12**). By MCO, Humana and WellCare each had 100% compliance for 10 of the 11 standard domains, followed by Anthem with 8 domains at 100% compliance; Aetna and United had 6 domains with 100%; and Molina had 4 domains with 100% compliance.

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

Table A1 in **Appendix A** shows opportunities for improvement for MCOs with compliance elements that received Not Met determinations**.**

V. Validation of Performance Measures

Objectives

Medicaid MCOs calculate performance measures (PMs) to monitor and improve processes of care. As per the CMS regulations, validation of PMs is one of the mandatory EQR activities. The methodology for validation of PMs was based on *Protocol 2 Validation of Performance Measures from CMS's External Quality Review Protocols, October 2019*.[7] The primary objectives of the PM validation process are to assess the following:

- structure and integrity of the MCO's underlying Information Systems (IS);
- MCO ability to collect valid data from various internal and external sources;
- vendor (or subcontractor) data and processes, and the relationship of these data sources to those of the MCO;
- MCO ability to integrate different types of information from varied data sources (e.g., member enrollment data, claims data, pharmacy data) into a data repository or set of consolidated files for use in constructing MCO PMs; and
- documentation of the MCO's processes to: collect appropriate and accurate data, manipulate the data through programmed queries, internally validate results of the operations performed on the data sets, follow specified procedures for calculating the specified PMs, and report the measures appropriately.

Technical Methods of Data Collection and Analysis

As part of the HEDIS MY 2020 compliance audit, each of the Kentucky Medicaid MCOs contracted with an NCQA-licensed audit organization to assess compliance with NCQA standards in the seven designated IS categories, as follows:

- **IS 1.0:** Medical Services Data – Sound Coding Methods and Data Capture, Transfer and Entry;
- **IS 2.0:** Enrollment Data – Data Capture, Transfer and Entry;
- **IS 3.0:** Practitioner Data – Data Capture, Transfer and Entry;
- **IS 4.0:** Medical Record Review Process – Training, Sampling, Abstraction and Oversight;
- **IS 5.0:** Supplemental Data – Capture, Transfer and Entry;
- **IS 6.0:** Member Call Center Data – Capture, Transfer and Entry; and
- **IS 7.0:** Data Integration – Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity.

In addition, the following HEDIS measure determination (HD) standards were assessed:

- **HD 1.0:** Denominator Identification;
- **HD 2.0:** Sampling;
- **HD 3.0:** Numerator Identification;
- **HD 4.0:** Algorithmic Compliance; and
- **HD 5.0:** Outsourced or Delegated HEDIS Reporting Functions.

HEDIS compliance audits result in audited rates or calculations at the measure level and indicate if the measures can be publicly reported. The auditor approves the rate or report status of each measure and survey included in the audit, as follows:

- Reportable (R) – a rate or numeric result. The organization followed the specifications and produced a reportable rate or result for the measure.
- Small Denominator (N/A) – the organization followed the specifications, but the denominator was too small (< 30 members) to report a valid rate.
- Benefit Not Offered (NB) – the organization did not offer the health benefit required by the measure.
- Not Reportable (NR) – the organization calculated the measure, but the rate was materially biased, or the organization chose not to report the measure or was not required to report the measure.

Description of Data Obtained

The five MCOs with performance data for MY 2020 (Aetna, Anthem, Humana, Passport and WellCare) reported HEDIS MY 2020 data. The MCOs' independent auditors determined that the rates reported by the MCOs were calculated in accordance with NCQA's defined specifications and there were no data collection or reporting issues identified by the MCOs' independent auditors.

IPRO reviewed each of the Kentucky MCOs' HEDIS MY 2020 Final Audit Reports (FARs) to determine compliance with ISCA standards. The FARs revealed that all MCOs met all standards for successful reporting **(Table 13).**

Table 13: MCO Compliance with Information System Standards – 2021

IS Standard	Aetna	Anthem	Humana	Passport	WellCare
HEDIS Auditor					
1.0 Medical Services Data	Met	Met	Met	Met	Met
2.0 Enrollment Data	Met	Met	Met	Met	Met
3.0 Practitioner Data	Met	Met	Met	Met	Met
4.0 Medical Record Review Processes	Met	Met	Met	Met	Met
5.0 Supplemental Data	Met	Met	Met	Met	Met
6.0 Data Preproduction Processing	Met	Met	Met	Met	Met
7.0 Data Integration and Reporting	Met	Met	Met	Met	Met

MCO: managed care organization; IS: information system; HEDIS: Healthcare Effectiveness Data and Information Set.

IPRO aggregated the MCO rates and calculated weighted statewide averages[8] to provide methodologically appropriate, comparative information for all MCOs consistent with guidance included in the EQR protocols issued in accordance with § 438.352(e). HEDIS rates produced by the MCOs were also reported to the NCQA.

For this report, the MCOs' reported rates are compared to the NCQA HEDIS MY 2020 Quality Compass national percentiles for Medicaid health maintenance organizations (HMOs) for all measures where the NCQA HEDIS MY 2020 Quality Compass national percentiles are available. The HEDIS rates are color coded to correspond to national percentiles (**Table 14**).

Table 14: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2020 Quality Compass National Percentiles

Color Key	How Rate Compares to the NCQA HEDIS MY 2020 Quality Compass National Percentiles
Red	Below the national Medicaid 25th percentile.
Pink	At or above the national Medicaid 25th percentile, but below the 50th percentile.
Yellow	At or above the national Medicaid 50th percentile, but below the 75th percentile.
Blue	At or above the national Medicaid 75th percentile, but below the 90th percentile.
Green	At or above the national Medicaid 90th percentile.
White	No national benchmarks available for this measure or measure not applicable (N/A).

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

HEDIS data presented in this section includes: Effectiveness of Care measures **(Table 15)**; Access and Availability measures **(Table 16)**; and Utilization and Risk Adjusted Utilization **(Table 17)**.

Conclusions and Comparative Findings

HEDIS MY 2020 Effectiveness of Care

HEDIS MY 2020 Effectiveness of Care measures evaluate how well an MCO provides preventive screening and care for respiratory conditions, cardiovascular conditions, diabetes and behavioral health conditions. In addition, measures for overuse/appropriateness are included. **Table 15** presents the HEDIS MY 2020 Effectiveness of Care rates along with statewide averages that are weighted by MCO enrollment size, referred to as the weighted statewide average. Color coding is used to provide a visual comparison to the NCQA HEDIS MY 2020 national percentiles for Medicaid (**Table 14**).

Table 15 displays the HEDIS performance measures for MY 2020 for all MCOs and the weighted statewide average.

Table 15: MCO HEDIS Performance Measures – Effectiveness of Care MY 2020

Measure	Aetna	Anthem	Humana	Passport	WellCare	Weighted Statewide Average
Prevention and Screening						
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)						
WCC: BMI Percentile Total	84.43%	76.79%	65.69%	50.61%	68.37%	67.93%
WCC: Counseling for Nutrition Total	56.45%	58.16%	56.69%	42.58%	54.01%	52.30%
WCC: Counseling for Physical Activity Total	52.55%	53.06%	49.64%	41.61%	53.53%	50.08%
Childhood Immunization Status: Combination 3 (CIS)	72.75%	75.67%	67.88%	70.07%	69.59%	70.65%
Immunizations for Adolescents (IMA)						
IMA: Meningococcal	82.97%	76.40%	78.59%	74.45%	83.45%	80.06%
IMA: Tdap/Td	89.29%	79.32%	82.73%	79.81%	90.51%	86.00%
IMA: Human Papillomavirus Vaccine for Female Adolescents (HPV)	37.71%	24.33%	31.63%	38.69%	31.63%	34.49%
IMA: Combination 1	82.73%	75.43%	76.89%	73.24%	82.73%	79.22%
IMA: Combination 2	34.55%	22.87%	28.71%	34.06%	27.74%	30.79%
Lead Screening in Children (LSC)	64.48%	70.57%	68.61%	77.37%	64.89%	69.73%
Breast Cancer Screening (BCS)	44.28%	47.83%	45.16%	44.67%	49.67%	46.90%
Cervical Cancer Screening (CCS)	56.20%	49.63%	44.71%	70.80%	51.80%	55.70%
Chlamydia Screening in Women (CHL) Total	51.10%	52.21%	53.76%	57.68%	50.77%	52.99%
Respiratory Conditions						
Appropriate Testing for Children with Pharyngitis (CWP)	80.36%	80.41%	79.38%	84.99%	79.97%	81.05%
Spirometry Testing in Assessment and Diagnosis of COPD (SPR)	24.18%	24.93%	25.55%	23.38%	21.66%	23.31%
Pharmacotherapy Management of COPD Exacerbation (PCE)						
PCE: Systemic Corticosteroid	85.38%	63.04%	61.94%	49.62%	71.69%	64.88%
PCE: Bronchodilator	90.58%	79.77%	70.19%	63.05%	84.19%	76.60%
Asthma Medication Ratio (AMR) Total	69.03%	64.88%	63.08%	70.14%	62.99%	66.12%
Cardiovascular Conditions						
Controlling High Blood Pressure (CBP)	60.10%	55.72%	62.77%	49.88%	52.07%	54.67%
Persistence of Beta-Blocker Treatment After Heart Attack (PBH)	80.00%	77.10%	80.41%	92.78%	89.06%	85.71%
Statin Therapy for Patients With Cardiovascular Disease (SPC)						

Measure	Aetna	Anthem	Humana	Passport	WellCare	Weighted Statewide Average
SPC: Received Statin Therapy Total	80.07%	77.40%	74.40%	64.77%	81.05%	76.02%
SPC: Statin Adherence 80% Total	70.27%	67.10%	68.17%	64.30%	73.58%	69.93%
Cardiac Rehabilitation (CRE)[1]						
CRE: Initiation (Total)[1]	3.44%	4.11%	3.75%	3.45%	2.73%	3.34%
CRE: Engagement1 (Total)[1]	2.89%	3.49%	4.65%	3.53%	3.02%	3.45%
CRE: Engagement 2 (Total)[1]	1.81%	3.70%	4.05%	1.89%	2.01%	2.46%
CRE: Achievement (Total)[1]	1.08%	2.05%	1.80%	0.78%	1.22%	1.27%
Diabetes						
Comprehensive Diabetes Care (CDC)						
CDC: Hemoglobin A1c (HbA1c) Testing	80.29%	84.18%	85.16%	83.45%	85.16%	84.04%
CDC: HbA1c Poor Control (> 9.0%)[2]	38.44%	40.63%	37.96%	56.93%	48.91%	46.80%
CDC: HbA1c Control (< 8.0%)	49.15%	49.64%	49.15%	35.28%	39.90%	42.53%
CDC: Eye Exam (Retinal) Performed	46.72%	46.72%	45.99%	45.99%	52.55%	48.70%
CDC: Blood Pressure Control (< 140/90 mmHg)	63.26%	58.39%	63.26%	55.23%	62.04%	60.43%
Kidney Health Evaluation for Patients With Diabetes (KED) Total[1]	21.15%	22.64%	22.69%	19.75%	21.88%	21.52%
Statin Therapy for Patients with Diabetes (SPD)						
SPD: Received Statin Therapy	64.97%	62.17%	61.94%	55.18%	68.49%	63.25%
SPD: Statin Adherence 80%	67.97%	64.65%	67.66%	63.52%	72.33%	68.48%
Behavioral Health						
Antidepressant Medication Management (AMM)						
AMM: Effective Acute Phase Treatment	51.56%	56.12%	56.83%	51.52%	54.24%	53.65%
AMM: Effective Continuation Phase Treatment	35.30%	40.44%	39.86%	34.63%	38.83%	37.49%
Follow-up Care for Children Prescribed ADHD Medication (ADD)						
ADD: Initiation Phase	55.45%	48.55%	39.70%	43.54%	59.75%	51.94%
ADD: Continuation and Maintenance (C&M) Phase	65.00%	55.63%	46.23%	51.07%	70.37%	61.27%
Follow-up After Hospitalization for Mental Illness (FUH)						
FUH: 30-Day Follow-up	62.72%	56.66%	58.09%	51.98%	59.30%	58.77%
FUH: 7-Day Follow-up	40.81%	36.49%	35.75%	30.73%	38.99%	37.72%
Follow-up After Emergency Department Visit for Mental Illness (FUM)						
FUM: 30-Day Follow-up	52.67%	47.76%	47.88%	53.25%	54.01%	52.52%
FUM: 7-Day Follow-up	38.00%	35.19%	37.57%	33.00%	39.23%	35.27%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)						
FUI: 7-Day Follow-up	26.73%	33.41%	42.73%	38.30%	26.60%	33.75%
FUI: 30-Day Follow-up	53.06%	59.66%	65.11%	63.83%	53.20%	59.21%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)						
FUA: 30-Day Follow-up Total	17.40%	25.19%	32.95%	41.03%	20.15%	31.42%
FUA: 7-Day Follow-up Total	12.00%	14.96%	24.65%	29.30%	12.74%	21.86%
Pharmacotherapy for Opioid Use Disorder Total (POD)	36.20%	35.17%	34.80%	27.38%	39.99%	34.13%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)	77.83%	79.68%	81.51%	81.58%	80.20%	80.35%

Measure	Aetna	Anthem	Humana	Passport	WellCare	Weighted Statewide Average
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	66.08%	61.29%	70.87%	62.44%	71.72%	67.35%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	57.89%	92.86%	66.67%	75.93%	73.56%	73.13%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	57.74%	56.51%	56.24%	54.44%	62.24%	58.01%
Metabolic Monitoring for Children and Adolescents on Antipsychotics – Blood Glucose and Cholesterol Testing Total (APM)	25.60%	28.52%	30.32%	34.81%	25.80%	28.58%
Overuse and Appropriateness						
Non-recommended Cervical Cancer Screening Adolescent Females (NCS)[2]	0.93%	0.54%	1.50%	0.82%	1.72%	1.21%
Appropriate Treatment for Children with URI (URI)	71.25%	74.42%	73.13%	82.13%	67.99%	73.02%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	31.54%	40.33%	37.94%	46.65%	34.18%	37.59%
Use of Imaging Studies for Low Back Pain (LBP)	67.42%	67.50%	65.36%	67.76%	66.84%	67.07%
Use of Opioids at High Dosage (HDO)[2]	1.61%	2.27%	1.71%	0.69%	1.96%	1.67%
Use of Opioids from Multiple Providers (UOP)[2]						
UOP: Multiple Prescribers[2]	25.02%	18.67%	17.52%	22.81%	14.90%	17.96%
UOP: Multiple Pharmacies[2]	12.99%	1.51%	2.96%	4.03%	1.87%	3.25%
UOP: Multiple Prescribers and Multiple Pharmacies[2]	8.45%	0.99%	1.44%	2.10%	0.92%	1.79%
Risk of Continued Opioid Use (COU)[2]						
COU: Rate ≥ 15 Days[2]	2.12%	5.68%	12.10%	6.57%	9.75%	7.62%
COU: Rate ≥ 31 Days[2]	1.54%	4.71%	8.66%	5.04%	7.70%	5.86%

[1] No national benchmarks were available for this measure.
[2] A lower rate reflects better performance.
Color key for how rate compares to the NCQA HEDIS MY 2020 Quality Compass national percentiles: red shading – below the national Medicaid 25th percentile; pink shading – at or above the national Medicaid 25th percentile, but below the 50th percentile; yellow shading – at or above the national Medicaid 50th percentile, but below the 75th percentile; blue shading – at or above the national Medicaid 75th percentile, but below the 90th percentile; green shading – at or above the national Medicaid 90th percentile; no shading (white) – no national benchmarks available for this measure or measure not applicable (N/A).
BMI: body mass index; ADHD: attention deficit and hyperactivity disorder; COPD: chronic obstructive pulmonary disease; URI: upper respiratory infection.

Table 15 shows the following results for ***HEDIS MY 2020 Effectiveness of Care measures***:

Prevention and Screening: Rates below the NCQA national Medicaid 50th percentile were predominant. Passport performed at or above the NCQA national Medicaid 50th percentile for 5 of the 13 measures. Aetna had four measures at or above the NCQA national Medicaid 50th percentile, while WellCare had three measures at or above the NCQA national Medicaid 50th percentile; Anthem had two measures at or above the NCQA national Medicaid 50th percentile and Humana had one measure at or above the NCQA national Medicaid 50th percentile. There was one weighted statewide average rate that met or exceeded the NCQA national Medicaid 50th percentile for prevention and screening measures (Childhood Immunization Status: Combination 3 [CIS]).

Respiratory Conditions: The weighted statewide average was at or above the national 50th percentile for two of the five measures with benchmarks. Aetna had four of the five measures at or above the national 50th percentile, while Anthem, Passport and WellCare each had two of the five measures at or above the national 50th percentile. Humana had one measure at or above the national 50th percentile.

Cardiovascular Conditions: Weighted statewide average rates were at or above the NCQA national Medicaid 50th percentile for one of the four cardiovascular measures with benchmarks. WellCare met or exceeded the national 50th percentile for three of the four measures, while Aetna, Anthem, Humana and Passport each had one of the four measures at or above the national 50th percentile.

Diabetes: Weighted statewide average rates for CDC: HbA1c Testing and CDC: Blood Pressure Control (<140/90 mmHg) showed improved performance with rates at or above the national 50th percentile. Weighted statewide average rates were above the NCQA national Medicaid 50th percentile for two of the seven diabetes measures with benchmarks. WellCare had five of the seven measures at or better than the national 50th percentile while Humana had four of the seven measures at or better than the national 50th percentile; Aetna and Anthem each had three of the seven diabetes measures at or better than the national 50th percentile. Six of Passport's seven diabetes measure rates were below the national 50th percentile.

Behavioral Health: For the 18 measures in this domain with NCQA national Medicaid benchmarks, there were 9 weighted statewide average rates at or above the NCQA national Medicaid 50th percentile. Anthem and WellCare each had 9 of the 18 measures at or above the national 50th percentile; Humana had 8 measures at or above the national 50th percentile and Aetna and Passport each had 7 measures at or above the national 50th percentile. All MCOs had rates at or above the NCQA national Medicaid 50th percentile for Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (SSD)**.**

Overuse and Appropriateness: Performance was generally poor for this domain. The weighted statewide average was below the national 50th percentile for 7 of the 10 measures. All five MCOs had rates below the national 25th percentile for 3 of the 10 measures of overuse and appropriateness.

HEDIS MY 2020 Access and Availability

HEDIS 2021 Access and Availability measures examine the following: adults who receive preventive/ambulatory health care services, children and adolescents who access their primary care providers, annual dental visits, alcohol and other drug abuse or dependence treatment, access to prenatal and postpartum care services, and use of first-line psychosocial care for children and adolescents on antipsychotics. **Table 16** presents selected HEDIS MY 2020 Access and Availability measure rates along with the weighted statewide averages and comparison to the NCQA HEDIS MY 2020 national percentiles for Medicaid (**Table 14**).

