TEAM KENTUCKY

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

Fiscal Year 2021 Comprehensive Evaluation Summary Commonwealth of Kentucky Strategy for Assessing and Improving the Quality of Managed Care Services

Final

State Fiscal Year 2021: July 1, 2020 – June 30, 2021

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Introduction

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

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

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

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

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

The intent of this summary report is to review and describe the quality monitoring and management of Kentucky's MMC program by using updated information, reports, and interviews conducted during the period July 1, 2020, through June 30, 2021. As part of the introduction, recent developments in Kentucky's MMC program are discussed including a description of program monitoring responsibilities and evaluation methodology.

Medicaid Managed Care in Kentucky – Recent Progress

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

Effective January 1, 2021, DMS entered into new contracts with six risk-based MCOs serving Kentucky Medicaid enrollees statewide: Aetna Better Health of Kentucky (Aetna), Anthem Blue Cross and Blue Shield (Anthem), Humana Healthy Horizons in Kentucky (Humana), Passport Health Plan by Molina Healthcare of Kentucky (Passport by Molina), UnitedHealthcare Community Plan (UHC), and WellCare of Kentucky (WellCare). Medicaid MCOs in Kentucky are required to obtain and maintain national accreditation with the National Committee for Quality Assurance (NCQA). Four MCOs (Aetna, Anthem, Humana, and WellCare) are currently accredited by NCQA, while the MCOs new to Kentucky Medicaid (Passport by Molina and UHC) will be required to obtain accreditation within two to four years. Any information provided in this evaluation prior to January 2021 will refer to Passport Health Plan.

Between April 2019 and April 2021, statewide program enrollment increased by 23.1%, with all MCOs experiencing enrollment growth. Anthem saw the largest percent increase in enrollment of 25.4%, while Passport by Molina had the

lowest percent increase of 6.4%. On 1/1/2021, UHC began managing the presumptive eligible population that was being covered by the FFS population in 2020. (**Table 1**).

Table 1: List of Current Kentucky Medicaid MCOs by Enrollment

MCO	Enrollment 4/2019	Enrollment 4/2020	Enrollment 4/2021	Percent Change 2019 - 2021
Aetna	213,996	211,220	244,373	14.2%
Anthem	127,620	136,633	159,978	25.4%
Humana	143,051	147,788	167,293	16.9%
Passport by Molina[1]	305,051	303,197	324,486	6.4%
UHC	N/A	N/A	140,251	N/A
WellCare	435,981	441,271	472,939	8.5%
Total	1,225,699	1,240,109	1,509,320	23.1%

[1] Passport Health Plan was purchased by Molina Healthcare of Kentucky effective 1/1/2021. Enrollment presented for 4/2019 and 4/2020 is for Passport Health Plan, while enrollment as of 4/2021 is for the newly contracted MCO referred to as Passport Health Plan by Molina Healthcare.
Source: Cabinet for Health and Family Services, Kentucky Data Warehouse Monthly Membership Counts by County; run dates respectively, 4/1/2019, 4/1/2020 and 4/6/2021.
MCO: managed care organization; UHC: UnitedHealthcare Community Plan. N/A: not applicable, UHC was not a KY MCO during 2019 or 2020.

Responsibility for Program Monitoring

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

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

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

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

Evaluation Methodology

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

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

Core Program Performance Results

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

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

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

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

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

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

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

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

Table 3 presents the statewide HEDIS measures listed in the 2019 Quality Strategy. The clinical measures, many of which are drawn from the National Quality Forum (NQF)[11] data set, were not collected in RY 2020. Overall, there were 41 measures evaluated, including 17 discrete measures and 9 measures with 2 or more sub-categories. Excluding the 6 measures that should not be trended according to NCQA, 19 of the remaining 35 measures (54%) showed improvement in rates between HEDIS 2018 and HEDIS 2020, while the other 16 trendable measures (46%) did not show improvement. Compared to national benchmarks, rates for 8 of the 41 measures (20%) met or exceeded the national 50th percentile, while 19 measure rates (46%) met or exceeded the national 25th percentile, but were below the national 50th percentile, and another 14 measure rates (34%) were below the national 25th percentile.