Table 16: MCO HEDIS Performance Measures – Access and Availability MY 2020

Measure	Aetna	Anthem	Humana	Passport	WellCare	Weighted Statewide Average
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
AAP: 20–44 Years	78.51%	73.37%	74.53%	76.75%	79.79%	77.21%
AAP: 45–64 Years	83.86%	81.57%	83.62%	84.08%	87.36%	84.80%
AAP: 65+ Years	69.21%	82.77%	87.20%	88.56%	91.03%	87.67%
AAP: Total	80.16%	76.31%	78.22%	79.46%	82.62%	79.99%
Well-Child Visits in the First 30 Months of Life (W30)[1]						
W30: First 15 Months[1]	55.92%	58.96%	53.83%	59.84%	57.77%	57.87%

Measure	Aetna	Anthem	Humana	Passport	WellCare	Weighted Statewide Average
W30: 15 Months-30 Months[1]	66.25%	69.39%	65.94%	69.71%	68.89%	68.54%
Child and Adolescent Well-Care Visits (WCV) Total[1]	36.16%	35.19%	34.89%	43.20%	40.83%	39.48%
Annual Dental Visit (ADV)	48.51%	35.42%	4.53%	42.68%	49.95%	42.44%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence (AOD) Treatment (IET)						
IET: Initiation of AOD Treatment: Total	49.60%	55.56%	57.73%	46.28%	51.62%	51.39%
IET: Engagement of AOD Treatment: Total	22.85%	27.07%	31.40%	24.29%	24.96%	25.87%
Prenatal and Postpartum Care (PPC)						
PPC: Timeliness of Prenatal Care	86.37%	85.64%	78.10%	78.83%	90.02%	84.31%
PPC: Postpartum Care	76.40%	76.89%	73.72%	72.75%	76.16%	75.01%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – Total (APP)	62.65%	60.20%	61.69%	65.35%	62.19%	63.04%

[1] No national benchmarks were available for this measure.
Color key for how rate compares to the NCQA HEDIS MY 2020 Quality Compass national percentiles: red shading – below the national Medicaid 25th percentile; pink shading – at or above the national Medicaid 25th percentile, but below the 50th percentile; yellow shading – at or above the national Medicaid 50th percentile, but below the 75th percentile; blue shading – at or above the national Medicaid 75th percentile, but below the 90th percentile; green shading – at or above the national Medicaid 90th percentile; no shading (white) – no national benchmarks available for this measure or measure not applicable (N/A).

Table 16 shows the following results for ***HEDIS My 2020 Access and Availability measures***:

Weighted statewide average rates related to access and availability show improved results for Kentucky Medicaid MCOs. The weighted statewide average ranked at or above the national Medicaid NCQA 50th percentile for 7 of the 10 measures with benchmarks (70%). Weighted statewide averages were below the NCQA national 50th percentile for three measures: Annual Dental Visit (ADV) and the two rates for the Prenatal and Postpartum Care (PPC) measure.

Aetna and WellCare performed at or above the NCQA national 50th percentile for 8 of the 10 measures (80%). Passport had 7 of the 10 rates (70%) at or above the national 50th percentile, followed by Anthem and Humana each with 4 of the 10 measures (40%) at or above the NCQA national 50th percentile.

All five MCOs ranked at or above the national 90th percentile for IET: Engagement of AOD Treatment: Total and all five also ranked above the national 50th percentile for IET: Initiation of AOD Treatment: Total.

HEDIS MY 2020 Utilization and Risk Adjusted Utilization

HEDIS MY 2020 Utilization and Risk Adjusted Utilization measures related to outpatient and emergency department visits; inpatient utilization; alcohol and other drug services; and mental health and antibiotic utilization. **Table 17** presents selected HEDIS MY 2020 Utilization and Risk Adjusted Utilization measure rates along with the statewide averages and comparison to the NCQA HEDIS MY 2020 national percentiles for Medicaid (**Table 14**).

Table 17: HEDIS Performance Measures – Utilization and Risk Adjusted Utilization – MY 2020

Measure	Aetna	Anthem	Humana	Passport	WellCare	Statewide Average
Total Outpatient Visits/1,000 MM (AMBA)[1]	396.46	352.85	368.00	329.76	506.02	390.62
Total Emergency Department Visits/1,000 MM (AMBA: ED)[1]	46.22	43.64	48.88	47.11	50.21	47.21
Inpatient Utilization: General Hospital/Acute Care (IPUA)[1]						
IPUA: Medicine Discharges (per 1,000 MM)[1]	2.15	4.58	3.67	3.31	3.34	3.41
IPUA: Surgery Discharges (per 1,000 MM)[1]	1.44	0.02	2.22	1.98	1.83	1.498
IPUA: Maternity Discharges (per 1,000 MM)[1]	2.51	2.32	2.27	2.65	2.50	2.45
IPUA: Total Discharges (per 1,000 MM)[1]	5.43	6.41	7.65	7.23	7.01	6.746
Identification of Alcohol and Other Drug Services (IAD)[1]						
IAD: Total Outpatient Rate[1]	5.02%	8.29%	11.81%	7.67%	6.57%	7.87%
IAD: Total Any Rate[1]	7.14%	11.13%	14.71%	10.16%	8.90%	10.41%
IAD: Total Intensive Rate[1]	0.58%	1.02%	1.23%	2.07%	0.76%	1.13%
IAD: Total Inpatient Rate[1]	1.54%	2.33%	2.89%	1.72%	1.85%	2.07%
IAD: Total Emergency Department Visit Rate[1]	1.78%	2.50%	3.03%	3.00%	2.04%	2.47%
Mental Health Utilization (MPTA)[1]						
MPT: Total Outpatient Rate[1]	12.10%	9.18%	10.39%	9.89%	11.33%	10.58%
MPT: Total Any Rate[1]	15.86%	12.87%	14.41%	14.63%	15.56%	14.67%
MPT: Total Intensive Rate[1]	0.36%	0.29%	0.41%	5.18%	0.35%	1.32%
MPT: Total Emergency Department Rate[1]	0.38%	0.03%	0.63%	0.54%	0.04%	0.32%
MPT: Total Inpatient Rate[1]	1.21%	1.11%	1.30%	0.28%	1.12%	1.00%
Antibiotic Utilization: Total (ABXA)[1]						
ABXA: Average # of Antibiotic Prescriptions PMPY [1]	1.13	0.79	0.87	0.75	1.14	0.94
ABXA: Average # Days Supplied per Antibiotic Prescription [1]	8.13	9.32	9.34	9.33	9.37	9.098
ABXA: Average # of Prescriptions for Antibiotics of Concern[1]	0.51	0.35	0.38	0.29	0.51	0.408
ABXA: Percent Antibiotics of Concern of all Antibiotic Prescriptions [1]	45.60%	43.97%	43.37%	38.62%	44.72%	43.26%
Plan All-Cause Readmissions (PCR)						
PCR: Expected Readmission Rate - Total Stays (Ages Total)	9.65%	9.71%	9.67%	9.75%	9.87%	9.73%
PCR: Observed to Expected Readmission Ratio - Total Stays (Ages Total)	1.0955	1.0264	1.0069	1.0848	0.9914	1.04

[1] Statewide average not weighted.

Color key for how rate compares to the NCQA HEDIS 2020 Quality Compass national percentiles: red shading – below the national Medicaid 25th percentile; pink shading – at or above the national Medicaid 25th percentile, but below the 50th percentile; yellow shading – at or above the national Medicaid 50th percentile, but below the 75th percentile; blue shading – at or above the national Medicaid 75th percentile, but below the 90th percentile; green shading – at or above the national Medicaid 90th percentile; no shading (white) – no national benchmarks available for this measure or measure not applicable (N/A).
MM: member months; PMPY: per member per year.

Table 17 shows the following results for ***HEDIS MY 2020 Utilization and Risk Adjusted Utilization measures***:

Rates for Use of Services measures were predominantly above the national 50th percentile. For the two selected AMBA measures, rates for all five MCOs were at or above the national Medicaid 50th percentile.

Statewide average rates for IPUA: Medicine, Surgery and Total Discharges (per 1,000 member months [MM]) were at or above the national 50th percentile, but below the 75th percentile, while statewide rates for IPUA: Maternity Discharges were below the national 50th percentile. Statewide average rates for IAD and MPTA measures were at or above the national 50th percentile for all categories.

Statewide average rates for the Antibiotic Utilization measures (ABXA) indicate a high level of use. The Average # of Antibiotic Prescriptions PMPY; Average # of Prescriptions for Antibiotics of Concern; and the Percent Antibiotics of Concern of all Antibiotic Prescriptions were high compared to national benchmarks. The statewide average number of antibiotic prescriptions filled per member per year (PMPY) and the average number of prescriptions for antibiotics of concern were both at or above the national Medicaid 90th percentile. The percent of antibiotics of concern compared to all antibiotics prescribed was also high with four of the five MCOs having rates that were at or above the national 90th percentile. Plan All-Cause Readmissions (PCR), expected rate and observed to expected ratios were below the national 25th percentile statewide and for all five MCOs.

VI. Administration or Validation of Quality of Care Surveys – CAHPS Member Experience Survey

Objectives

DMS requires that all MCOs conduct an annual assessment of member satisfaction with the quality of and access to services using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys.

Technical Methods of Data Collection and Analysis

MCOs contract with an NCQA-certified survey vendor to conduct the member satisfaction surveys for both the adult (ages 18 years and over) and child (ages 17 years and under) member populations in order to assess both satisfaction with the MCO and with participating providers.

The adult and child member satisfaction surveys were sent to a random sample of members (as of December 31, 2020), who were continuously enrolled for at least 5 of the last 6 months of 2020 and were enrolled at the time the survey was completed.

Description of Data Obtained

IPRO received the MY 2020 CAHPS results reported by each MCO. The CAHPS data included de-identified member-level data and NCQA summary reports.

The CAHPS rates are color coded to correspond to the national percentiles as shown in **Table 18**.

Table 18: Color Key for CAHPS Rate Comparison to NCQA HEDIS MY 2020 Quality Compass National Percentiles

Color Key	How Rate Compares to the NCQA MY 2020 Quality Compass National Percentiles
Red	Below the national Medicaid 25th percentile.
Pink	At or above the national Medicaid 25th percentile, but below the 50th percentile.
Yellow	At or above the national Medicaid 50th percentile, but below the 75th percentile.
Blue	At or above the national Medicaid 75th percentile, but below the 90th percentile.
Green	At or above the national Medicaid 90th percentile.
White	No national benchmarks available for this measure or measure not applicable (N/A).

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

Conclusions and Comparative Findings

Table 19 presents the HEDIS CAHPS 5.0 Adult and Child Survey measures for selected MY 2020 (reporting year [RY] 2021) for each of the MCOs along with the weighted statewide averages[9] and comparison to the NCQA MY 2020 national percentiles for Medicaid, where possible.

Table 19: CAHPS Performance – Adult and Child Members – MY 2020

Measure[1]	Aetna	Anthem	Humana	Passport	WellCare	Weighted Statewide Average
CAHPS 5.0 Adult Survey						
Rating of health care	80.53%	84.31%	75.57%	80.65%	83.25%	81.20%
Rating of health plan	77.25%	82.17%	79.80%	79.57%	89.06%	82.05%
Rating of personal doctor	87.50%	89.14%	82.32%	80.00%	90.00%	86.14%
Got care as soon as needed when care was needed right away	90.48%	88.24%	83.21%	80.56%	89.27%	86.61%
Got care believed to be necessary	92.92%	94.12%	86.82%	87.10%	90.91%	90.52%
Personal doctor explained things	93.20%	97.84%	95.24%	94.34%	97.80%	96.04%
Personal doctor listened carefully	92.45%	97.12%	93.65%	93.46%	95.63%	94.70%
Personal doctor showed respect	93.40%	95.65%	94.44%	95.24%	96.72%	95.29%
Personal doctor spent enough time	91.51%	93.53%	92.86%	92.52%	96.20%	93.66%
Health plan forms were easy to fill out	95.14%	97.77%	92.82%	95.11%	96.80%	95.66%
Smoking and Tobacco Use Cessation:						
Advised smokers/tobacco users to quit	69.89%	71.95%	74.27%	68.06%	80.33%	72.90%
Discussed cessation medications	45.95%	53.01%	54.41%	49.47%	56.90%	51.95%
Discussed cessation strategies	41.30%	42.94%	48.77%	42.25%	51.69%	45.39%
CAHPS 5.0 Child Survey						
Rating of health care	88.89%	89.84%	86.52%	94.40%	88.81%	89.47%
Rating of health plan	86.04%	83.11%	86.17%	88.07%	94.37%	87.21%
Rating of personal doctor	92.18%	90.72%	88.64%	94.18%	92.59%	91.67%
Got check-up routine appointment as soon as needed	87.61%	84.75%	81.06%	82.79%	95.28%	86.22%
Ease of getting care, tests or treatment	92.25%	92.25%	88.57%	91.27%	94.74%	91.86%
Personal doctor explained things	97.14%	93.02%	91.27%	99.13%	98.41%	95.95%
Personal doctor listened carefully	97.96%	96.88%	95.20%	97.41%	99.22%	97.44%
Personal doctor showed respect	97.96%	96.88%	93.55%	97.41%	99.22%	97.17%
Personal doctor spent enough time	95.12%	93.02%	84.92%	95.61%	94.53%	93.00%
Health plan forms were easy to fill out	98.88%	94.67%	96.72%	94.79%	96.71%	96.79%

[1] For rating of health care, health plan and personal doctor, Medicaid rates are based on survey scores of 8, 9 and 10.
Color key for how rate compares to the NCQA HEDIS 2021 Quality Compass national percentiles: red shading – below the national Medicaid 25th percentile; pink shading – at or above the national Medicaid 25th percentile, but below the 50th percentile; yellow shading – at or above the national Medicaid 50th percentile, but below the 75th percentile; blue shading – at or above the national Medicaid 75th percentile, but below the 90th percentile; green shading – at or above the national Medicaid 90th percentile; no shading (white) – no national benchmarks available for this measure or measure not applicable (N/A).

Overall, Kentucky MMC MCOs showed a high level of member satisfaction in the MY 2020 Adult and Child CAHPS surveys (**Table 19**). Weighted statewide average rates ranked at or above the NCQA national 50th percentile for 9 of the 13 adult measures and for all 10 of the child survey measures. Opportunities for improvement are evident for the three adult smoking and tobacco use cessation measures as well as for the rate for health plan forms being easy to fill out (**Table 19**).

For the adult survey measures, WellCare had all 13 measures equal to or above the national 50th percentile, including 9 measures that were equal to or greater than the national 90th percentile (**Table 19**). Anthem had 10 measures (77%) at or above the national 50th percentile, followed by Humana with 9 measures (69%), Passport with 8 measures (62%) and Aetna with 6 measures (46%) at or above the national 50th percentile. All MCOs had adult rates at or above the national 50th percentile for four measures: Got care as soon as needed when care was needed right away; Got care believed to be necessary; Personal doctor explained things and Personal doctor spent enough time (**Table 19**).

For the child survey measures, Aetna and WellCare each had 9 of the 10 measures (90%) at or above the national 50th percentile, followed by Passport with 8 measures (80%), Anthem with 6 measures (60%) and Humana with 1 measure (10%) at or above the national 50th percentile.

VII. Focus Studies

Described in federal regulation as an optional quality review activity, the Commonwealth of Kentucky includes focus studies in their quality improvement program. A focus study examines a particular aspect of clinical or non-clinical service. The following studies were completed in FY 2021:

- COVID-19 Hospital Encounters, Mortality and Access to Telehealth Services Among Kentucky Medicaid Managed Care Enrollees; and
- Access to Colorectal Cancer Screening and Care Management for Kentucky Medicaid Managed Care Enrollees, May 2021.

Focus Study: COVID-19 Hospital Encounters, Mortality and Access to Telehealth Services Among Kentucky Medicaid Managed Care Enrollees

Objectives

The purpose of this study was to profile health care utilization, including hospitalizations and emergency department visits for COVID-19, as well as utilization of telehealth services, overall, and among Kentucky MMC enrollees with COVID-19 symptoms during April 1, 2020 through December 31, 2020.

Technical Methods of Data Collection and Analysis

IPRO used encounter data to evaluate demographic, clinical, and health care access-related risk factors for COVID-19-related hospitalizations, hospital mortality, and non-receipt of telehealth services. The methodology included a profile of the outcomes of COVID-19 prevalence and non-receipt of telehealth services among Kentucky MMC enrollees; *chi*-squared statistical analysis to identify associations between demographic, clinical, SDoH, and healthcare system access-related factors; and multiple logistic regression analyses to quantify risk factors for hospitalization and non-receipt of telehealth services.

Description of Data Obtained

Adult enrollees with conditions of asthma, heart disease, diabetes, obesity, cancer, BH, and SUD showed elevated odds for COVID-19-related hospitalization (data not shown). Additional COVID-19 risk factors highlighted by the current study included the following chronic conditions: chronic kidney disease, COPD/emphysema, sickle cell disease, thalassemia, hypertensive disease, cerebrovascular disease, Down syndrome, dementia, and liver disease. Adult enrollees with housing issues, social connectivity/isolation issues, and frailty were also found to be at risk for COVID-19-related hospitalization. Among adults and children, urban residence was a risk factor for COVID-19-related hospitalization (data not shown).

Conclusions and Comparative Findings

This study confirmed the importance of DMS's contractual requirement for MCOs to establish and operate an integrated Population Health Management (PHM) Program to address both medical and non-medical drivers of health. Further, variability in access to telehealth services by MCO indicates opportunities for MCOs to identify and address barriers to telehealth services.

Focus Study: Access to Colorectal Cancer (CRC) Screening and Care Management for Kentucky Medicaid Managed Care Enrollees, May 2021

Objectives

The objectives of this study were to evaluate disparities in access to CRC screening among enrollees aged 45–75 years overall and to evaluate their access to timely initial CRC screening. It further sought to assess receipt of care coordination and case management for enrollees with a CRC diagnosis.

Technical Methods of Data Collection and Analysis

IPRO conducted a cross-sectional study using encounter data for the study period from July 1, 2018 to June 30, 2020 to evaluate disparities in access to CRC screening and to evaluate receipt of CRC screening in accordance with the American Cancer Society (ACS) recommendations, as well as timely receipt of initial CRC screening. Multiple logistic regression was used to identify risk factors for the non-receipt of CRC screening. A random sample of 100 enrollees aged 45 years and older per MCO was used to conduct MCO care management chart reviews to assess member receipt of care coordination and referral for CRC screening, barriers to screening and, for enrollees with a diagnosis of CRC, assess care coordination and referral, as well as care planning, for cancer treatment.

Description of Data Obtained

Kentucky MMC adults aged 45–50 years had a CRC screening rate of only 6.46%, compared to 16.45% for the entire Kentucky MMC population aged 45 years and older (data not shown). A disproportionate over-representation of CRC prevalence was found in these susceptible subpopulations: Hispanic enrollees; enrollees with disabilities; enrollees with SDoH issues that include social connectivity/isolation issues, adverse childhood experiences (ACEs) and frailty; enrollees with multiple chronic conditions, serious mental illness (SMI), and both alcohol and drug abuse disorders (data not shown).

Conclusions and Comparative Findings

This focus study highlighted several opportunities for MCOs to improve the quality of preventive care provided to Kentucky MMC enrollees by enhancing member outreach, education, and engagement in CRC screening. Furthermore, case management programs merited improvement by expanding to meet the specialized physical health, mental health, and SDoH needs of individuals with cancer.

VIII. Validation of Network Adequacy

Title 42 CFR § 438.68(a) requires that states, which contract with an MCO to deliver services, must develop and enforce network adequacy standards consistent with the CFR. At a minimum, states must develop time and distance standards for the following provider types: adult and pediatric primary care, obstetrics/gynecology (ob/gyn), adult and pediatric BH (for mental health and SUD), adult and pediatric specialists, hospitals, pediatric dentists, and long-term services and support (LTSS), per 42 CFR § 438.68(b). The Commonwealth of Kentucky has developed access standards based on the requirements outlined at 42 CFR § 438.68(c). These access standards are described in the 2021 Medicaid Managed Care Contract, Section 28.4 Provider Network Access and Adequacy. Kentucky MCOs are required to meet these standards in achieving network adequacy.

Title 42 CFR § 438.356(a)(1) and 42 CFR § 438.358(b)(1)(iv) establish that state agencies must contract with an EQRO to perform the annual validation of network adequacy. To meet these federal regulations, DMS contracted with IPRO, an EQRO, to perform the validation of network access and availability for Medicaid MCOs

IPRO's validation of network adequacy for FY 2021 was performed using network data and provider directories submitted to DMS by the MCOs. The EQRO conducted two types of surveys regarding network adequacy for Kentucky Medicaid MCOs:

- provider network submissions and web-based directories audit; and
- provider access and appointment availability survey.

Provider Network Submissions and Web-Based Directory Audits

Objectives

The objective of the provider network validation audit is to assess the accuracy of the MCO provider directory data files for Medicaid participating PCPs and specialists. The EQRO completed two recent audits of Kentucky's provider network submissions and web-based directories:

- Fiscal Year 2021 Validation of Managed Care Provider Network Submissions: Audit Report June 2021; and
- FY 21 Web-Based Provider Directory Validation Summary Report – Final, July 2021.

Note that these are the first audits that included UnitedHealthcare Community Plan (United). In addition, Passport Health Plan by Molina Healthcare (Molina) became operational in January 2021 with the acquisition of Passport Health Plan.

Technical Methods of Data Collection and Analysis

Provider Network Submissions Validation:

In January 2021, six MCOs (Aetna, Anthem, Humana, Molina, United, and WellCare) submitted electronic files to IPRO containing their provider directory data for the most recent month. After removing duplicate providers and other excluded providers, the file contained 37,167 providers. Random sampling of 84 PCPs and 83 specialists was performed for each MCO, resulting in a total sample size of 1,002 providers.

IPRO conducted a two-phase mailing to validate the accuracy of the provider directory data submissions for PCPs and specialists participating with any of the six MCOs operating in Kentucky with a Medicaid product line. The following analyses were conducted to address the objectives of this study: response rate calculations; accuracy rates on all survey items; comparison of September 2020 and February 2021 results; and comparisons of PCPs and specialists on all applicable February 2021 survey items.

Web-Based Provider Network Validation:

The objectives of this study were to determine if all providers included in the MCO provider file submission for each MCO are displayed in the web-based provider directory and to ensure that information provided to members is consistent with the provider information submitted to DMS.

Using the provider network data files submitted by the six MCOs in January 2021, a random sample of providers who responded to the survey was drawn, but no more than 50 providers from each MCO, i.e., 25 PCPs and 25 specialists. For each survey that was included in the web validation sample, the reported provider information was validated against the corresponding MCO's web directory within one week of receiving the survey response in order to minimize the chance that any differences were due to real provider information changes over time. Web-based directories were searched using the sampled providers' names. A Microsoft® Access® database was developed by IPRO, which presented MCO provider data and provider network survey responses side by side. If the information published in the MCO's web directories matched either the MCO provider data or the provider's survey response, the information was considered accurate.

Conclusions and Comparative Findings

The overall response rate for the provider network submissions validation survey was 18.2% with response rates by MCO ranging from a high of 30.9% for Humana to a low of 10.8% for Aetna (data not shown). Out of the 169 completed surveys, 53.8% were returned without revisions. WellCare providers reported the highest accuracy rate of 68.2%, followed by Aetna and Anthem at 62.5%, Molina at 61.1%, United at 58.8% and Humana with the lowest accuracy rate of 30% (data not shown).

The web-based provider network audit showed overall accuracy rates of 76% for primary care providers and 89% for specialists (data not shown). Accuracy rates ranged from a high of 91% for Humana PCPs to a low of 33% for Aetna's PCPs, while the accuracy rate for specialist providers ranged from a high of 95% for Humana to 67% for United providers (data not shown).

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

Provider Access and Availability Survey

Objectives

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

Technical Methods of Data Collection and Analysis

In October 2020, each MCO electronically submitted their provider network data, used to populate their web directory, to IPRO. After removing duplicate providers, the file contained 11,414 providers. Random sampling was performed to select 250 providers from each plan, resulting in a total of 1,250 providers.

A "secret shopper" methodology was used to conduct this phone call survey. Surveyors were instructed to role-play as MMC members seeking care and using scripted scenarios attempted to get appointments for care

as early as possible. The survey tool included data entry sheets that were developed by IPRO to capture any contact with a provider's office, as well as a Microsoft Access database that was used for data collection.

Conclusions and Comparative Findings

A summary of survey results for appointment availability by MCO and appointment type is shown in **Table 20**.

Table 20: Appointment Availability for Network PCPs, Behavioral Health, and Substance Use Disorder Providers, FY 2021

Appointment Type[1]	Aetna	Anthem	Humana	Passport	WellCare	Total
% of providers contacted	78.8%	67.8%	84.2%	66.4%	76.0%	74.7%
Routine[2]						
# of providers contacted	84	79	103	85	86	437
# of appointments made	53	55	68	23	54	253
% of appointments	63.1%	69.6%	66.0%	27.1%	62.8%	57.9%
% of timely appointments[2]	39.1%	38.1%	46.0%	14.2%	38.8%	34.9%
Urgent[3]						
# of providers contacted	52	45	46	39	56	238
# of appointments made	37	32	27	16	41	153
% of appointments	71.2%	71.1%	58.7%	41.0%	73.2%	64.3%
% of timely appointments[3]	22.6%	21.1%	17.0%	5.1%	30.3%	19.5%
After-Hours						
# of providers compliant	14	15	18	11	22	80
% of providers compliant	42.4%	45.5%	54.5%	33.3%	66.7%	48.5%

[1] Substance use disorder providers includes alcohol and drug and other substance use providers.
[2] Appointment standard for routine appointments is within 30 days.
[3] Appointment standard for urgent appointments is within 48 hours.
PCP: primary care provider; FY: fiscal year.

Data from the Access and Availability Survey for PCPs, behavioral health and SUD providers indicated that 57.9% of the time appointments could be made for routine care and 64.3% of the time appointments could be made for urgent care; however, only 34.9% of the routine appointments and 19.5% of the urgent appointments were compliant with Kentucky's respective appointment standards (**Table 20**). The proportion of providers compliant with after-hours access ranged from 66.7% for WellCare providers to 33.3% for Passport, resulting in an overall rate of 48.5%.

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

IX. MCO Quality Ratings

Objectives

IPRO collaborates with DMS to produce an MCO report card titled, *2022 Guide to Choosing Your Health Plan* (English and Spanish versions), which presents the performance for each of the MCOs on selected **access** and **quality of care** measures. The guide is intended to help members compare MCO performance and assist members in choosing an MCO during the open enrollment period. IPRO updates the MCO report cards annually prior to the open enrollment period.

Technical Methods of Data Collection and Analysis

For the 2022 report IPRO compared quality metrics for five performance areas: Getting Care; Children and Adolescent Wellness; Satisfaction with Plan Services; Women's Health; and Treatment. Each area includes selected representative measures from HEDIS MY 2020 Effectiveness of Care and the MY 2020 adult and child CAHPS surveys. MCO performance was rated by indicating how each MCO compares to the NCQA Quality Compass benchmarks using a scale of 1 to 5 stars (5 stars representing highest performance, 4 stars for high performance, 3 stars for average performance, 2 stars for low performance, and 1 star for lowest performance; **Table 21**).

Table 21: MCO Quality Rating Scale

Stars	Quality Rating Description
★☆☆☆☆	Lowest performance
★★☆☆☆	Low performance
★★★☆☆	Average performance
★★★★☆	High performance
★★★★★	Highest performance

MCO: managed care organization.

Quality ratings were determined for five Kentucky Medicaid MCOs using MY 2020 (RY 2021) performance data **(Table 22)**. United was not in the Kentucky MMC Program in 2020 and did not report performance measures in 2021.

Description of Data Obtained

IPRO received the MY 2020 HEDIS and CAHPS results reported by each MCO. The HEDIS data included the Interactive Data Submission System (IDSS) workbook and comma-separated value (CSV) files. The CAHPS data included de-identified member level data and NCQA summary reports. UHC is not included in the QRS since they were a new plan to the Kentucky market and were not required to submit HEDIS and CAHPs data for this reporting period.

Conclusions and Comparative Findings

Table 22: MCO Quality Report Card

Performance Areas[1]	Aetna	Anthem	Humana	Molina	United	WellCare
Getting Care	★★★★☆	★★★★☆	★★★★☆	★★★☆☆	No data available. This MCO was not a KY Medicaid MCO in 2020 and did not report performance measures in 2021.	★★★★★
Children and Adolescent Wellness	★★☆☆☆	★★☆☆☆	★★☆☆☆	★★☆☆☆		★★☆☆☆
Satisfaction with MCO Services	★★★★☆	★★★★☆	★★★★★	★★★★☆		★★★★★
Women's Health	★★☆☆☆	★★★☆☆	★★☆☆☆	★★☆☆☆		★★☆☆☆
Treatment	★★★☆☆	★★★☆☆	★★☆☆☆	★★☆☆☆		★★☆☆☆

[1] 5 stars: highest performance; 4 stars: high performance; 3 stars: average performance; 2 stars; low performance; 1 star: lowest performance.

All MCOs showed average or better performance for 2 of the 5 metrics, namely Getting Care and Satisfaction with MCO Services (**Table 22**). WellCare had two metrics rated highest performance (Getting Care; and Satisfaction with MCO Services) and Humana had one metric rated highest performance (Satisfaction with MCO Services) and a second metric rated high performance (Getting Care) Aetna and Anthem each had two metrics with high performance (Getting Care and Satisfaction with MCO Services). Molina had one metric rated high performance. All Kentucky MCOs showed low performance for the Children and Adolescent Wellness metric as indicated by two stars for each MCO. Four of the five MCOs had low performance scores for Women's Health and three of the five MCOs had low performance ratings for Treatment (**Table 22**).

X. NCQA Accreditation

Objectives

Section 19.1 of the Medicaid Managed Care Contract and Appendices requires that each MCO seek and maintain NCQA accreditation.

NCQA's Health Plan Accreditation Program is considered the industry's gold standard for assuring and improving quality care and patient experience. It reflects a commitment to quality that yields tangible, bottom-line value. It also ensures essential consumer protections, including fair marketing, sound coverage decisions, access to care, and timely appeals.

Technical Methods of Data Collection and Analysis

The accreditation process is a rigorous, comprehensive, and transparent evaluation process through which the quality of key systems and processes that define a health plan are assessed. Additionally, accreditation includes an evaluation of the actual results the health plan achieved on key dimensions of care, service, and efficacy. Specifically, NCQA reviews the health plan's quality management and improvement, utilization management, provider credentialing and recredentialing, members' rights and responsibilities, standards for member connections, and HEDIS and CAHPS performance measures.

Beginning with Health Plan Accreditation 2020 and the HEDIS RY 2020, the health plan ratings and accreditation were aligned to improve consistency between the two activities and to simplify the scoring methodology for accreditation. An aggregate summary of MCO performance on these two activities is summarized in the NCQA *Health Plan Report Cards*.

To earn NCQA accreditation, each MCO must meet at last 80% of applicable points in each standard category, submit HEDIS and CAHPS during the RY after the first full year of accreditation, and submit HEDIS and CAHPS annually thereafter. The standard categories include quality management, population health management, network management, utilization management, credentialing and recredentialing, and member experience.

To earn points in each standard category, MCOs are evaluated on the factors satisfied in each applicable element and earn a designation of "met," "partially met" or "not met" for each element. Elements are worth 1 or 2 points and are awarded to the MCO based on the following:

- Met = earns all applicable points (either 1 or 2),
- Partially met = earns half of applicable points (either 0.5 or 1), and
- Not met = earns no points (0).

Within each standard category, the total number of points is added. MCOs achieve one of three accreditation levels based on how they score on each standard category. **Table 23** displays the accreditation determination levels and points needed to achieve each level.

Table 23: NCQA Accreditation Status Levels and Point System

Accreditation Status	Points Needed
Accredited	At least 80% of applicable points
Accredited with provisional status	Less than 80% but no less than 55% of applicable points
Denied	Less than 55% of applicable points

NCQA: National Committee for Quality Assurance.

To distinguish quality among the accredited MCOs, NCQA calculates an "overall rating" for each MCO as part of its Health Plan Ratings Program. The overall rating is the weighted average of an MCO's HEDIS and CAHPS measure ratings, plus accreditation bonus points (if the plan is accredited by NCQA), rounded to the nearest half point displayed as stars.

Overall ratings are recalculated annually and presented in the health plan ratings that are released every September. However, in response to the COVID-19 pandemic's impact on health plans and the changes to HEDIS and CAHPS for MY 2019, NCQA did not calculate the Health Plan Ratings 2020.

The Health Insurance Plan Ratings 2021 methodology used to calculate an overall rating is based on MCO performance on dozens of measures of care and is calculated on a 0–5 scale in half points, with 5 being the highest. Performance includes these three subcategories (also scored 0–5 in half points):

- Patient Experience: Patient-reported experience of care, including experience with doctors, services, and customer service (measures in the Patient Experience category).
- Rates for Clinical Measures: The proportion of eligible members who received preventive services (prevention measures) and the proportion of eligible members who received recommended care for certain conditions (treatment measures).
- NCQA Health Plan Accreditation: For a plan with an accredited or provisional status, 0.5 bonus points are added to the overall rating before rounding to the nearest half point and displaying the score as stars. A plan with an interim status receives 0.15 bonus points added to the overall rating before rounding to the nearest half point and displaying the score as stars.

The NCQA health plan rating scale and definitions for each are displayed in **Table 24**.

Table 24: NCQA Health Plan Star Rating Scale

Star Ratings	Rating Definition
★★★★★	The top 10% of health plans, which are also statistically different from the mean.
★★★★☆	Health plans in the top one-third of health plans that are not in the top 10% and are statistically different from the mean.
★★★☆☆	The middle one-third of health plans and health plans that are not statistically different from the mean.
★★☆☆☆	Health plans in the bottom one-third of health plans that are not in the bottom 10% and are statistically different from the mean.
★☆☆☆☆	The bottom 10% of health plans, which are also statistically different from the mean.

NCQA: National Committee for Quality Assurance.

For 2021 only, NCQA implemented a special Overall Rating Policy for NCQA-accredited plans. The Health Plan Ratings 2021 displays the better of the overall rating score between the Health Plan Ratings 2019 and Health Plan Ratings 2021, for plans with accredited, provisional, and interim status as of June 30, 2021. Individual measures, subcomposites and composites continued to be scored and displayed using Health Plan Rating 2021 performance (i.e., MY 2020 data) for all plans.

Description of Data Obtained

IPRO accessed the NCQA *Health Plan Reports* website[10] to review the *Health Plan Report Cards 2021* for Aetna, Anthem, Humana, Passport and WellCare. For each MCO, star ratings, accreditation status, plan type, and distinctions were displayed. At the MCO-specific pages, information displayed was related to membership size, accreditation status, survey type and schedule, and star ratings for each measure and overall rating. The data presented here were as of January 15, 2022.

Conclusions and Comparative Findings

Aetna, Anthem, Humana and WellCare were all compliant with the state's requirement to achieve and maintain NCQA accreditation. **Table 25** displays each MCO's accreditation level achieved and the effective dates for the accreditation.

Table 25: MCO Medicaid Accreditation Status – 2021

MCO	Accreditation Level Achieved	Start Date	Expiration Date
Aetna	Accredited	8/13/2020	8/13/2023
Anthem	Accredited	3/31/2020	3/31/2023
Humana	Accredited	11/5/2019	11/5/2022
Passport[1]	Not Accredited	N/A	N/A
WellCare	Accredited	9/18/2020	9/18/2023

[1] Molina Healthcare took over operation for Passport Health Plan and contracted with the Kentucky Medicaid Managed Care Program as of January 1, 2021.
MCO: managed care plan. N/A: not applicable.

Table 26 displays the MCOs' overall health plan star ratings as well as the ratings for the three overarching categories and their subcategories under review. Aetna, Anthem and WellCare achieved overall health plan star ratings of 3.5 out of 5 for the *Health Plan Report Cards 2021*[11] and Humana and Passport each achieved a star rating of 3.

Table 26: MCO NCQA Ratings by Category, 2021

	Aetna	Anthem	Humana	Passport	WellCare
Highest Possible Star Rating[1]	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
Overall Rating	★★★⯪☆	★★★⯪☆	★★★☆☆	★★★☆☆	★★★⯪☆
Patient Experience	★★★☆☆	★★★★⯪	Insufficient data	Insufficient data	Insufficient data
Getting Care	★★★★☆	★★★★★	Insufficient data	Insufficient data	Insufficient data
Satisfaction with Plan Physicians	★★★☆☆	★★★★⯪	★★★☆☆	★★★★☆	★★★★☆
Satisfaction with Plan Services	Insufficient data	Insufficient data	Insufficient data	Insufficient data	Insufficient data
Prevention	★★★☆☆	★★⯪☆☆	★★☆☆☆	★★★☆☆	★★⯪☆☆
Children and Adolescent Well Care	★★★☆☆	★★☆☆☆	★★☆☆☆	★★★☆☆	★★☆☆☆
Women's Reproductive Health	★★★☆☆	★★★☆☆	★★⯪☆☆	★★☆☆☆	★★★⯪☆
Cancer Screening	★★⯪☆☆	★★☆☆☆	★★☆☆☆	★★★⯪☆	★★☆☆☆
Other Preventive Services	Insufficient data	Insufficient data	Insufficient data	Insufficient data	Insufficient data

Highest Possible Star Rating[1]	Aetna	Anthem	Humana	Passport	WellCare
	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
Treatment	★★★☆☆	★★★☆☆	★★★☆☆	★★⯪☆☆	★★★☆☆
Asthma	Insufficient data	Insufficient data	Insufficient data	Insufficient data	Insufficient data
Diabetes	★★★☆☆	★★★☆☆	★★★☆☆	★★⯪☆☆	★★★☆☆
Heart Disease	★★★⯪☆	★★⯪☆☆	★★★☆☆	★★☆☆☆	★★⯪☆☆
Mental and Behavioral Health	★★★☆☆	★★★☆☆	★★★⯪☆	★★★⯪☆	★★★⯪☆

[1] Getting Needed Care includes 2 measures; Satisfaction with Plan Physicians includes 4 measures; Satisfaction with Plan Services includes 1 measure; Children and Adolescent Well-Care includes 4 measures; Women's Reproductive Health includes 2 measures; Cancer Screening includes 2 measures; Other Preventive Services includes 2 measures; Asthma includes 1 measure; Diabetes includes 5 measures; Heart Disease includes 4 measures; Mental and Behavioral Health includes 10 measures; and Other Treatment Measures, which is not included in the table, includes 9 measures.
MCO: managed care plan; NCQA: National Committee for Quality Assessment.