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

Measure	Goal[1]	Data[2] Admin (A) or Hybrid (H)	Kentucky HEDIS Rate Denominators 2018	2019	2020	Kentucky HEDIS Statewide Averages[3] 2018	2019	2020	Trend[4] Percentage Point Change HEDIS 2018 to HEDIS 2020	Benchmark Kentucky HEDIS 2020 vs. National Percentile
Antidepressant Medication Management (AMM)										
AMM: Effective Acute Phase Treatment	1	A	29,102	29,645	31,599	52.92%	51.49%	51.58%	-1.34	> 25
AMM: Effective Continuation Phase Treatment	1	A	29,102	29,645	31,599	38.61%	35.11%	35.04%	-3.57	> 25
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET) denominator										
IET: Initiation of Treatment: Total	1	A	46,488	51,439	49,028	42.67%	45.71%	51.12%	8.45	> 75
IET: Engagement of Treatment: Total	1	A	46,488	51,439	49,028	19.43%	21.69%	26.28%	6.85	> 90
Use of Opioids at High Dosage (HDO)[5]	1	A	NR	50,483	39,278	NR	1.30%	1.91%	NT	> 75
Controlling High Blood Pressure (CBP)	2	H	2,042	2,055	2,055	51.68%	56.48%	56.48%	4.80	> 25
Comprehensive Diabetes Care (CDC)										
CDC: Hemoglobin A1c (HbA1c) Testing	2	H	3,124	2,976	3,008	86.93%	87.38%	88.03%	1.10	> 25
CDC: HbA1c Poor Control (> 9.0%)[5]	2	H	3,124	2,976	3,008	47.18%	48.19%	47.96%	0.78	< 25
CDC: HbA1c Control (< 8.0%)	2	H	3,124	2,976	3,008	43.22%	41.89%	42.82%	-0.40	< 25
CDC: HbA1c Control (< 7.0%)	2	H	2,214	2,198	2,198	31.75%	30.98%	31.09%	-0.66	> 25
CDC: Eye Exam (Retinal) Performed	2	H	3,124	2,976	3,008	52.12%	50.63%	50.70%	-1.42	< 25
CDC: Medical Attention for Nephropathy	2	H	3,124	2,976	3,008	89.81%	90.01%	89.65%	-0.16	> 25
CDC: Blood Pressure Control (< 140/90mmHg)	2	H	3,124	2,976	3,008	51.68%	59.73%	59.66%	7.98	> 25
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	2	A	7,167	7,712	7,713	32.90%	30.78%	28.81%	-4.09	> 25
Pharmacotherapy Management of COPD Exacerbation (PCE; 2 measures)										
PCE: Systemic Corticosteroid	2	A	10,117	10,204	9,931	70.91%	65.87%	67.54%	-3.37	> 25
PCE: Bronchodilator	2	A	10,117	10,204	9,931	82.11%	76.55%	76.73%	-5.38	< 25
Medication Management for People with Asthma (MMA)										
MMA: Total – Medication Compliance 75%	2	A	15,812	15,051	14,603	40.29%	42.34%	42.61%	2.32	> 50