XI. MCO Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR." **Tables 27–31** display the MCOs' responses to the recommendations made by IRPO during the previous EQR, as well as IPRO's assessment of these responses.

Aetna Response to Previous EQR Recommendations

Table 27 displays Aetna's progress related to the *2021 External Quality Review Technical Report*, as well as IPRO's assessment of Aetna's response.

Table 27: Aetna Response to Previous EQR Recommendations

Recommendation for Aetna	Aetna Response/Actions Taken	IPRO Assessment of MCO Response[1]
Aetna should successfully implement corrective actions for access/timeliness compliance review elements that were rated minimal or non-compliant.	All nine of the access/timeliness domain areas reviewed received full or substantial overall determinations during 2020 review. Three domains had a total of 12 elements with either minimal or non-compliant elements: CM/CC (2); Enrollee Rights and Protection: Enrollee Rights (9); and HRA (1). Aetna submitted a Word document outlining the internal changes made as a result of the compliance review along with the determination letter from DMS noting no further action needed. All actions are still current and in force.	Addressed
Focusing on the HEDIS measures which fell below the NCQA national 25th percentile, Aetna should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	**Initial Plan of Action:** • Provided telehealth solutions due to pandemic related issues. • Provider Education regarding HEDIS, Value Based Services, tip sheets updated on the provider website, and monthly educational HEDIS training webinars. Provided free monthly provider HEDIS training webinar series. The goals of the HEDIS training webinar series are to: • Educate about HEDIS measure specifics • Explore ways to reduce the burden of medical record review and maximize administrative data capture • Discuss HEDIS measures applicable to certain populations • Encourage open discussion to learn how other providers are addressing HEDIS and barriers to care • Develop strategies for improvement • Connect providers with a single point of contact at the health plan for HEDIS/Quality questions • Member Education regarding HEDIS via: • Care Management • Behavioral Health Management	Partially Addressed; improvement not yet observed

Recommendation for Aetna	Aetna Response/Actions Taken	IPRO Assessment of MCO Response[1]

	• Lock-in Program
	    ▪ Educational information on the website
	    ▪ Member telephonic outreach
	    ▪ Member Handbook
	• Member Services
	• Member Educational Mailers
	• Diabetes
	• Women's Health
	• Text messaging campaigns:
	• Txt4Health
	• Aetna Monthly Health Messages
	• Aetna Welcome and Benefits Messages
	• Coronavirus Awareness
	• Diabetes Support
	• Flu shot and COVID
	• Smoking Cessation Program
	• Well Child Reminders
	• Identify Barriers and Non-Compliant Members
	• Internal Plan Staff Education regarding HEDIS
	• Monitor HEDIS rates monthly to compare rates from month over month, and monthly rates year over year.
	How was this accomplished?
	• Conducted member outreach to members identified as needing a health screen/test.
	• Collaborated with the Outreach Department and the Prevention and Wellness Program via webinars due to the pandemic.
	• Conducted member outreach to members identified breast cancer and/or cervical cancer screening.
	• To Promote Health and Wellness, internal HEDIS® staff contact members identified as qualifying for member incentives to ensure accurate member demographics so that the gift cards were distributed to the appropriate address. Member incentives included the following:
	• A $10.00 gift card for members completing their first prenatal visit within 42 days of enrollment or in the first trimester of pregnancy and completion of their postpartum visit 21-56 days after delivery.
	• A portable crib for members attending 7 or more prenatal visits during their pregnancy.
	• A $10 gift card for completing a Lead Screening test for children prior to their 2nd birthday.
	• A $10 gift card for completing an eye exam for adults 18 – 75 years old.
	• A $10 gift card for completing spirometry testing for members 42 years or older with COPD.	

Recommendation for Aetna	Aetna Response/Actions Taken	IPRO Assessment of MCO Response[1]
	• A $20 gift card for completing a follow-up visit with a mental health practitioner within 7 days of discharge after a hospitalization for mental illness (6 years of age or older). • Staff promoted specific health screenings for the member incentive program during outreach calls. • Utilized automated telephonic/electronic educational outreach to members. • Assisted members with well child appointment scheduling. • Provider and Member Newsletters include articles on promoting the health of Kentucky Medicaid children (EPSDT services), Oral Health, Smoking Cessation, Healthy BMI and other pertinent health topics such as Diabetes, COPD, Asthma, high blood pressure, CAD and other health screenings, etc. Targeted articles for both audiences provide information on how to access care, shared decision making on care and compliance with medications and understanding medications prescribed. • The Unite Us platform is a SDOH (Social Determinants of Health) services integrated model that connects members to community-based organizations who participate in the closed-loop referral network, including all types of social service agencies. Member referrals for integrated service needs (PH, BH, SDOH) are triggered through multiple sources; there are not any limitations on how member referrals are triggered. Aetna is partnering with Unite Us in a unique collaboration to address the full spectrum of SDOH. The partnership, currently in Louisville, establishes new and innovative models that improve the engagement between members, traditional health care providers (e.g. PCPs), and social services providers. Aetna's intent is to expand this partnership statewide. • Population Health Management programs were initiated and will continue. There are multiple activities involved in PHM that include: focusing on keeping members healthy, managing members with emerging risk, keeping members safe and managing members with multiple chronic conditions. PHM focus areas include Integration to Health Access, Obesity and Diabetes programs, smoking cessation, combating opioid use, addressing adverse childhood events, and integration to health access. Additionally, Community Health Workers will be hired to assist with the PHM program activities. Collection of member level data helps us target interventions to members with SDOH needs. CHWs will collect and document data to incorporate into care planning. • Published educational articles in the provider newsletter promoting the use of Case Management services. Aetna Better Health of Kentucky offers Disease Management (DM) programs to patients with asthma, diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), depression, Hepatitis C, and chronic renal disease (CRD). Aetna Better Health of Kentucky believes it is important to have a program to promote the engagement of pregnant women who have significant opiate use or opiate addiction in prenatal care management. Care management will continue with the same Case Manager (CM) for the mother and baby for the first year of the baby's life. The goal of the program is to identify pregnant woman with Substance Use Disorder (SUD) and refer them for treatment to reduce the incidence of neonatal abstinence syndrome. Aetna Better Health of Kentucky has a	

Recommendation for Aetna	Aetna Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Foster Care Case Management Team that works collaboratively with the Department for Community Based Services (DCBS), state agencies and service providers to improve the quality of care for plan members and their families. The care management team provides behavioral and medical support for children who are medically fragile, currently hospitalized, and those at medical risk. A case manager will work with DCBS focusing on member's inpatient status at a behavioral health facility and members who are being decertified. These coordination services are individualized, member-centered and comprehensive. • Distributed educational mailings related to children's healthcare via the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program. • Educational mailings to promote health and wellness screenings. • Care gap reports were distributed to providers which identify members in need of a health screen/test for members on the provider panel. • 24- hour clinical hotlines remain available seven days a week for medical and behavioral member needs. • Collaboration with the behavioral health team continues to monitor and improve coordination between medical care and behavioral healthcare. **Outcome and Monitoring:** HEDIS Performance Measures of Quality • Aetna had 26 HEDIS Effectiveness of Care measures with rates equal to or better than the national 50th percentile out of a total of 58 measures (45%). Four of these measures were equal to or better than the national 90th percentile. • Aetna's rates for 13 out of the 58 (22%) HEDIS Effectiveness of Care measures were below the national 25th percentile, including 6 measures in the Overuse/Appropriateness domain. HEDIS Performance Measures of Access/Timeliness • Nine (9) of the 14 measures (64%) of Access and Availability were equal to or greater than the national 50th percentile. • One measure of access/timeliness was below the national 25th percentile: AAP for members 65 years and older. **Future Actions/Plans:** • Implement the new SKY Program for members in the Foster Care and/or Juvenile Justice System. • Place emphasis on patient centered medical homes to increase access to physicians and reduce barriers of care. • Revise Aetna Better Health of Kentucky's incentive program, offered for adults, teens, and children, that is designed to encourage members to obtain important preventive services, while emphasizing personal responsibility and ownership of healthy living. Revise member incentives for Value Added Benefits to include: ▪ $10 for completion of Diabetic Retinal Eye exam	

Recommendation for Aetna	Aetna Response/Actions Taken	IPRO Assessment of MCO Response[1]
	▪ $20 for follow-up visit with Mental Health Practitioner ▪ $25 HRA Incentive ▪ $25 Initial Prenatal Visit ▪ $10 Subsequent prenatal visits ▪ Cribs for Moms ▪ $25 Post-Partum Visit ▪ Family Transportation • Promote the free monthly provider HEDIS training webinar series • Provide additional automated telephonic/electronic educational outreach (calls, texts, IVR) • Utilize the HEDIS® nurses and internal staff to create positive relationships with providers • Utilize the HEDIS® nurses and internal staff to educate provider offices regarding HEDIS® • Update and maintain a comprehensive HEDIS® toolkit to educate providers and distribute to each office for provider reference regarding HEDIS® measures • Continue collaboration with the Outreach Department and the Prevention and Wellness Program Coordinator to identify opportunities to outreach to members regarding the importance of health screenings by participating in community events (as appropriate due to the pandemic), health fairs, back to school events, and community baby showers • Collaborate with the Plan's Vision and Dental Vendors to promote screenings • Utilize the access to the Kentucky Immunization Registry to improve immunization rates *Disclaimer: Aetna Better Health of Kentucky recognizes planned educational activities may be impacted by COVID-19 resulting in delays or cancellations. We have created materials and virtual platforms to continue addressing the needs of our members in a convenient and safe manner.	
Aetna should review the consistency of performance indicator calculation methodology for each year in the Reducing Potentially Preventable Hospitalizations and ED Visits for Ambulatory Care Sensitive Conditions (ACSC) PIP and consider implementing improved data integrity procedures to foster reliable measurement	The ACSC PIP did have its challenges with non-NCQA technical specifications for each of the 5 conditions and we had confusion with the methodology. Once it was determined that we were pulling the HEDIS measures noted in the specs for each condition instead of the coding that was provided we corrected our methodology for the previous dates as well as moving forward. Once corrected, our score from the January 2021 Final ACSC PIP submission was an 87.2%. For the PIPs moving forward (currently the Diabetes, SDOH and the SKY WCC PIPs) Aetna Better Health of Kentucky's PIP teams meet bi-weekly to discuss the status of interventions, results, methodologies, trainings (internal and external), provider/member involvement and feedback from IPRO/DMS with multiple departments within our plan. Another point of emphasis has been to bring in the IT department for any recurring quarterly reports that are not HEDIS based or from another platform within the organization to ensure the understanding and accuracy of the methodology and data being reported.	Addressed

Recommendation for Aetna	Aetna Response/Actions Taken	IPRO Assessment of MCO Response[1]
of performance indicators in future PIPs.		

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCO's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.
MCO: managed care organization; EQR: external quality review; PH: physical health; BH: behavioral health; SDOH: social determinants of health; CM/CC: case management/care coordination; HRA: health risk assessment; CAD: coronary artery disease; PHM: population health management; CHW: community health worker; CM: case manager; SUD: substance use disorder; DCBS: Department for Community Based Services; SKY: Supporting Kentucky Youth; PIP: performance improvement project; IVR: interactive voice response; WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents; ACSC: Ambulatory Care Sensitive Conditions.

Anthem Response to Previous EQR Recommendations

Table 28 displays Anthem's progress related to the *2021 External Quality Review Technical Report* as well as IPRO's assessment of Anthem's response.

Table 28: Anthem Response to Previous EQR Recommendations

Recommendation for Anthem	Anthem Response/Actions Taken	IPRO Assessment of MCO Response[1]
While Anthem showed strong performance in the 2020 Compliance Review, the MCO should successfully implement corrective actions for elements in two access/timeliness-related domains.	**Letter Of Concern – AN2021IPRO-1 Response** **Enrollee Rights & Protection: Education & Outreach Plan, Amanda Stamper, Dir Marketing** (Attached Separately – 1.1.21 KY Marketing Plan.pptx – Calendar of Events.pdf) – Submitted to IPRO during 2021 Audit process – Outcome Expectation: plan has been fully implemented in 2021 and is managed ongoing. **Plan Status: Case Management/Care Coordination, David Crowley, Dir HCMS** As of January 1, 2021, SKY is the designated managed care program for a DCBS foster youth in Kentucky. If a member is determined to be in DCBS custody, the case manager will work with the foster parent and/or DCBS staff to develop a case management plan. If needs are identified, until the member is transitioned to SKY, Anthem will support this transition to SKY in collaboration with Aetna, as appropriate, for the transition of care warm transfer. Anthem KY Medicaid completed all foster care case management warm transfers to Aetna SKY case managers in January 2021. Throughout 2021 Anthem continued to coordinate case management warm transfers for two DCBS youth that were transitioned to Aetna SKY while under Anthem Medicaid coverage. We continue to monitor communication and care coordination needs with DCBS as cases arise to ensure a warm transfer to Aetna Sky.	Addressed

Recommendation for Anthem	Anthem Response/Actions Taken	IPRO Assessment of MCO Response[1]
Anthem should focus improvement interventions to address the Child Survey CAHPS measure of Rating of Health Plan and HEDIS measures that underperformed the NCQA national 25th percentile especially targeting those measures that have continued to underperform from the previous year.	**CAHPS & HEDIS Measures Response, Stuart Cox, Clinical Quality Program Director** All new Quality Management Team in place for 2021 – Includes Total Optimization of Plan QM Team. The Anthem KY team has implemented the "Elevate - Population Health Management" (PHM) program in July 2021. This will be an ongoing strategic program and drives annual QM goal development. The PHM program is an integrated plan wide approach that features data/information sharing, performance measurement monitoring and process improvement. The plan Quality Leadership Team, HEDIS Workgroups and PIP team leaders are imbedded into the 8 Domains of PHM focus: Behavioral, Cancer, Covid, Chronic Conditions (Diabetes & Cardiac), Dental, Maternal/Child, Substance Use Disorder and Social Determinants Of Health (SDOH). 1 & 2 Star HEDIS measure opportunities identified along with PHM metrics and Key Performance Indicators. HEDIS Workgroups Executed throughout 2021: Adult Preventive, Chronic Condition, Behavioral and Maternal/Infant/Child. - Identified MY2020 1-2 Star Measures – Communicate and conduct intervention ideation sessions with all HEDIS, PIP and PHM Workgroups – Interventions identified for execution by Workgroups and PHM Domain Teams. - Workgroup prioritization and focus on: ADV Dental (2 Stars), IMA Immunizations (1 Star), Cancer Screening (BCS & CCS – 1 Star) + Adding COL Colorectal Screening, CDC Eye Exams (2 Stars), Diabetes & Cardiac / Statin Therapy & Adherence (2 Stars), Smoking Advice (2 Stars), Adherence to Antipsychotic Meds/Schizophrenia (2 stars), Antibiotic Use (1 Star) & Imaging for Lower Back Pain (LBP – 1 Star). - New Tableau HEDIS Report Developed – Analytical features included to identify Gaps-In-Care by measure and current Star Rating, Region/County Breakouts for all measures with output capability for heat mapping, Provider/TIN Grouping, HEDIS Workgroup Groupings and Race/Ethnicity filter for disparity data stratification analysis. - CIS Combo 10 / IMA Combo 2 / Lead / W30 – Member/Provider Gap Closure Tool developed and utilized by HEDIS Workgroups, PHM Maternal/Child and Care Delivery Transformation Teams to identify immunization "Gaps In Care" by Member, Provider, and actual immunization/shots by 30/60/90 day timing to assist in closing gaps & W30 visits. - Outcome expectation is to improve gap closures and 1-2 Star HEDIS measure ratings for MY2021/22. Implemented NEW Member Experience Committee in September 2021 – MY2020 CAHPS / Provider Survey / Member Experience, ME-7 Reports - Anthem MC Plan Achieved MY2020 CAHPS 4.5 Star NCQA Rating - CAHPS Adults Focus: Rating of Specialist Seen Most Often and Coordination Of Care - CAHPS Child (Gen Population) Focus: Rating of All Health Care, Rating of Specialist Seen Most Often & Rating of Health Plan	Partially Addressed; improvement not yet observed.

Recommendation for Anthem	Anthem Response/Actions Taken	IPRO Assessment of MCO Response[1]
	- QMAC & New Member Orientation Implemented – Education, Awareness of Survey Results and solicitation of feedback implemented in Q4 2021 – Presented CAHPS Results at QMAC and ensured that National Call Center routes member inquiries on CAHPS survey results and performance to plan QM Team leaders as appropriate. - Implemented provider awareness and training – leveraging enterprise resources for providers to include centralized website with educational materials. Reported Provider Survey results to providers through Provider Solutions to ensure awareness of reported concerns and opportunities regarding "balanced billing", member utilization of Telehealth resources and importance of optimizing provider office hours and communication on "after-hours" phone response to increase member access and utilization opportunity. - Outcome expectation is to sustain or improve plan CAHPS 4.5 Star NCQA Rating for MY2021/22. Leveraging PIP Workgroups (Diabetes & SDOH) and integrating efforts with PHM Domains (See Below) for increased focus on 1 & 2 Star Measurement opportunities. Re-vamped Chip Reward Member Incentives & VAB Structure for 2022 – Re-initiated retired campaigns and ensured alignment with priority 1 & 2 Star Measurement opportunity areas. Plan has restructured incentive award cards to include pre-funded Visa card (with ATF lock-out), along with Walmart & CVS (with ATF Lockout) and Amazon and others that are most relevant with our Kentucky MC members. New Health Equities Director Hired Q4, 2021 – Partnering with Quality Management team to increase focus on health disparity awareness and performance improvement opportunities with Workgroups and PHM domain teams ongoing.	
Anthem should review ITM and performance indicator calculation issues raised by the EQRO in the Reducing Potentially Preventable Hospitalizations and ED Visits for Ambulatory Care Sensitive Conditions (ACSC) PIP validation and consider implementing improved data integrity procedures to foster improved quality monitoring of performance indicators and ITMs in future	**Improved PIP Data Integrity & Quality Monitoring Response, Lisa Zinkovich, Clinical Quality Program Manager (PIPS)** ACSC PIP occurred during transitional period for the Anthem KY MC plan. All new Quality Management Team in place for 2021 – PIP Managers, Lisa Zinkovich – Clinical Quality Program Manager & Rhonda Witten – Program Manager, Case Mgmt. Anthem has reviewed IPRO recommendations and has optimized data and analytics QC processes during 2021 on our current Diabetes and SDOH PIPS. 1) Data analytics team performs a quality and integrity review of data provided to the PIP team. Plan QM/PIP team then reviews data again applying subject matter expertise. Previous manually prepared reports have been automated by query to ensure data integrity and stability during subsequent and ongoing runs. 2) A continuous quality improvement process has been implemented to address ongoing challenges and	Addressed

Recommendation for Anthem	Anthem Response/Actions Taken	IPRO Assessment of MCO Response[1]
PIPs.	opportunities, specifically with Case Management related data documentation that is formatted as narrative notes. 3) Trends, stagnating or declining rates and unexpected results are evaluated, and a "deep dive" analysis of individual records is performed by the PIP team. 4) Actions are identified and initiated based on findings of "deep dive" analysis 5) Modified or new interventions are documented and implemented accordingly. 6) Intervention performance is monitored and evaluated ongoing with ongoing adjustments made per the continuous quality improvement process. Outcome Expectation is to ensure ongoing PIP data integrity and ensure that all recommendations are included in workplans. In addition, the Anthem KY team has Implemented the "Elevate - Population Health Management" (PHM) program in July 2021. This will be an ongoing strategic program and drives annual QM goal development. The PHM program is an integrated plan wide approach that features data/information sharing, performance measurement monitoring and process improvement. The plan Quality Leadership Team, HEDIS Workgroups and PIP team leaders are imbedded into the 8 Domains of PHM focus, including the Chronic Conditions/Diabetes and SDOH domains. Each domain utilizes HEDIS measurement and/or additional Key Performance Indicator (KPI) metrics to include at least two focus areas for the general population and one for disparity groups identified by stratification. Ongoing domain meetings occur bi-weekly and performance results are tracked and reported monthly to a PHM steering committee to optimize communication and attainment of PIP goals.	