Measure	Goal[1]	Data[2]	Kentucky HEDIS Rate Denominators			Kentucky HEDIS Statewide Averages[3]			Trend[4]	Benchmark
		Admin (A) or Hybrid (H)	2018	2019	2020	2018	2019	2020	Percentage Point Change HEDIS 2018 to HEDIS 2020	Kentucky HEDIS 2020 vs. National Percentile
Statin Therapy for Patients with Cardiovascular Disease (SPC)										
SPC: Received Statin Therapy Total	2	A	10,349	11,304	11,453	77.54%	75.98%	77.38%	-0.16	> 25
SPC: Statin Adherence 80% Total[4]	2	A	8,025	8,581	8,852	65.97%	65.03%	66.69%	0.72	> 25
Adult BMI Assessment (ABA)	3	H	1,863	1,992	1,992	86.57%	90.29%	90.72%	4.15	> 25
Cervical Cancer Screening (CCS)[4,6]	3	H	42,037	2,039	2,055	54.65%	58.86%	58.86%	4.21	> 25
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)										
WCC: BMI Percentile Total	3	H	2,032	2,055	2,055	72.06%	82.65%	80.91%	8.85	> 50
WCC: Counseling for Nutrition Total	3	H	2,032	2,055	2,055	57.12%	61.98%	61.44%	4.32	< 25
WCC: Counseling for Physical Activity Total	3	H	2,032	2,055	2,055	51.52%	54.93%	55.53%	4.01	< 25
Childhood Immunization Status: Combination 3 (CIS)	3, 5	H	2,055	2,055	2,055	64.37%	71.02%	70.78%	6.41	> 25
Breast Cancer Screening (BCS)	3	A	45,906	50,618	52,094	52.93%	51.90%	50.84%	-2.09	< 25
Chlamydia Screening in Women (CHL) Total	3	A	53,981	54,123	52,708	53.88%	55.21%	55.23%	1.35	> 25
Immunizations for Adolescents (IMA)										
IMA: Human Papillomavirus Vaccine for Female Adolescents (HPV)	3	H	2,055	2,055	2,055	23.87%	33.01%	34.80%	10.93	> 25
Annual Dental Visit (ADV)	3	A	449,417	456,040	449,035	60.64%	59.52%	48.39%	-12.25	< 25
Well-Child Visits in the First 15 Months of Life ≥ 6 Visits (W15)[6]	3, 5	H	4,021	1,931	1,912	65.77%	63.02%	65.46%	-0.31	> 25
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	3, 5	H	1,965	1,903	1,903	69.00%	67.42%	67.42%	-1.58	< 25
Follow-up After Hospitalization for Mental Illness (FUH)										
FUH: 7-Day Follow-up	4	A	10,509	12,329	1,1047	34.26%	35.12%	36.72%	2.46	> 25
FUH: 30-Day Follow-up	4	A	10,509	12,329	1,1047	56.62%	55.97%	57.27%	0.65	> 25
Appropriate Testing for Children with Pharyngitis (CWP)	4	A	39,124	33,531	146,677	81.09%	83.52%	80.97%	NT	> 50
Appropriate Treatment for Children with URI (URI)	4	A	37,442	36,753	177,467	70.77%	75.35%	71.12%	NT	< 25
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	4	A	18,887	18,376	48,502	20.77%	23.64%	34.28%	NT	< 25

Measure	Goal[1]	Data[2]	Kentucky HEDIS Rate Denominators			Kentucky HEDIS Statewide Averages[3]			Trend[4]	Benchmark
		Admin (A) or Hybrid (H)	2018	2019	2020	2018	2019	2020	Percentage Point Change HEDIS 2018 to HEDIS 2020	Kentucky HEDIS 2020 vs. National Percentile
Use of Imaging Studies for Low Back Pain (LBP)	4	A	24,051	23,230	21,687	60.74%	60.86%	65.25%	4.51	< 25
Follow-up Care for Children Prescribed ADHD Medication (ADD)										
ADD: Initiation Phase	5	A	7,530	7,756	8,024	57.18%	46.45%	51.41%	-5.77	> 75
ADD: Continuation and Maintenance (C&M) Phase	5	A	2,741	2,354	2,473	63.55%	57.22%	63.32%	-0.23	> 75
Prenatal and Postpartum Care (PPC)										
PPC: Timeliness of Prenatal Care	5	H	2,020	2,051	2,051	79.46%	82.09%	83.97%	NT	< 25
PPC: Postpartum Care	5	H	2,020	2,051	2,051	56.41%	60.21%	65.63%	NT	< 25

[1] Kentucky's 2019 Quality Strategy identified five program goals:

Goal 1. Reduce the burden of SUD and engage enrollees to improve behavioral health outcomes.