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCP's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCP's QI response did not address the recommendation; improvement was not observed or performance declined.

MCP: managed care plan; EQR: external quality review; QM: quality management; PHM: population health management; SKY: Supporting Kentucky Youth; BCS: Breast Cancer Screening; CCS: Cervical Cancer Screening; IMA: Immunizations for Adolescents; CIS: Childhood Immunization Status; W30: Well Child Visits in the First 30 months of Life; QMAC: Quality Management and Advisory Council; QC: quality control; DCBS: Department for Community Based Services; TIN: Taxpayer Identification Number; VAB: value added benefit; ACSC: Ambulatory Care Sensitive Conditions; ITM: intervention tracking measure.

Humana Response to Previous EQR Recommendations

Table 29 display's Humana's progress related to the *2021 External Quality Review Technical Report*, as well as IPRO's assessment of Humana's response.

Table 29: Humana Response to Previous EQR Recommendations

Recommendation for Humana	Humana Response/Actions Taken	IPRO Assessment of MCO Response[1]
Humana should successfully implement corrective actions for the four quality-related and four access/timeliness-related domains where elements were rated minimal or non-compliant in the 2020 Compliance Review.	Humana's review totaled 676 applicable elements, of which sixteen in the following areas required corrective action: **Grievance System: 25.2 Enrollee Grievance and Appeal Policies and Procedures include: T. Inform the enrollee of limited time to present evidence and allegations of fact or law in the case of an expedited appeal (one minimal).** Humana revised the Enrollee Handbook to include language for compliance. The Department approved the Enrollee Handbook 5/6/21. Humana revised all letter templates with Grievance and Appeal rights to include compliant language. The Department approved the templates 5/10/21. **Appeal File Review: Provide enrollee reasonable opportunity to present evidence of the facts or law; and to provide enrollee an opportunity, before and during the appeals process, to examine the enrollee's case file, including medical or clinical records (two minimal).** Humana revised all letter templates with Grievance and Appeal rights to include compliant language. The Department approved the templates 5/10/21. **Expedited Appeals File Review: Inform enrollee of limited time available to present evidence and allegations in fact or law (one minimal).** Humana revised all letter templates with Grievance and Appeal rights to include compliant language. The Department approved the templates 5/10/21. **QAPI: Access: 31.1 Medicaid Covered Services: Not prohibit or restrict a provider from advising an enrollee about his or her health status, medical care, or treatment (one non-compliant).** Humana revised the Required Provisions Attachment to the Provider Agreement to include compliant language. The Department approved this document 2/2/21. **Program Integrity: Complaint System contains: J. Suspend and escrow provider payments in accordance with Section 6402 (h) (2) of the Affordable Care Act pending investigation of credible allegation of fraud (one non-compliant).** At the time of the audit Humana was under 2 corrective actions relating to suspending and escrowing Provider payment at the direction of the Department. Humana successfully demonstrated compliance to this requirement and completed the corrective action requirements by 7/31/21 including a revision to the Kentucky Medicaid Suspension and Escrow Policy. Humana received acceptance of our response from the Department 9/23/21. **Availability and Access to Data: A. Gather, produce and maintain records (one minimal).** Humana created the Kentucky Medicaid Records Retention Policy. Humana provided a copy of the policy to the Department on	Addressed

Recommendation for Humana	Humana Response/Actions Taken	IPRO Assessment of MCO Response[1]
	5/14/21. **QAPI: Structure and Operations: Delegated Services: 4.3 Delegations of Authority: B. Before any delegation, evaluate the prospective subcontractor's ability to perform delegated activities (one non-compliant).** As part of the Department's CAP Humana identified that while Humana was conducting the prospective reviews, the documentation did not demonstrate this evaluation. All possible procurement and work streams were identified by 5/21/21. Updates to the documentation to standardize the pre-delegation evaluation was completed 5/28/21. By 6/7/21 Humana developed a process including revision and requirement of forms to track subcontractor analysis and vetting, sign-off requirements and standardization in collection and storage of forms. All procurement associates were trained on 6/18/21 and the new standardized process went live 6/21/21. With these steps Humana is in compliance with this requirement and the review and sign-off requirements serve as monitoring for completion. **Enrollee Rights and Protection: ER: 23.7 Enrollee Rights and Responsibilities: Policies and procedures to protect the rights of enrollees include: K. Any Indian eligible to receive services from a participating I/T/U provider or an I/T/U primary care provider is allowed to receive services from that provider if part of Contractor's network (one non-compliant).** Humana revised the Enrollee Handbook to include compliant language. The Enrollee Handbook was approved by the Department 5/6/21. **23.2 Enrollee Handbook: Include: R. Procedures for obtaining covered services from non-network providers (one non-compliant).** Humana revised the Enrollee Handbook to include compliant language. The Enrollee Handbook was approved by the Department 5/6/21. Humana reviewed policy HUM-KYMCD-Member Calls-002-Access to Covered Services and Providers to include compliant language. This policy was provided to the Department 5/11/21. **23.1 Required Functions: Enrollee Services function responsible for: I. Assure minimal waiting periods for scheduled enrollee office visits and telephone requests, and avoid undue pressure to select specific providers (one non-compliant).** Humana revised our HUM-KYMCD-Member Calls 001 - Enrollee Services Required Functions – Enrollee Rights policy and procedure to include compliant language. This policy was provided to the Department 5/11/21. **31.5 Referrals for Services not Covered by Contractor: When it is necessary for an enrollee to receive a Medicaid service that is outside the scope of the covered services (one minimal).** Humana revised our HUM-KYMCD-Member Calls 001 - Enrollee Services Required Functions – Enrollee Rights policy and procedure to include compliant language. This policy was provided to the Department 5/11/21. **Medical Records: 39.1 Medical Records: Conduct HIPAA privacy and security audits of providers (one minimal).** Humana created a policy specific to conducting HIPAA privacy and security audits of providers. Humana created a Provider Office Visit Evaluation Tool. Both documents were provided to the	

Recommendation for Humana	Humana Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Department 5/11/21. Once the Public Health Emergency is lifted Humana will conduct the onsite audits. Leadership will monitor completed site visit forms for compliance. **Behavioral Health Services: 34.11 Program and Standards: C. Identify a method to evaluate the continuity and coordination of care; and E. Monitor and evaluate communication and coordination (two minimal).** Humana revised policy QM-06 (QLT-006) Medicaid Record Documentation Review (MRDR) Strategy and provided a copy of this revised policy to the Department on 5/5/2021. Behavioral health MRDR is conducted quarterly to monitor accessibility, availability, referral and triage to effective physical and behavioral health care and adherence to behavioral health clinical practice guidelines. This includes monitoring the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions and evaluating the continuity and coordination of care, including Enrollee-approved communications between behavioral health care providers and Primary Care Providers. The findings of BH MRDR along with recommendations are shared with the audited providers. If failed, the provider will be re-audited. Trends and opportunities for improvement are identified and reported quarterly to the Kentucky Medicaid Quality Improvement Committee (QIC) for recommendations **Pharmacy Benefits: 32.9 Pharmacy Claims Payment Administration: Process, adjudicate, and pay Kentucky Medicaid pharmacy claims, including voids and full or partial adjustments (one minimal).** Revised policy OPS PBM 1.11 HPS PBM Operations Shared Responsibilities with Claim Processor and provided a copy to the Department of this revised policy on 5/5/2021. As of 7/1/21 the Department moved to a single PBM model	
Humana should focus improvement initiatives on the HEDIS and CAHPS measure areas that underperformed the NCQA national 25th percentile especially targeting those measures that have continued to underperform from the previous year.	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)*: BMI: HEDIS 2020: 68.68% HEDIS 2021: 65.59% Most Recent Prospective Run (claims thru 10/31/2021): 34.63% (admin) Counseling for Nutrition: HEDIS 2020: 54.99% HEDIS 2021: 56.69% Most Recent Prospective Run (claims thru 10/31/2021): 21.37% (admin) Counseling for Physical Activity: HEDIS 2020: 50.61% HEDIS 2021: 49.64% Most Recent Prospective Run (claims thru 10/31/2021): 20.60% (admin) • Developed flyer in 2021 to educate providers on this measure • Trained provider facing teams on the measure (2021) • Developed reporting to identify children with a well-visit and no WCC coding (completed Q4) • Monitoring measure progress MOM thru prospective reporting (in place since Q1 2021) and reported out monthly to provider facing teams • Measure is part of Compass, Humana's tool which provides data to providers on outstanding care gaps (in place since Q1 2021)	Partially Addressed; improvement not yet observed

Recommendation for Humana	Humana Response/Actions Taken	IPRO Assessment of MCO Response[1]
	• Included in Star Quality Reports sent to providers (sent quarterly, on-going) • 2021 Administrative data is trending upward from data at the same time last year • Continue to pursue data integration with providers, such as those using Epic payer platform (on-going) *Immunizations for Adolescents (IMA):* *HPV*: HEDIS 2020: 33.33% HEDIS 2021: 31.63% Most Recent Prospective Run (claims thru 10/31/2021): 24.14% • HPV vaccination will be added to Go365 in 2022– members who participate in Go365 will be eligible for rewards after HPV vaccination • Identified billing glitch for mid-level providers and fix going in place (retrospective to 1/1/2020) • IMA Combo 2 (which includes HPV) is one of the measures included in the provider Quality Recognition Program and Value Based Contracts (started 1/1/2021) • Trained Care Management team on measure (Q2 2021) • With each family outreach by care management, vaccination status assessed and access to care barriers assessed (on-going) • Vaccinations are addressed during EPSDT outreach calls (on-going) • Identified opportunity to bring in additional pharmacy passes by mapping NDC codes (Q4 2021) • Included in Star Quality Reports sent to providers (sent quarterly, on-going) • Monitoring progress MOM thru prospective claims and reviewed in Child measure focused work group and provider facing teams meetings • Social Media posts on immunizations Oct. 1, 2021, Aug. 20, 2021, Aug. 2, 2021, July 2, 2021, June 18, 2021, April 16, 2021, April 2, 2021, Mar 12, 2021, Mar 5, 2021 • Developed IMA measure guide Q3 2021 to educate providers • Continue to pursue data integration with providers, such as those using Epic payer platform (ongoing) • Unable to Contact (UTC) letter updated for members we were not able to reach telephonically. Updated letter includes members over 18-21 years old. Approved Dec 2021, to be implemented Q1 2022 *Breast Cancer Screening (BCS)*: HEDIS 2020: 49.76% HEDIS 2021: 45.16% Most Recent Prospective Run (claims thru 10/31/2021): 43.15% • Outreach calls by population health team to women missing BCS (Q3 2021) • Outreach calls by population health team to alert women of mobile mammography opportunities near their residence (Q3 2021) • Care gap addressed by Care Management team when working with the member (on-going)	

Recommendation for Humana	Humana Response/Actions Taken	IPRO Assessment of MCO Response[1]
	• Icario Omni channel outreach to encourage BCS (Q4 2021) • This measure is eligible for member rewards thru Go365 (started 1/1/2021) • BCS is one of the measures included in the provider Quality Recognition Program and Value Based Contracts (started 1/1/2021) • Measure is part of Compass, Humana's tool which provides data to providers on outstanding care gaps (on going) • Included in Star Quality Reports to Providers (distributed quarterly) • Data reviewed in Adult workgroup focused on improving performance measures (on-going) • Monitoring total rate MOM thru prospective claims data (in place since Q1 2021) • Developed flyer in Q3 2021 to educate providers on this measure • Developed "Unable To Contact" letter to educate members on need of completing preventing screening upon unsuccessful telephonic outreach.(Letter approved Q4 2021 and to implement Q1 2022) • Developed Medicaid HEDIS measure provider pocket guide (Planned implementation Q1 2022) • Pursue data integration with providers, such as those using Epic payer platform (ongoing) *Cervical Cancer Screening (CCS)*: HEDIS 2020 54.26% HEDIS 2021: 44.71% Most Recent Prospective Run (claims thru 10/31/2021): 43.10% • Outreach calls by population health team to women missing CCS (Q32021) • Care gap addressed by Care Management team when working with the member (on-going) • Icario omni-channel outreach to encourage CCS (Q4 2021) • This measure is eligible for Go365 member rewards (began in 2021) • CCS is one of the measures included in the provider Quality Recognition Program and Value Based Contracts (began in 2021) • Measure is part of Compass, Humana's tool which provides data to providers on outstanding care gaps (on-going) • Included in Star Quality Reports to providers (implemented in 2021) • Monitored in adult workgroup focused on improving performance measures (on-going) • Monitoring rate MOM thru prospective claims data (on-going) • Developed flyer in Q3 2021 to educate providers on this measure • Developed "Unable To Contact" letter to educate members on need of completing preventing screening upon unsuccessful telephonic outreach (Letter approved Q4 2021 and to implement Q1 2022) • Developed Medicaid HEDIS measure provider pocket guide (Planned implementation Q1 2022)	

Recommendation for Humana	Humana Response/Actions Taken	IPRO Assessment of MCO Response[1]
	• Pursue data integration with providers, such as those using Epic payer platform (on-going) *Controlling High Blood Pressure*: HEDIS 2020: 51.09% HEDIS 2021: 62.77% (significant improvement) Most Recent Prospective Run (claims thru 10/31/2021): 34.19% • Care gap addressed by Care Management team when working with the member (on-going) • Education to providers about how to code and submit blood pressure readings (during 2021 provider engagement outreach to provider groups) • Measure is part of Compass, Humana's tool which provides data to providers on outstanding care gaps (on-going) • Included in Star Quality Reports to providers (sent quarterly, on-going) • Monitoring total rate MOM thru prospective claims data. Note our admin rate this year has surpassed our admin rate for end of year 2020 • Developed flyer in Q3 2021 to educate providers on this measure • Developed Medicaid HEDIS measure provider pocket guide (Planned implementation Q1 2022) • Pursue data integration with providers, such as those using Epic payer platform (on-going) • Social media posts developed and implemented Q2 2021 *Comprehensive Diabetes Care (CDC): All sub measures* *HbA1c Testing:* HEDIS 2020: 85.30 HEDIS 2021: 85.15% Most Recent prospective Run (claims thru 10/31/2021): 82.38% *Controlling blood pressure*: HEDIS 2020: 49.23% HEDIS 2021: 63.26% (significant improvement) Most Recent Prospective Run (claims thru 10/31/2021): 34.93% *CDC Eye Exams*: HEDIS 2020: 50.77% HEDIS 2021: 45.99% Most Recent Prospective Run (claims thru 10/31/2021): 38.98% *CDC-HbA1c <8*: HEDIS 2020: 37.09% HEDIS 2021: 49.15% (significant improvement) Most Recent Prospective Run (claims thru 10/31/2021): 34.50% *CDC HbA1c >9*: HEDIS 2020: 54.36% HEDIS 2021: 37.96% (significant improvement) Most Recent Prospective Run (claims thru 10/31/2021): 58.17% • Care gap addressed by Care Management team when working with the member (on-going)	

Recommendation for Humana	Humana Response/Actions Taken	IPRO Assessment of MCO Response[1]
	• Measure is part of Compass, Humana's tool which provides data to providers on outstanding care gaps (on-going) • Included in Star Quality Reports to providers (sent quarterly, on-going) • Monitored as part of the Adult workgroup focused on performance measure improvement (on-going) • Monitoring total rate MOM thru prospective claims data. Note our admin rates this year has surpassed our admin rate for end of year 2020 • Year-end claims review to identify records where a negative eye exam was received in 2020 to submit via supplemental data (Q4 2021) • Year-end claims review to identify members with HbA1c lab claim and no result: Requesting result to submit as supplemental data (Q4 2021) • Member newsletter: Diabetes and taking care of your vision (November 2021),Go365 overview and rewards table • Provider newsletter: Improve patient outcomes, close care gaps with Comprehensive Diabetes Care-Eye Exam (CDC-EYE) performance measure (August 2021) • Planning pilot with Avesis, vision vendor, to perform outreach calls to approx. 1000 members who are missing a vision exam to provide education and assist with scheduling appointment. This will start in Q1 2022. • Developed Medicaid HEDIS measure provider pocket guide (Planned implementation Q1 2022) • Pursue data integration with providers, such as those using Epic payer platform (on-going) • Diabetes social media posts developed and implemented weekly Q2 2021 *CAHPS*: • Humana had no adult or child CAHPS elements in the 2021 Technical Report that underperformed the 25th percentile • Humana has a CAHPS workgroup that meets quarterly to discuss member satisfaction. We have a five-question voice activated technology survey that is deployed after PCP visits. Additionally, we continually monitor the voice of the customer thru customer service reporting. This information is reviewed quarterly and the information is used by provider engagement as they work directly with provider groups. • Humana seeks input from stakeholders and members via the Quality Member Access Committee. Humana submitted application for multicultural distinction thru NCQA in December 2021. This work included specific interventions to address subpopulation concerns contributing to lower access to primary / preventive care visits. Some of these interventions included cultural competency training and specific outreach to subpopulations to understand and address access to care issues and social determinant of health concerns. Access to care concerns directly impact CAHPS as do meeting the cultural needs of our population.	

Recommendation for Humana	Humana Response/Actions Taken	IPRO Assessment of MCO Response[1]
Humana should build on collaborative work with the HIE vendor to spread successes for sustained improvement beyond the "Reducing Potentially Preventable Hospitalizations and ED Visits for Ambulatory Care Sensitive Conditions (ACSC)" PIP measurement cycles.	Humana has built on the success of our HIE vendor relationship. We use the vendor to help with early identification of member discharges, especially with the UM pause secondary to the pandemic. We continue to monitor for members with ACSC conditions and ED visits. We also use our HIE vendor as a source for valid telephone numbers when members are unreachable.	Addressed

[1] IPRO assessments are as follows: **addressed**: MCO's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCO's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.