Goal 2. Reduce the burden of and outcomes for chronic diseases.

Goal 3. Increase preventive service use.

Goal 4. Promote access to high quality care and reduce unnecessary spending.

Goal 5. Improve care and outcomes for children and adults, including special populations.

[2] A: Administrative measures use claims/encounters for hospitalizations, medical office visits, and procedures or pharmacy data.

H: Hybrid measures combine data obtained from the member's medical record with administrative data.

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

[4] Trending should be viewed with caution as per NCQA.

[5] A lower rate is better.

[6] Aetna reported administrative for this measure in HEDIS 2018.

HEDIS: Healthcare Effectiveness Data and Information Set; NR: not reported; BMI: body mass index.

NT: not trendable, as per NCQA includes the following measures: Goal 1: Use of Opioids at High Dosage (HDO); Goal 4: Appropriate Testing for Children with Pharyngitis (CWP); Appropriate Treatment for Children with URI (URI) and Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB); and Goal 5: PPC: Timeliness of Prenatal Care and PPC: Postpartum Care.

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

There are five HEDIS measures in Goal 1, but only four could be compared to previous years' rates. The two IET measures, Initiation and Engagement of AOD Abuse and Dependence Treatment, increased steadily over the last three years, while the two rates for Antidepressant Medication Management (AMM) decreased. Since the previous year, the rate for IET: Initiation of Treatment Total showed an improved benchmark rating at or above the national 75th percentile but below the 90th percentile, while the rate for IET: Engagement of Treatment Total continued to be greater than the national 90th percentile. The Use of Opioids at High Dosage (HDO) measure resulted in a rate that met or exceeded the national 75th percentile but was below the 90th percentile. Both of the AMM measures were at or above the national 25th percentile but below the 50th percentile.

Goal 2: Reduce the Burden of Outcomes for Chronic Diseases

Measures of chronic disease continue to perform poorly. Of the 14 measures for this goal, 5 (36%) saw improvement between HEDIS 2018 and HEDIS 2020. Of the Goal 2 measures, 1 (7%) was rated at or above the national 50th percentile, but below the 75th percentile (MMA: Total – Medication Compliance 75%), leaving 13 measures (93%) with rates below the national 50th percentile, including 4 measure rates that were below the national 25th percentile.

Goal 3: Increase Preventive Service Use

Kentucky's performance in preventive service use showed much improvement, with rates for 8 (67%) of the 12 measures showing increases between HEDIS 2018 and 2020. While this is encouraging, only 1 (8%) of the Goal 3 measures had a HEDIS 2020 rate that was at or above the national 50th percentile but below the national 75th percentile, leaving opportunities for improvement in the other 11 measures, including 5 measures with HEDIS 2020 rates below the national 25th percentile.

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

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

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

There were seven HEDIS measures in Goal 5, including three measures that were also considered in Goal 3 (CIS, W15, and W34). Of these seven measures, five were able to be trended, but only one of the five measure rates (20%), CIS: Combination 3, increased between HEDIS 2018 and HEDIS 2020. The two ADD measures had rates at or above the national 75th percentile but below the 90th percentile, while rates for two other measures (CIS: Combination 3 and W15) were at or above the national 25th percentile but below the 50th percentile. The remaining three measures (W34, PPC: Timeliness of Prenatal Care and PPC: Postpartum Care) were below the national 25th percentile.

It should be noted that the data measured for HEDIS 2020 (MY 2019) predated the COVID-19 pandemic; however, data collection during the pandemic was a challenge for all the MCOs. Using remote access, medical record retrieval was hindered by physician offices that were often closed and by an overall decrease in utilization of services.