MCO: managed care plan; EQR: external quality review; MOM: month over month; YOY: year over year; MRDR: medical record documentation review; QIC: Quality Improvement Committee; HIPAA: Health Insurance Portability and Accountability Act of 1996; UM: utilization management; ED: emergency department; HIE: health information exchange; ACSC: Ambulatory Care Sensitive Conditions.

Passport/Molina Response to Previous EQR Recommendations

Table 30 displays Passport's progress related to the *2021 External Quality Review Technical Report*, as well as IPRO's assessment of Passport's response.

Table 30: Molina Response to Previous EQR Recommendations

Recommendation for Passport	Molina Response/Actions Taken	IPRO Assessment of MCO Response[1]
Passport should successfully implement corrective actions in the three quality-related and four access/timeliness-related domains where elements were rated minimal or non-compliant in the 2020 Compliance Review.	**What has the MCO done/planned to address each recommendation?** **When and how was this accomplished? For future actions, when and how will they be accomplished?** Update on the 2020 Compliance Review elements that were rated minimal and non-compliant: • Tool 12a – Non-Compliant - The Contractor shall allow the Enrollees to select another PCP within ten (10) days of the approved change or the Contractor shall assign a PCP to the Enrollee if a selection is not made within the timeframe. ○ CAP issued, and operations amended the attached PCP selection policy to comply.	Addressed

Recommendation for Passport	Molina Response/Actions Taken	IPRO Assessment of MCO Response[1]
	• Tool 6 – Prepayment policy for Program Integrity - Policy was effective after the start of the review period. The policy is compliant, but there's nothing to fix going forward. ○ No CAP – Current policy meets compliance • Tool 5 - During the MCO interview, PHP stated that there is no Provider Enrollment policy that documents the process for receipt of the Department of Medicaid provider file, use of the provider master file to obtain the ten-digit provider number, CLIA certification and other information; or use of ten-digit provider number when communicating with the Department or receipt of the monthly provider data file at this time, a policy will be developed. ○ CAP issued – Attached CR 02 Assessment of Organization Providers Policy amended to comply • Tool 1 - 1. The Department will provide the Contractor with an expedited enrollment process to assign provider numbers for providers not already enrolled in Medicaid for emergency situations only. 2. The Contractor will have access to the Department Medicaid provider file either by direct on-line inquiry access, by electronic file transfer, or by means of an extract provided by the Department. The Medicaid provider master file is to be used by the Contractor to obtain the ten-digit provider number assigned to a medical provider by the Department, the Provider's status with the Medicaid program, CLIA certification, and other information. The Contractor shall use the Medicaid Provider number as the provider identifier when transmitting information or communicating about any provider to the Department or its Fiscal Agent. The Contractor shall transmit a file of Provider data specified in this Contract for all credentialed Providers in the Contractor's network on a monthly basis and when any information changes. 3. The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor. ○ CAP Issued – See CR 02 policy above • Tool – 1 The Behavioral Health Services Hotline shall not be answered by any automated means. CAP issued - This requirement is addressed in Beacon Health Options Policy CUR 135.4 Clinical Coverage and Access to Utilization Management Staff, which indicates incoming calls to Beacon are answered by live voice on page 2 and Beacon Health Options Policy QM24E Measurement of Availability and Accessibility of Clinical Services-Kentucky Specific on page 2. However, Policy CUR 135.4 Clinical Coverage and Access to Utilization Management Staff also indicates that calls can be answered in one of three ways on page 2, with one of the ways described as "Auto attendant that provides the caller with a number-based menu option that routes the call directly to the appropriate department. Note: "Emergent" callers are instructed to select the first option that connects them directly to a Beacon staff member". Passport Health Plan clarified during interviews that the behavioral health hotline is the Beacon Health Options Behavioral Health Services Hotline referenced in policy. The MCO provided a member services training document called Passport Health Plan Behavioral	

Recommendation for Passport	Molina Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Health/Substance Abuse Cheat Sheet that refers to the Behavioral Health Hotline number as 1-855-834-5651 on page 1. The Passport Health Plan 2020 Member Handbook refers to the Behavioral Health Crisis Hotline number 844-231-7946 on page 5, 7 and 30, while the number 855-834-5651 is referred to as the Behavioral Health Access Line on page 7. The requirement for non-automated answering of the Behavioral Health Services Hotline is not clearly documented in policy or procedure. **What is the expected outcome of the actions that were taken or will be taken?** **What is the MCO's process for monitoring the actions to determine their effectiveness?** • All the specified actions completed above will meet IPRO recommendations • Monitoring will occur as part of CAP process to confirm effectiveness.	
With overall average performance in HEDIS measures of Effectiveness of Care and Access and Availability, Passport should focus on the numerous opportunities for improvement especially in areas where performance rates are below the national 25th percentile.	**What has the MCO done/planned to address each recommendation?** **When and how was this accomplished? For future actions, when and how will they be accomplished?** Passport by Molina is taking a multi-faceted approach to improving the measures with low historical performance rates. There have been targeted member outreach mailings, birthday cards, as well as articles in the member newsletter. The Healthy Rewards program also incentivized members to complete preventative services. Our highest volume requested member rewards: 1. COVID, 2. Dental, 3. Preventive exam. Passport has also performed provider outreach and education through the provider newsletter and meetings with provider services and the quality team. Passport developed a robust strategy to establish data connectivity with priority labs and providers based on HEDIS measures and membership. Effective data sharing efforts will result in more timely compliance rates as well as clarity on member actual gaps in care for provider focused activity. **What is the expected outcome of the actions that were taken or will be taken?** **What is the MCO's process for monitoring the actions to determine their effectiveness?** HEDIS measure rates are monitored at a plan level no less than on a monthly basis to evaluate progress and trends. Additionally, key primary care provider groups receive panel specific HEDIS measure summary and detailed member reports no less than quarterly in order to address their patients' gaps in care. **If a recommendation in the 2021 technical report was repeated from the prior year, please indicate if actions taken as a response to the prior recommendation are still current and describe any new initiatives that have been implemented and/or planned.** HEDIS rate and intervention activity is consistent from 2020 response and ongoing although processes vary as part of the transition from legacy Passport Health Plan to Passport by Molina. COVID continues to impact the entire community presenting ongoing challenges for members and providers to engage in new ways safely to meet healthcare needs. Efforts to support COVID vaccine efforts did impact resources to outreach members to support HEDIS and other preventive activities. Passport by Molina developed a provider value-based strategy in 2021 with a planned launch date in January 2022 for targeted high volume providers. The Passport VBP will focus on pay for quality in 2022 closely aligned with HEDIS and annual preventive exams. Passport	Partially addressed; improvement not yet observed

Recommendation for Passport	Molina Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Quality improvement Specialists established relationships with approximately 250 key provider groups (based on TIN) and met at least quarterly to review Passport QI strategy, initiatives and provide practice specific reports regarding HEDIS gaps in care.	
Regarding Passport 's Corrective Action Plan for the "Reducing Potentially Preventable Hospitalizations and ED Visits for Ambulatory Care Sensitive Conditions (ACSC)" PIP, Passport should: - utilize the PIP template as a working document for ongoing monitoring and proactive modification of interventions in order to conduct ongoing quality improvement, as well as to ensure adherence to all due date deadlines; and - utilize ITMs to monitor the progress of PIP interventions, to flag declining ITM rates, then conduct barrier analysis and use findings to inform modifications to interventions on an ongoing basis.	**What has the MCO done/planned to address each recommendation?** **When and how was this accomplished? For future actions, when and how will they be accomplished?** Passport by Molina is consistently using the 2021 PIP template for both the quarterly and baseline reports YTD. The Passport Quality team has had multiple conference calls with Carolyn Kerr and Carolyn Gallagher to confirm Passport's strategy and implementation for the 2021 PIPs. Passport is actively working the PIP interventions and Intervention Tracking Measures including monitoring rates, analyzing the results, assessing problems including root cause and developing action plans to address barriers. Passport initiated a PDSA for the SDOH PIP in Q4 2021 and plans to start another for the Diabetes PIP in Q1 2022. **What is the expected outcome of the actions that were taken or will be taken?** **What is the MCO's process for monitoring the actions to determine their effectiveness?** Passport expects to display effectiveness of our plans in the PIP required reporting at a minimum of quarterly basis. **If a recommendation in the 2021 technical report was repeated from the prior year, please indicate if actions taken as a response to the prior recommendation are still current and describe any new initiatives that have been implemented and/or planned.** The ASCS recommendations remain in place but may not apply specifically to the current PIPs focused on Diabetes and SDOH. Provider education on PIPs and EPSDT occurred in the quarterly QI specialists' meetings as well as being offered in separate eNews and webinars to the entire network of participating providers. Tracking system developed to document these education efforts across Quality and provider services staff. EPSDT dashboard developed and monitored on a minimum of a monthly basis.	Addressed

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCP's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCP's QI response did not address the recommendation; improvement was not observed or performance declined.

MCP: managed care plan; EQR: external quality review; PIP: performance improvement project; PDSA: Plan-Do-Study-Act; SDOH: social determinants of health; VBP: value-based payment; TIN: taxpayer identification number; MRDR: medical record documentation review; CAP: corrective action plan; HIPAA: Health Insurance Portability and Accountability Act of 1996; CLIA: Clinical Laboratory Improvement Amendments Act; ACSC: Ambulatory Care Sensitive Conditions; ITM: intervention tracking measure.

WellCare Response to Previous EQR Recommendations

Table 31 displays WellCare's progress related to the *2021 External Quality Review Technical Report*, as well as IPRO's assessment of WellCare's response.

Table 31: WellCare Response to Previous EQR Recommendations

Recommendation for WellCare	WellCare Response/Actions Taken	IPRO Assessment of MCO Response[1]
While WellCare showed strong performance in the 2020 Compliance Review, the MCO should successfully implement corrective actions in the two quality-related domains with minimal findings.	**Grievance System:** As noted in WellCare's response to the 2020 Annual Compliance Review findings for Tool # 5, corrective action was taken to address the NABD letter template recommendation, prior to the 2020 audit. Specifically, WellCare's NABD letter template was updated to include a notification to enrollees regarding the limited time available to present evidence in relation to an expedited appeal. The updated template was approved by DMS and implemented in 2020. **Program Integrity:** Per IPRO's recommendation, WellCare posted a Program Integrity Coordinator position in April of 2021, and successfully filled the position in September of 2021. The Program Integrity Coordinator is located in Kentucky and is dedicated exclusively to the coordination, management, and oversight of the WellCare of Kentucky Program Integrity Unit.	Addressed
Opportunities for improvement in HEDIS 2020 should be a focus for WellCare's improvement strategy particularly for measures rated below the national 25th percentile, and also measures with rates just below the national 50th percentile.	WellCare uses Quality Practice Advisors (QPA) and Provider Relations Representatives (PR) to inform and educate providers about HEDIS® measures. The QPA and PR teams meet with providers on a monthly, bi-monthly, or quarterly basis to provide updates and educate on HEDIS® measures. During provider meetings care gap reports are reviewed, low performing providers are identified, barriers are discussed, and education occurs to improve scores in identified measures. Provider newsletters are published quarterly to keep providers informed of an array of quality related topics. To ensure our members are with the correct provider, WellCare performs a quarterly cleanup to move members who are identified via claims to the provider they current seek care from. Methods of outreach to members include text message campaigns, IVR messages, and educational information via quarterly member newsletters. Measures below the 25th percentile: • Measure Specialist project: Individual quality team members are assigned to specific HEDIS® measures to track, trend, and implement new interventions to increase the rates in these areas. Measures included in this project include CIS, IMA, WCC (BMI percentile), AAB, URI, recently added measures include LBP and COU. • Wellcare offers provider incentives for the following measures CIS, IMA, and WCC (BMI percentile). • Prevention and Screening – CIS and IMA – Partnering with Pfizer for pilot program for outreaching	Partially Addressed; improvement not yet observed

Recommendation for WellCare	WellCare Response/Actions Taken	IPRO Assessment of MCO Response[1]
	members prior to their due dates for their immunizations. Measures between the 25th and 50th percentile: • Measure Specialist project: Individual quality team members are assigned to specific HEDIS® measures to track, trend, and implement new interventions to increase the rates in these areas. Measures included in this project are AMM, FUA, APM, SAA, BCS, CCS, CHL, APP, PPC, CBP, CDC, recently added measures include PCE and AMR. • Wellcare offers provider incentives for the following measures APM, FUA, SAA, CCS, CHL, BCS, and CDC. • To encourage our members to be an active participant in their health, WellCare offers member incentives for the following measures PPC, BCS, CCS, CHL, and CDC. Diabetes Measures – WellCare collaborates with Good Measures to provide diabetes prevention and management solutions for our members.	

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCP's QI response was appropriate; however, improvement was not yet observed; **remains an opportunity for improvement**: MCP's QI response did not address the recommendation; improvement was not observed or performance declined.

MCP: managed care plan; EQR: external quality review; NABD: notice of adverse benefit determination; IVR: interactive voice response; QPA: quality practice advisor; CIS: Childhood Immunization Status; IMA: Immunizations for Adolescents; WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents; BMI: body mass index; AAB: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis; URI: Appropriate Treatment for Children with Upper Respiratory Illness; LBP: Use of Imaging Studies for Low Back Pain; COU: Risk of Continued Opioid Use; AMM: Antidepressant Medication Management; FUA: Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse of Dependence; APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics; SAA: Adherence to Antipsychotic Medications for Individuals with Schizophrenia; BCS: Breast Cancer Screening; CCS: Cervical Cancer Screening; CHL: Chlamydia Screening in Women; APP: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics; PPC: Prenatal and Postpartum Care; CBP: Controlling Blood Pressure; CDC: Comprehensive Diabetes Care; PCE: Pharmacotherapy Management of COPD Exacerbation; AMR: Asthma Medication Ratio.

XII. MCO Strengths and Opportunities for Improvement, and EQR Recommendations

Tables 32–36 highlight each MCO's performance strengths and opportunities for improvement and this year's recommendations based on the aggregated results of SFY 2021 EQR activities as they relate to **quality**, **timeliness**, and **access**.

Aetna Strengths and Opportunities for Improvement, and EQR Recommendations

Table 32: Aetna Strengths and Opportunities for Improvement, and EQR Recommendations

Aetna – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	Strengths	Opportunities for Improvement
Compliance Review	Of the 9 quality-related standard areas reviewed in 2021, 4 areas received 100% compliance.	There were 3 elements (0.4%) determined to be Not Met, one in each of the following areas: Confidentiality; Grievance and Appeal Systems and HIS.
HEDIS Performance Measures of Quality	• Aetna was compliant with all seven Information System Standards (ISS). • Aetna had 22 HEDIS MY 2020 Effectiveness of Care measures with rates equal to or better than the national 50th percentile out of a total of 57 measures with benchmarks (39%). Three of these measures were equal to or better than the national 90th percentile and another six were greater than the 75th national percentile, but below the 90th percentile.	Aetna's rates for 13 out of the 57 (23%) HEDIS MY 2020 Effectiveness of Care measures were below the national 25th percentile, including 7 measures in the Overuse/Appropriateness domain.
Consumer Satisfaction	Aetna showed average performance in measures of consumer satisfaction with 6 adult CAHPS measures (46%) meeting or exceeding the national 50th percentile. Aetna's child CAHPS measures showed stronger performance with 9 of the 10 child CAHPS measures (90%) meeting or exceeding the national 50th percentile. Two adult measures and one child measure had rates at or above the national 90th percentile.	Aetna had three adult CAHPS measures (23%) with rates below the national 25th percentile. All three were related to Smoking and Tobacco Use Cessation.
PIP Validation	• The MCO submitted baseline reports for two statewide PIPs and one plan specific PIP. • The Improving Diabetes Management report fully addressed 2 of the 6 validation elements; and the Improving Assessment, Referral and Follow-up for Social Determinants of Health (SDoH) report fully addressed 4 of the 6 validation elements. • Aetna's plan specific PIP regarding weight assessment and counseling for children and adolescents in the SKY Program fully addressed 4 of the 6 validation elements.	The Improving Diabetes Management PIP had four validation elements that were partially addressed and the SDoH PIP had two elements that were partially addressed. For Aetna's plan specific PIP, there were two elements that were partially addressed.

Aetna – Strengths, Opportunities for Improvement, and EQR Recommendations		
MCO Quality Ratings	Aetna showed high performance in Getting Care and Satisfaction with MCO Services.	Children and Adolescent Wellness and Women's Health were two of the five Quality Report Card areas that Aetna had low performance (2 stars out of 5).
NCQA Accreditation	Aetna achieved a Commendable level of NCQA accreditation. The MCO overall rating was 3.5 stars out of 5; with 4 stars for Getting Care and three and a half stars for Treatment of Heart Disease.	The MCO showed lower performance in the area of cancer screening.
Access/Timeliness of Care	Strengths	Opportunities for Improvement
Compliance Review	Aetna received 100% compliance for the two access related standard areas: Availability of Services and Assurances of Adequate Capacity and Services.	There are no opportunities for improvement identified.
HEDIS Performance Measures of Access/Timeliness	Eight of the 10 Access and Availability measures with benchmarks (80%) were equal to or greater than the national 50th percentile. One measure rate was at or above the 90th national percentile.	One measure of access/timeliness continues to be below the national 25th percentile: AAP for members 65 years and older.
Network Adequacy	Of the Aetna providers surveyed for the Access and Availability survey, 78.8% were able to be contacted.	Of the Aetna providers surveyed for the Access and Availability survey: • Rates of appointments made within the time standards were low: 39.1% for routine appointments and 22.6% for urgent appointments; • 42.4% were compliant with after-hours standards.
Recommendations		
• Aetna should successfully implement corrective actions for the three quality-related compliance review elements that were rated Not Met. • Focusing on the HEDIS quality-related measures which fell below the NCQA national 25th percentile, Aetna should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period. • Results of the survey of PCP, Behavioral Health and Substance Use Disorder Providers indicate a priority area for improvement. Aetna needs to implement interventions to raise provider awareness of access and availability contractual expectations.		

ISS: Information System Standards; HEDIS: Healthcare Effectiveness Data and Information Set; CAHPS: Consumer Assessment of Healthcare Providers and Systems; PIP: performance improvement project; SDoH: social determinants of health; SKY: Supporting Kentucky Youth; HIS: health information systems: NCQA: National Committee for Quality Assurance.