Discussion of Core Program Performance Results

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

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

Goal	Clinical Measures	HEDIS 2020 Measures Used
1	Screening for Clinical Depression and Follow-up Plan (NQF 418)	No HEDIS equivalent for RY 2020
2	Statin Therapy for Patients with Cardiovascular Disease (CMS 347v1eCQM)	Statin Therapy for Patients with Cardiovascular Disease (SPC)
2	Diabetes Care: Hemoglobin (HbA1c) Poor Control (> 9.0%) (NQF 59)	CDC: HbA1c Poor Control (> 9.0%)
2	Controlling High Blood Pressure (Hypertension) (NQF 18)	Controlling High Blood Pressure (CBP)
3	Breast Cancer Screening (NQF 2372)	Breast Cancer Screening (BCS)
3	Colorectal Cancer Screening (NQF 32)	Not collected for Medicaid in RY 2020
3	Tobacco Use: Screening and Cessation (NQF 28)	No HEDIS equivalent for RY 2020
3	Body Mass Index (BMI) Screening and Follow-up (NQF 42)	Adult BMI Assessment (ABA) and Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC: BMI Percentile Total); No HEDIS equivalent for Follow-up
3	Childhood Immunization Status (NQF 38)	Childhood Immunization Status: Combination 3 (CIS)
3, 5	Well-Child Visits, 3–6 years and first 15 months (NQF 1516)	NQF 1516 includes only Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life. This analysis used Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)
3, 5	Well-Child Visits, First 15 months (NQF 1392)	Well-Child Visits in the First 15 Months of Life ≥ 6 Visits (W15)
4	Medication Reconciliation Post-Discharge (NQF 97)	No HEDIS equivalent for RY 2020
4	30-day All Cause Readmissions (NQF 1768)	Not collected in Kentucky for RY 2020

HEDIS: Healthcare Effectiveness Data and Information Set; RY: reporting year.

There were also two listed HEDIS measures that have been retired by NCQA. No current data are available for either measure:

- Appropriate Medications for People with Asthma (ASM – Goal 2); and
- Frequency of Ongoing Prenatal Care (FPC – Goal 5).

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

The strategy also notes that DMS will establish state-level baselines for all reported measures and set state-level performance thresholds for each measure using the baseline data as they continue to evaluate the effectiveness of the MMC program in meeting the goals set forth in this strategy. This is now being addressed in the QM-03 reporting tool as follows: Benchmark Goal, Annual HEDIS Rate and Quarterly Rate Target – In state fiscal year (FY) fourth (4th) quarter, include the annual HEDIS rate for the most recently concluded calendar year as soon as results are available and no later than August 15th of each year. For the annual HEDIS rate for each measure, set Benchmark goal to exceed previous year Quality Compass percentile results for the measure's most recent available annual HEDIS rate. For each quarterly administrative rate target, set goal to increase the prior calendar year quarter rate by a minimum of 2% in the same quarter in the current calendar year.

Quality Monitoring

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

Data Reporting Systems Review

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

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

Provider Network Data

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

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

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

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

The objective of the provider network validation audit is to assess the accuracy of the MCOs' provider directory data files for Medicaid participating PCPs and specialists. Data validation surveys were sent to a random sample of 100 primary care providers (PCPs) and 100 specialists from each of the five MCOs: Aetna, Anthem, Humana, Passport, and WellCare. The overall response rate was 22.1%. After removing exclusions, data from 207 providers was available for analysis.