Anthem Strengths and Opportunities for Improvement, and EQR Recommendations

Table 33: Anthem Strengths and Opportunities for Improvement, and EQR Recommendations

Anthem – Strengths, Opportunities for Improvement and EQR Recommendations		
Quality of Care	Strengths	Opportunities for Improvement
Compliance Review	Of the 9 quality-related domains reviewed, 6 domains received 100% compliance determinations.	The MCO received a Not Met determination for one element in the 2021 Compliance Review in the HIS domain.
HEDIS Performance Measures of Quality	• Anthem was compliant with all seven Information System Standards (ISS). • With 57 measures in HEDIS MY 2020 Effectiveness of Care with benchmarks, Anthem had rates at or above the national 50th percentile for 22 measures (39%), including one measure rate at or above the national 90th percentile and three others between the 75th and 90th percentiles.	Opportunities for improvement are evident for 13 (23%) of the HEDIS MY 2020 Effectiveness of Care measures with rates below the national 25th percentile. Included in these underperforming measures were 8 of the 13 Prevention and Screening rates.
Consumer Satisfaction	The MCO showed strong performance for measures of consumer satisfaction with 10 of the 13 adult CAHPS measures (77%) and 6 of the 10 child CAHPS measures (60%) meeting or exceeding the national 50th percentile. There were six child CAHPS rates at or above the national 90th percentile.	Rates for one adult CAHPS measure and two child CAHPS measures were below the national 25th percentile.
PIP Validation	• The MCO submitted baseline reports for two statewide PIPs. • The Improving Diabetes Management report fully addressed 2 of the 6 validation elements; and the Improving Assessment, Referral and Follow-up for Social Determinants of Health (SDoH) report fully addressed 3 of the 6 validation elements.	The Improving Diabetes Management PIP had four validation elements that were partially addressed and the SDoH PIP had three elements that were partially addressed.
MCO Quality Ratings	Anthem showed high performance in Getting Care and Satisfaction with MCO Services (4 out of 5 stars).	Anthem had low performance (2 stars out of 5) for the Children and Adolescent Wellness metric in the MCO Quality Report Card.
NCQA Accreditation	Anthem is NCQA accredited and for 2021 received an overall quality rating of 3.5 stars out of 5; with 5 stars for Getting Care and 4.5 stars for Satisfaction with Plan Physicians.	NCQA Quality ratings were low for Children and Adolescent Well Care and Cancer Screening, both with 2 stars out of 5.
Access/Timeliness of Care	Strengths	Opportunities for Improvement
Compliance Review	Anthem received 100% compliance for the two access related standard areas: Availability of Services and Assurances of Adequate Capacity and Services.	There are no opportunities for improvement identified.
HEDIS Performance Measures of Access/Timeliness	Anthem had four HEDIS MY 2020 Access and Availability measure rates that were at or above the national 50th percentile out of the 10 measures (40%) with benchmarks. The two IET measures had rates at or above the national 90th percentile.	Six of the HEDIS MY 2020 measures of Access/Timeliness (60%) were above the national 25th percentile, but below the 50th percentile.

Anthem – Strengths, Opportunities for Improvement and EQR Recommendations		
Network Adequacy	Of the Anthem providers surveyed for the Access and Availability survey, 67.8% were able to be contacted.	Of the Anthem providers surveyed for the Access and Availability survey: • Rates of appointments made within the time standards were low: 38.1% for routine appointments and 21.1% for urgent appointments; • 45.5% were compliant with after-hours standards.
Recommendations		
• Anthem should focus improvement interventions to address the HEDIS MY 2020 and CAHPS measures that underperformed the NCQA national 25th percentile especially targeting measure rates in Prevention and Screening. • Anthem needs to address the PIP validation elements that were determined to be partially addressed in both of their statewide PIP topics. • Results of the survey of PCP, Behavioral Health and Substance Use Disorder Providers indicate a priority area for improvement. Anthem needs to implement interventions to raise provider awareness of access and availability contractual expectations.		

ISS: Information System Standards; HEDIS: Healthcare Effectiveness Data and Information Set; MCO: managed care organization; CAHPS: Consumer Assessment of Healthcare Providers and Systems; PIP: performance improvement project; SDoH: social determinants of health; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; NCQA: National Committee for Quality Assurance.

Humana Strengths and Opportunities for Improvement, and EQR Recommendations

Table 34: Humana Strengths and Opportunities for Improvement, and EQR Recommendations

Humana – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	Strengths	Opportunities for Improvement
Compliance Review	Of the 9 quality-related domains reviewed, 8 domains received 100% compliance determinations. None of the 730 elements reviewed in Humana's 2021 Compliance Review received a Not Met determination.	Humana had one compliance review domain with a partially met determination: Coordination and Continuity of Care.
HEDIS Performance Measures of Quality	• Humana was compliant with all seven Information System Standards (ISS). • Humana had 19 HEDIS MY 2020 Effectiveness of Care measures (33%) with rates at or above the national 50th percentile out of a total of 57 measures. Two measure rates were at or above the national 90th percentile.	The MCO continues to have opportunities for improvement in several quality of care domains, with 18 (32%) of the HEDIS MY 2020 Effectiveness of Care measure rates below the national 25th percentile. Twelve of the 13 measures in the Prevention and Screening domain were below the national 50th percentile and six measures in the Overuse/Appropriateness domain were below the national 25th percentile.
Consumer Satisfaction	Measures of consumer satisfaction were above average for adults with 7 of the 13 adult CAHPS measures (54%) at or above the national 50th percentile, including two measures that were at or above the national 75th percentile, but below the 90th percentile. One of the 11 child survey measures (11%) was at or above the national 50th percentile.	There was one adult CAHPS survey measure with a rate below the national 25th percentile. Nine of the 10 child CAHPS measures (90%) were below the national 50th percentile.

Humana – Strengths, Opportunities for Improvement, and EQR Recommendations		
PIP Validation	• The MCO submitted baseline reports for two statewide PIPs. • The Improving Diabetes Management report fully addressed 4 of the 6 validation elements; and the Improving Assessment, Referral and Follow-up for Social Determinants of Health (SDoH) report fully addressed 4 of the 6 validation elements.	For both statewide PIPs, Humana had two partially addressed validation elements: Barrier Analysis and Interventions.
MCO Quality Ratings	Humana showed high performance in Satisfaction with MCO Services (5 stars) and Getting Care (4 out of 5 stars).	Humana had low performance (2 stars out of 5) in 3 of the 5 performance areas in the MCO Quality Report Card: Children and Adolescent Wellness; Women's Health; and Treatment.
NCQA Accreditation	Humana is NCQA accredited and for 2021 received an overall quality rating of 3 stars out of 5; with 3.5 stars for Mental and Behavioral Health Treatment and 3 stars each for Satisfaction with Plan Physicians; Diabetes and Heart Disease Treatment.	NCQA Quality ratings were low for Children and Adolescent Well Care and Cancer Screening, both with 2 stars out of 5.
Access/Timeliness of Care	Strengths	Opportunities for Improvement
Compliance Review	Humana received 100% compliance for the two access related standard areas: Availability of Services and Assurances of Adequate Capacity and Services.	There are no opportunities for improvement identified.
HEDIS Performance Measures of Access/Timeliness	Humana had rates for four of the 10 (40%) HEDIS MY 2020 measures of Access and Availability that were at or above the national 50th percentile, including two measures for IET that were above the national 90th percentile.	Rates for 6 of the 10 HEDIS MY 2020 access/timeliness measures (60%) were below the national 50th percentile, including the Annual Dental Visit measure which was below the national 25th percentile.
Network Adequacy	Of the Humana providers surveyed for the Access and Availability survey, 84.2% were able to be contacted.	Of the Humana providers surveyed for the Access and Availability survey: • Rates of appointments made within the time standards were low: 46% for routine appointments and 17% for urgent appointments. • 54.5% were compliant with after-hours standards.
Recommendations		
• Humana should focus improvement initiatives on the HEDIS and CAHPS measure areas that underperformed the NCQA national 50th percentile in both quality and access-related domains especially addressing the 12 out of 13 measures in the Prevention and Screening domain that were below the national 50th percentile; the six measures in the Overuse/Appropriateness domain that were below the national 25th percentile; and the nine child CAHPS measures that were below the national 50th percentile. • Results of the survey of PCP, Behavioral Health and Substance Use Disorder Providers indicate a priority area for improvement. Humana needs to implement interventions to raise provider awareness of access and availability contractual expectations.		

ISS: Information System Standards; HEDIS: Healthcare Effectiveness Data and Information Set; MCO: managed care organization; CAHPS: Consumer Assessment of Healthcare Providers and Systems; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; PIP: Performance Improvement Project; SDoH: Social Determinants of Health; NCQA: National Committee for Quality Assurance.

Passport/Molina Strengths and Opportunities for Improvement, and EQR Recommendations

Table 35: Passport/Molina Strengths and Opportunities for Improvement, and EQR Recommendations

Passport/Molina – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	Strengths	Opportunities for Improvement
Compliance Review	Of the 9 quality-related domains reviewed in 2021, 2 domains received 100% compliance determinations: Grievance and Appeal Systems and Practice Guidelines.	In the 2021 Compliance Review, Molina received Not Met determinations for 7 elements in the following quality-related domains: Coordination and Continuity of Care; Confidentiality; HIS and QAPI.
HEDIS Performance Measures of Quality	• The MCO was compliant with all seven Information System Standards (ISS). • Of the 57 HEDIS MY 2020 Effectiveness of Care measures with national benchmarks, 17 (30%) were rated at or above the national 50th percentile. Three measures had rates at or above the national 75th percentile, but below the 90th percentile and another five measures were rated at or above the national 90th percentile.	Twenty-four HEDIS MY 2020 Effectiveness of Care measures (42%) were rated below the national 25th percentile, including measures in all domains.
Consumer Satisfaction	Overall, the MCO showed strong performance for measures of consumer satisfaction with 8 of the 13 (62%) adult CAHPS survey measures and for 8 of the 10 (80%) child CAHPS survey measures equal to or better than the national 50th percentile. There were four child survey measures with rates at or above the national 90th percentile.	Three adult survey measure rates and one child survey measure rate were below their respective national 25th percentiles.
PIP Validation	• The MCO submitted baseline reports for two statewide PIPs. • The Improving Diabetes Management report fully addressed 4 of the 6 validation elements; and the Improving Assessment, Referral and Follow-up for Social Determinants of Health (SDoH) report fully addressed 4 of the 6 validation elements.	For both statewide PIPs, Molina had two partially addressed validation elements: Barrier Analysis and Interventions.
MCO Quality Ratings	Molina showed high performance in Satisfaction with MCO Services (4 out of 5 stars).	The MCO had low performance (2 stars out of 5) in 3 of the 5 performance areas in the MCO Quality Report Card: Children and Adolescent Wellness; Women's Health; and Treatment.
NCQA Accreditation	Passport received an overall 2021 NCQA rating of 3 stars out of 5; with 4 stars for Satisfaction with Plan Physicians; and 3.5 stars for Cancer Screening and Mental and Behavioral Health Treatment.	• Passport showed low performance (2 stars out of 5) for Women's Reproductive Health and Heart Disease Treatment; and 2.5 stars for Diabetes Treatment. • Passport is not NCQA accredited according to the NCQA website.[11] Molina contracted with the KY MMC Program as of January 1, 2021 and has two years from then to complete NCQA accreditation.

Passport/Molina – Strengths, Opportunities for Improvement, and EQR Recommendations		
Access/Timeliness of Care	Strengths	Opportunities for Improvement
Compliance Review	Molina received 100% compliance for the two access related standard areas: Availability of Services; and Assurances of Adequate Capacity and Services.	There are no opportunities for improvement identified.
HEDIS Performance Measures of Access/Timeliness	Seven of the 10 (70%) HEDIS MY 2020 measures of access and availability met or exceeded the national 50th percentile, with one measure rate (IET) at or above the national 90th percentile.	One of the 10 (10%) HEDIS MY 2020 measures related to access and availability was below the national 25th percentile: PPC: Timeliness of Prenatal Care and Postpartum Care.
Network Adequacy	Of the Passport providers surveyed for the Access and Availability survey, 66.4% were able to be contacted.	Of the Passport providers surveyed for the Access and Availability survey: • Rates of appointments made within the time standards were low: 14.2% for routine appointments and 5.1% for urgent appointments. • 33.3% were compliant with after-hours standards.
Recommendations		
• Molina should successfully implement corrections for the 7 elements rated Not Met in their 2021 Compliance Review • There are numerous opportunities for improvement in HEDIS MY 2020 Effectiveness of Care measures. Molina should identify barriers and consider interventions to improve performance especially in areas where performance rates are below the national 25th percentile. • Results of the survey of PCP, Behavioral Health and Substance Use Disorder Providers indicate a priority area for improvement. Molina needs to implement interventions to raise provider awareness of access and availability contractual expectations.		

ISS: Information System Standards; QAPI: quality assessment and performance improvement; HIS: health information systems; HEDIS: Healthcare Effectiveness Data and Information Set; CAHPS: Consumer Assessment of Healthcare Providers and Systems; PIP: performance improvement project; SDoH: social determinants of health; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; PPC: Prenatal and Postpartum Care.

WellCare Strengths and Opportunities for Improvement, and EQR Recommendations

Table 36: WellCare Strengths and Opportunities for Improvement, and EQR Recommendations

WellCare – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	Strengths	Opportunities for Improvement
Compliance Review	Eight of the 9 quality-related compliance review areas achieved 100% determinations. None of the 730 elements reviewed in Humana's 2021 Compliance Review received a Not Met determination.	WellCare had one compliance review area with a partially met compliance finding: Subcontractual Relationships and Delegation.
HEDIS Performance Measures of Quality	• WellCare was compliant with all seven Information System Standards (ISS). • Twenty six of the 57 (46%) HEDIS MY 2020 Effectiveness of Care measures with	Twelve HEDIS MY 2020 Effectiveness of Care measure rates (21%) were below the national 25th percentile, including six measures in the Overuse/Appropriateness domain.

WellCare – Strengths, Opportunities for Improvement, and EQR Recommendations		
	national benchmarks, were rated at or above the national 50th percentile, including two measures at or greater than the national 90th percentile and another eight measure rates at or above the national 75th percentile, but lower than the 90th percentile.	
Consumer Satisfaction	WellCare showed strong performance for measures of consumer satisfaction with all 13 adult CAHPS measure rates and 9 of the 10 (90%) child CAHPS measure rates at or above the national 50th percentile. Nine adult measure rates and six of the child measure rates were at or above their respective national 90th percentiles.	There was one child survey measure with a rate at or above the 25th percentile, but below the national 50th percentile.
PIP Validation	• The MCO submitted baseline reports for two statewide PIPs. • The Improving Diabetes Management report fully addressed 5 of the 6 validation elements; and the Improving Assessment, Referral and Follow-up for Social Determinants of Health (SDoH) report fully addressed 2 of the 6 validation elements.	For the Improving Diabetes Management PIP, the Barrier Analysis element was partially addressed. For the SDoH PIP, 4 of the 6 validation elements were partially addressed: Aim, Barrier Analysis, Interventions and Results.
Access/Timeliness of Care	Strengths	Opportunities for Improvement
Compliance Review	WellCare received 100% compliance for the two access related standard areas: Availability of Services; and Assurances of Adequate Capacity and Services.	There are no opportunities for improvement identified.
HEDIS Performance Measures of Access/Timeliness	The MCO exhibited strong performance in the HEDIS MY 2020 results for Access and Availability. Rates for 8 of the 10 measures with benchmarks (80%) were at or above the national 50th percentile, including one measure rate at or above the national 90th percentile and another six measure rates that were at or above the national 75th percentile, but below the 90th percentile.	There is an opportunity for improvement for two access-related measures with rates at or above the national 25th percentile, but below the 50th percentile: PPC: Postpartum Care; and APP.
Network Adequacy	Of the WellCare providers surveyed for the Access and Availability survey, 76% were able to be contacted.	Of the WellCare providers surveyed for the Access and Availability survey: • Rates of appointments made within the time standards were low: 38.8% for routine appointments and 30.3% for urgent appointments. • 66.7% were compliant with after-hours standards.
Recommendations		

- Opportunities for improvement in HEDIS MY 2020 quality and access-related domains should be a focus for WellCare's improvement strategy particularly for measures rated below the national 25th percentile, and also measures with rates just below the national 50th percentile.
- Results of the survey of PCP, Behavioral Health and Substance Use Disorder Providers indicate a priority area for

WellCare – Strengths, Opportunities for Improvement, and EQR Recommendations
improvement. WellCare needs to implement interventions to raise provider awareness of access and availability contractual expectations.

ISS: Information System Standards; HEDIS: Healthcare Effectiveness Data and Information Set; CAHPS: Consumer Assessment of Healthcare Providers and Systems; PIP: performance improvement project; SDoH: social determinants of health; PPC: Prenatal and Postpartum Care; APP: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics; MCO: managed care organization.

XIII. References

[1] Prepaid inpatient health plan.
[2] Prepaid ambulatory health plan.
[3] Primary care case management.
[4] CMS defines *validation* in *Title 42 CFR § 438.320 Definitions* as "the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis."
[5] Public Health, Managed Care State Quality Strategy, 42 C.F.R. § 438.340. (2016). https://www.govinfo.gov/app/details/CFR-2016-title42-vol4/CFR-2016-title42-vol4-sec438-340.
[6] *CMS External Quality Review (EQR) Protocols, October 2019.* https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf . Accessed February 16, 2022.
[7] Available on the CMS website: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf .
[8] The statewide average is weighted by adjusting for MCO enrollment size and is referred to as the weighted statewide average. Weighting the rates by eligible population sizes ensures that the rate for the MCO with more members has a proportionately greater impact on the overall statewide weighted average rate than the rate for an MCO with fewer members.
[9] The statewide average is weighted by adjusting for MCO enrollment size and is referred to as the weighted statewide average. Weighting the rates by eligible population sizes ensures that the rate for the MCO with more members has a proportionately greater impact on the overall statewide weighted average rate than the rate for an MCO with fewer members.
[10] NCQA *Health Plan Report Cards* Website: https://reportcards.ncqa.org/health-plans . Accessed February 15, 2022.
[11] NCQA *Health Plan Report Cards* website: https://reportcards.ncqa.org/health-plans . Accessed February 15, 2022.

XIV. Appendix A

MCO – Level Compliance Findings for State Fiscal Year 2021

This section contains a summary of the current year findings by MCO. Elements rated Not Met are identified by domain and review area.

Table A1: MCO-Level Compliance Review Findings, All MCOs – October 2021

Summary of Not Met Review Findings
Aetna
Aetna's review totaled 800 elements, of which 3 elements were determined to be Not Met in the following areas and (number of elements per area): **Confidentiality (1):** **Pursuant to 42 C.F.R. 438.52**, for Enrollees in a designated rural area in which only the Contractor provides services, the restrictions on changing PCPs cannot be more restrictive than for Enrollee Disenrollment as outlined in Section 26.13 "Enrollee Request for Disenrollment." • **Recommendation:** The MCO should address this requirement in the PCP Assignment and Changes policy and Enrollee Disenrollment policy. • **Aetna response:** We agree with this finding. This requirement has been added to Policy A-KY 4500.03 PCP Assignment and Changes after Initial Enrollment. **Grievance and Appeal Systems (1):** **24.3 State Fair Hearings for Enrollees:** Failure of the Contractor to comply with the State Fair Hearing requirements of the Commonwealth and federal Medicaid law in regard to an Adverse Benefit Determination made by the Contractor or to appear and present evidence shall result in an automatic ruling in favor of the Enrollee. • **Recommendation:** The MCO should finalize the policy update as indicated. • **Aetna response:** We agree with this finding and it has been added to A-KY 3100.70 Enrollee Appeals. **HIS (1):** **16.1 State Contract Encounter Data Submission:** The Contractor shall submit Encounter data after the Contract ends for services rendered during the Contract period for a sufficient time as determined by the Department to ensure timely filing and complete data. • **Recommendation:** Aetna did not have any language in its policies related to submitting Encounter data after the Contract ends for services rendered during the Contract period for a sufficient time as determined by the Department. • **Aetna response:** Agree. This will be added to our encounter submission policy.
Anthem
Anthem's review totaled 730 elements, of which 1 element was determined to be Not Met in the following area and (number of elements per area): **HIS (1):** The Encounter File will be received and processed by the Department's Fiscal Agent and will be stored in the existing MMIS. The Contractor shall submit Encounter data after the Contract ends for services rendered during the Contract period for a sufficient time as determined by the Department to ensure timely filing and complete data. • **Recommendation:** Anthem should obtain final approval for the policy. • **Anthem response:** Anthem agrees with the determination and recommendation. Policy has been revised and finalized.
Humana
Humana's review totaled 730 elements, of which none of the elements were determined to be Not Met.
Passport/Molina
Molina's review totaled 730 elements, of which 7 were determined to be Not Met in the following areas and (number of elements per area): **Coordination and Continuity of Care (1):** **State Contract B. Health Risk Assessments (HRA):** As part of the HRA process, the Contractor shall explain the purpose

Summary of Not Met Review Findings

to Enrollees and available PHM Program services should they be determined in need of such services.

- **File review results:** Zero (0) of the 25 reviewed files included documentation of an explanation of the purpose of the HRA or available services.
- **Recommendation:** The MCO should ensure that enrollees are informed of the purpose of the HRA and available services to facilitate completion of HRAs.
- **Molina response:** Agree with this finding.
  Passport's Healthcare Services (HCS) team began working with the call center in April to improve HRA processes and outcomes. We held monthly meetings beginning at that time. In August we increased the meeting frequency to twice monthly. Meetings are now held weekly.
  Passport Health Plan by Molina Healthcare's Healthcare Services (HCS) team began working with the call center in April to improve HRA processes and outcomes. We held monthly meetings beginning at that time. In August we increased the meeting frequency to twice monthly. Meetings are now held weekly.
  One focus of these meetings has been to add additional reporting and oversight to ensure more timely outreach to members for the HRA. This includes troubleshooting members who fall off the roster (such as for changes in enrollment information). Through this analysis we identified and corrected an issue with our ingestion of overlapping enrollment segments, which were causing some newly enrolled members to not be identified for HRA outreach correctly.
  These efforts have also included refining the method with which HCS provides call reports/lists to the call center team. We've identified situations where calls were made earlier than expected (for annual HRAs) and therefore may not have been included in our initial reporting. We've also worked collaboratively to identify potential gaps in reporting that need to be addressed so that we can appropriately capture the full body of work completed by the call center and demonstrate reasonable outreach efforts are being completed.
  Molina is in the midst of an enterprise-wide HRA strategy update. The work, which will be completed in 2022, includes proposing revisions to the HRA tool, streamlining HRA completion processes, and creating better points of access for members to complete the HRA (such as the potential to have the HRA available in the member portal).

Confidentiality (4):

22.1: State Contract - Required Functions: X. Assisting enrollees in completing the Health Risk Assessment (HRA) as outlined in Appendix F "Covered Services" upon any telephone contact; and referring Enrollees to the appropriate areas to learn how to access the health education and prevention opportunities available to them including referral to the Population Health Management (PHM) Program; and

- **Recommendation:** This requirement was not addressed in the Enrollee Education/Information Session policy and the Member Handbook. The MCO should provide a policy for assisting enrollees in completing the HRA and the Member Handbook should inform members how to contact the MCO for assisting in completing the HRA.
- **Molina response:** AGREE: This has been added to the 2022 Member Handbook currently in edit. We will add the following to page 32 "Extra Support to Manage Your Health" section (after Behavioral Health Crisis Line, but before Health Management)
  "Completing a Health Risk Assessment (HRA) will allow us to better understand your unique needs so we can connect you with additional supports and services you might need. Return your completed HRA to Passport Health Plan at CareManagement_KY@passporthealthplan.com or to 5100 Commerce Crossing Drive, Louisville, KY 40229.
  Also, Stephanie Stone has a policy for this (HCS-061).

22.1: State Contract - Required Functions: Y. The Enrollee Services staff shall be responsible for making an annual report to management about any changes needed in enrollee services functions to improve either the quality of care provided or the method of delivery. A copy of the report shall be provided to the Department.

- **Recommendation:** This requirement was not addressed in the Enrollee Education/Information Session policy and the Member Handbook. The MCO should provide a policy for staff to make annual reports about any changes needed in enrollee services function.
- **Molina response:** Agree: We will incorporate into our procedures the annual report to notify management of any needed changes to the enrollee services functions regarding the quality of care provided or the method of delivery.

23.6 State Contract - Primary Care Provider (PCP) Changes: 4. The Contractor shall allow the Enrollees to select another PCP within ten (10) days of the approved change or the Contractor shall assign a PCP to the Enrollee if a selection is not made within the timeframe.

- **Recommendation:** The Member Handbook does not specify the 10 day period to change to other PCP after

Summary of Not Met Review Findings
approval. The MCO should update the Member Handbook to support this requirement. • **Molina response:** AGREE: This has been added to the 2022 Member Handbook currently in edit (page 16). **5. Pursuant to 42 C.F.R. 438.52**, for Enrollees in a designated rural area in which only the Contractor provides services, the restrictions on changing PCPs cannot be more restrictive than for Enrollee Disenrollment as outlined in Section 26.13 "Enrollee Request for Disenrollment." • **Recommendation:** This requirement is not addressed in Member Handbook. The MCO should update the Member Handbook to support this requirement. • **Molina response:** DISAGREE with this finding. : Page 15 of the Member Handbook currently states "You can change PCPs at any time. We do not limit the number of times you can change PCPs." Added the additional designated rural areas language to the 2022 Member Handbook currently in edit. • **IPRO Final Determination:** IPRO acknowledges the response; however, we did not find the reference to "rural" in the current member handbook. Passport noted that they added the language to the 2022 member handbook. No change in determination. **QAPI (1):** **CFR 438.204 and State Contract 19.5 Reporting HEDIS Performance Measures:** 6. The Department reserves the right to evaluate the Contractor's performance on targeted measures based on the Contractor's submitted encounter data. The Contractor shall have sixty (60) days to review and respond to findings reported as a result of these activities. • **Recommendation:** This requirement is not addressed in a policy document. This requirement should be incorporated into the appropriate HEDIS policy document. • **Molina response:** Agree - Will incorporate this requirement into the relevant policy. **HIS (1):** **The completeness penalties** set forth in Appendix A "Remedies for Violation, Breach, or Non-Performance of Contract" will not be assessed for the first two (2) quarters following implementation of the Encounter Data Monitoring template used to determine compliance. Accuracy: The Contractor shall submit Encounter data accurately in the required file formats with all data elements completed. Encounter File transmissions that exceed a five percent (5%) threshold error rate (total Claims/documents in error equal to or exceeding five percent (5%) of Claims/documents records submitted) will be subject to penalties as set forth in Appendix A "Remedies for Violation, Breach, or Non-Performance of Contract." Encounter File transmissions with a threshold error rate not exceeding five percent (5%) will be accepted and processed by the Department. Only those Erred Encounters will be returned to the Contractor for correction and resubmission. Denied Claims submitted for Encounter processing will not be held to normal edit requirements and rejections of denied Claims will not count towards the minimum five percent (5%) rejection. • **Recommendation:** This requirement is not met since Passport provided a penalty report showing that they did not meet the accuracy threshold. • **Molina response:** Agree: We continue to work with the department and our internal partners on optimization of encounters submissions to achieve standards outlined in our contract.
United
United's review totaled 730 elements, of which 12 were determined to be Not Met in the following areas and (number of elements per area): **Coordination and Continuity (2):** **B. Management of Chronic Conditions.** The Contractor shall provide Care Coordination support to Enrollees who have been identified as having emerging risk factors and/or one (1) targeted chronic condition. The Contractor shall provide services to Enrollees that aim to reduce healthcare costs and improve quality of life for Enrollees who have a chronic condition through integrative care. Care Coordination should help Enrollees to address potential co-morbidities or other complications and help to avoid complications. **Tobacco Use:** • **Recommendation:** There was no evidence of prioritization of tobacco use as a condition for population health management. The MCO provided a narrative that describes an initiative targeting enrollees using Nicotine Replacement Therapy. The MCO should prioritize conditions identified by the Department, including tobacco use, for population health management and identify priority conditions as determined by the Department in the program description or policy.

Summary of Not Met Review Findings
• **United response:** Agree: Further define interventions for members identified with Tobacco use as a priority condition. Specifically create a priority conditions Policy and Procedure to address specifics of the programs, services and identification of those members. **Cancer:** • **Recommendation:** Evidence of prioritization of cancer as a condition for population health management was not identified. The MCO should prioritize conditions identified by the Department, including cancer, for population health management. • **United response:** Agree: Further define interventions for members identified with Cancer as a priority condition. Specifically create a priority conditions Policy and Procedure to address specifics of the programs, services and identification of those members. **Grievance and Appeal Systems (1):** **State contract 27.3 Provider Services Website:** 29.2: The Contractor shall provide to each Medicaid Provider the opportunity for an in-person meeting with a representative of the Contractor on any Clean Claim that remains unpaid in violation of KRS 304.17A-700 to 304.17A-730; and on any Claim that remains unpaid for forty-five (45) Days or more after the date on which the Claim is received by the Contractor and that individually, or in the aggregate, exceeds twenty five hundred dollars ($2,500.00). • **Recommendation:** United submitted a provider Orientation slide deck. No specific information related to the opportunity for an in-person meeting was found. United could include this notification in the provider handbook, orientation materials or on the provider website. • **United response:** Agreed, submitting to add to KY Provider Manual. Estimated publication is early January, 2022. **Coverage and Authorization of Services (4):** **CFR 438.210 and State contract 20.1 Utilization Management Program:** The Contractor shall submit the UM Program description to the Department for approval within thirty (30) Days of signing the Contract, annually and at any time when making material revisions. • **Recommendation:** The MCO provided two Utilization Management Program Description documents. However, IPRO was unable to locate language which met this requirement in either document. Language stipulating that, "The Contractor shall submit the UM Program description to the Department for approval within thirty (30) Days of signing the Contract, annually and at any time when making material revisions" should be included into the MCO's Utilization Management Program Description. • **United response:** Agree: The plan will update the language in the program description. **CFR 438.21 and State Contract 20.5 Service Authorization:** A. Require Prior Authorization, medical review, or administrative clearance for telehealth that would not be required if a service were provided in person; • **Recommendation:** The MCO provided a Telehealth and Telemedicine Reimbursement Policy. However, this policy did not include language in accordance with KRS 205.5591. IPRO recommends that the plan includes language into their Telehealth and Telemedicine Policy restricting any mandate of prior authorization, medical review, or administrative clearance for telehealth that would not otherwise be required if a service were provided in person. "KY Medicaid and Medicaid managed care organizations are restricted from requiring prior authorization, medical review or administrative clearance for telehealth that would not be required if a service were provided in-person". • **United Response:** Agree: UCSMM 06 10 Clinical Review Criteria updated 12/28/2021 has been updated to include this information. **CFR 438.21 and State Contract 20.5 Service Authorization:** B. Demonstration that it is necessary to provide services to an Enrollee through telehealth; and • **United response:** Agree: UCSMM 06 10 Clinical Review Criteria updated 12/28/2021 has been updated to include this information. **CFR 438.21 and State Contract 20.5 Service Authorization:** C. Restrict or deny coverage of telehealth based solely on the communication technology or application used to deliver the telehealth services. • **Recommendation:** The MCO provided a Telehealth and Telemedicine Reimbursement Policy. However, this policy did not include language in accordance with KRS 205.5591. IPRO recommends that the plan includes language concerning the restriction or denial of coverage into their Telehealth and Telemedicine Policy. "KY Medicaid and Medicaid managed care organizations are restricted from restricting or denying coverage of

Summary of Not Met Review Findings

telehealth based solely on the communication technology or application used to deliver the telehealth service."

- **United response:** Agree: UCSMM 06 10 Clinical Review Criteria updated 12/28/2021 has been updated to include this information.

Subcontractual Relationships and Delegation (5):

State Contract H. For Subcontractors that will contract with Providers, specify the following:

1. Use of only Medicaid enrolled providers in accordance with this Contract;

- **Recommendation:** The Plan did not provide evidence to show subcontractors that contract with Providers specify the Use of only Medicaid enrolled providers in accordance with the Contract.
  Includes review results for each subcontractor.
  This requirement was not demonstrated in subcontracts provided by the Plan for review.
- **United response:** Disagree: The section referenced above includes details of the review that is conducted by the Department. Their review is outside the scope of United's delegation. Our only responsibility is to provide documentation to the Department and receive their documented approval using the Sharpoint Vendor Library.
  As stated in the #8_Approval of Subcontractors Narrative, UnitedHealthcare Community Plan of KY only partners with subcontractors that have been approved in writing by the Department. All current subcontractors have been approved by the Department, using the state Sharepoint Vendor library (https://sp13external.chfs.ky.gov/sites/DMS/mcoreview/SitePages/Home.aspx). Along with any pertinent Scope of Work or Master Service Agreement, UHC will also provide the Department with a summary of services to be provided by the subcontractor; this is also sent through the same Sharepoint Vendor Library. Attached is the most recent vendor summary submitted and approved by the department, which includes the scope of services.
- **IPRO Final Findings:** The context of this requirement is that [Line 26] all Subcontract template agreements include the following information and related requirements: [Line 34] For Subcontractors that will contract with Providers, specify the following: Since the required language that Subcontractors use only Medicaid enrolled providers is not included within documentation provided for review, including Subcontracts, this requirement is Not Met. No change in review determination.

State Contract - The Department's review shall ensure that all Subcontract template agreements include the following information and related requirements, at a minimum and as applicable to the given Subcontract:

H. For Subcontractors that will contract with Providers, specify the following:

2. Inclusion of all requirements set forth in Appendix B. "Required Standard Provisions for Network Provider Contracts";

- **Recommendation:** The Plan did not provide evidence to show subcontractors that contract with Providers, specify the Inclusion of all requirements set forth in Appendix B. "Required Standard Provisions for Network Provider Contracts"
  Includes review results for each subcontractor.
  This requirement was not addressed in subcontracts provided by the Plan for review.
- **United response:** The section referenced above includes details of the review that is conducted by the Department. Their review is outside the scope of United's delegation. Our only responsibility is to provide documentation to the Department and receive their documented approval using the Sharpoint Vendor Library.
  As stated in the #8_Approval of Subcontractors Narrative, UnitedHealthcare Community Plan of KY only partners with subcontractors that have been approved in writing by the Department. All current subcontractors have been approved by the Department, using the state Sharepoint Vendor library (https://sp13external.chfs.ky.gov/sites/DMS/mcoreview/SitePages/Home.aspx). Along with any pertinent Scope of Work or Master Service Agreement, UHC will also provide the Department with a summary of services to be provided by the subcontractor; this is also sent through the same Sharepoint Vendor Library. Attached is the most recent vendor summary submitted and approved by the department, which includes the scope of services.
- **IPRO Final Findings:** The context of this requirement is that [Line 26] all Subcontract template agreements include the following information and related requirements: [Line 34] For Subcontractors that will contract with Providers, specify the following: Since the required language that "Required Standard Provisions for Network Provider Contracts" is not included within documentation provided for review, including Subcontracts, this requirement is Not Met. No change in review determination.

O. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the Subcontract, including without limitation, the obligation to comply with all applicable federal and Commonwealth law and regulations, including but not limited to, KRS 205.8451-8483, all rules, policies and procedures

Summary of Not Met Review Findings
of FAC and the Department, applicable sub-regulatory guidance and contract provisions, and all standards governing the provision of Covered Services and information to Enrollees, all QAPI requirements, • **Recommendation:** The requirement that the requirement of subcontractors follow all QAPI requirements be included within subcontracts was not demonstrated in documentation provided by the Plan for review. • **United response:** Disagree: The section referenced above includes details of the review that is conducted by the Department. Their review is outside the scope of UHC's delegation. Our only responsibility is to provide documentation to the Department and receive their documented approval using the Sharpoint Vendor Library. As stated in the #8_Approval of Subcontractors Narrative, UnitedHealthcare Community Plan of KY only partners with subcontractors that have been approved in writing by the Department. All current subcontractors have been approved by the Department, using the state Sharepoint Vendor library (https://sp13external.chfs.ky.gov/sites/DMS/mcoreview/SitePages/Home.aspx). Along with any pertinent Scope of Work or Master Service Agreement, UHC will also provide the Department with a summary of services to be provided by the subcontractor; this is also sent through the same Sharepoint Vendor Library. Attached is the most recent vendor summary submitted and approved by the department, which includes the scope of services. • **IPRO Final Findings:** The context of this requirement is that [Line 26] all Subcontract template agreements include the following information and related requirements. Since the required language that subcontractors follow all QAPI requirements is not included within Subcontracts provided for review, this requirement is Not Met. No change in review determination. **Z. A statement that the Subcontract may be terminated by the Contractor** for convenience and without cause upon a specified number of days written notice; • **Recommendation:** A statement that the Subcontract may be terminated by the Contractor for convenience and without cause upon a specified number of days written notice was not included in any documentation provided by the Plan for review. Includes review results for each subcontractor. The subcontracts reviewed did not include a statement that the Subcontract may be terminated by the Contractor for convenience and without cause upon a specified number of days written notice. • **United response:** Agree that our subcontracts do not contain termination for convenience, but would still like to appeal, based on the following: We should not be held accountable to this item because this is the responsibility of the Department. • **IPRO Final Findings:** The context of this requirement is that [Line 26] all Subcontract template agreements include the following information and related requirements: Since the required statement that the Subcontract may be terminated by the Contractor for convenience and without cause upon a specified number of days written notice is not included within Subcontracts provided for review, this requirement is Not Met. No change in review determination. **AA. Specify procedures and criteria** for extension, renegotiation and termination. • **Recommendation:** The procedures and criteria for extension, renegotiation and termination were not included in any documentation provided by the Plan for review. Includes review results for each subcontractor. The subcontracts reviewed did not include procedures and criteria for extension, renegotiation and termination. • **United response:** Agree that the subcontracts provided do not provide specific language around criteria for extension or renegotiations, but I would still like to appeal, based on the following: We should not be held accountable to this item because this is the responsibility of the Department. • **IPRO Final Findings:** The context of this requirement is that [Line 26] all Subcontract template agreements include the following information and related requirements:. Since the required language specifying procedures and criteria for extension, renegotiation and termination is not included within provided for review, this requirement is Not Met. No change in review determination.
WellCare
WellCare's review totaled 730 elements, of which none of the elements were determined to be Not Met.

MCO: managed care organization; HIS: health information systems; MMIS: Medicaid Management Information System; QAPI: Quality Assessment and Performance Improvement; HEDIS: Healthcare Effectiveness Data and Information Set; KRS: Kentucky Revised Statutes; UM: utilization management; UHC: UnitedHealthcare Community Plan.