Based on the findings of this audit, it was recommended that DMS:

- follow up with MCOs to correct provider records for the errors identified by this audit;
- work with plans to enhance the accuracy and completion of critical fields in the provider directory data files, especially fields relating to license number, phone number, address and languages spoken;
- expand the data dictionary to include more specificity in the definitions of the data elements to help facilitate MCOs' submission of accurate and complete data. For example, for the language fields, codes are provided without further instruction to ensure that each provider should report at least one language;
- consider adding data elements to the Managed Care Assignment Processing System (MCAPS) that collect information about wheelchair access, hours at site, provider usage of health information technology (HIT; such as electronic medical record [EMR] systems), and providers' patient-centered medical home (PCMH) certification status and level;
- consider removing the field "Spanish" and incorporating it into the "Language" field;
- consider recording "Secondary Specialty" on the same row as "Primary Specialty" instead of on separate rows; and
- consider adding interpreter services/translation services as codes to the data dictionary of the language field, since some providers noted this on the survey, but there is no code to capture such services in the MCAPS.

It was also recommended that IPRO:

- furnish the names and addresses of the surveys that were undeliverable to the MCOs for further research. This information was provided to DMS as part of the provider survey plan specific results files.

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

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

The objectives of this study were twofold:

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

Using the most recent monthly provider data submitted to the EQRO from each of the 5 Medicaid MCOs (Aetna, Anthem, Humana, Passport by Molina, and WellCare) in February 2021, a random sample of providers who responded to the provider network submission survey was selected, with a limit of no more than 50 providers from each MCO (i.e., 25 PCPs and 25 specialists). Overall, 85% of PCPs and 71% of specialists in the web validation sample were found in the web directories. Seventy-four percent (74%) of the sampled PCPs across all the plans and 98% of sampled specialists had accurate information published in the web directories.

It was recommended that DMS follow up with MCOs to ensure that any inaccuracies in provider information from this validation study and the provider network survey are corrected, and that these corrections are also reflected in the MCOs' provider files and web directories. They were further encouraged to work with the MCOs to enhance the accuracy and completeness of the web directories regarding critical fields in the MCO provider files, especially with respect to phone numbers and addresses.

Quality Performance Data

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

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

- 2021 Guide to Choosing Your Health Plan; and
- 2021 External Quality Review Technical Report.

2021 Guide to Choosing Your Health Plan

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

The format for 2021 is a two-page document with an MCO comparison of quality metrics for five performance areas: Getting care; Children and adolescent wellness; Satisfaction with plan services; Women's health; and Treatment. Each area is further defined by a brief list of what information is evaluated for each area. This tool is a consumer-friendly document that assesses each MCO's performance by the number of stars shown (i.e., 5 stars represents highest performance, 4 stars for high performance, 3 stars for average, 2 stars for low performance, and 1 star for lowest performance). There are also five questions to ask when trying to determine which MCO one should choose and a list of MCO phone numbers and website addresses.

With each new version, DMS, in collaboration with the EQRO, has revised the content and format of the report. In light of the new Final Rule requirement for MMC programs to develop and publish an annual Quality Rating System (QRS) report, DMS will need to further evaluate the content and format of this annual report card. During the MCO interviews, all MCOs were generally supportive of the format and design of the report card but had numerous comments and suggestions regarding the content of the report and thoughts about future report cards.

- There were several comments concerning the COVID-19 pandemic and how it may have adversely affected the HEDIS and CAHPS results; MCOs suggested that next year's report could include a statement regarding this.

- One MCO would like to see the same measures repeated from year to year so the MCO could focus on improving those rates.
- Another MCO commented that they would like to see the HEDIS and CAHPS measure data separated rather than combined in composite measures.
- MCOs expressed concern regarding the timing of the report card. Because the report card is used during the open enrollment period, the Quality Compass benchmarks for that year are not yet available; thus, the measure data for each report are compared to the previous year's Quality Compass benchmark percentiles.
- One MCO commented that they would like to have an opportunity to review the underlying data included and see a visual of the report before it is finalized.

2021 External Quality Review Technical Report

The BBA requires state agencies that contract with Medicaid MCOs to prepare an annual external, independent review of quality outcomes, timeliness, and access to healthcare services. The 2021 External Quality Review Technical Report, completed in April 2021 for MCO contract years 2018–2020, includes results for five Kentucky Medicaid MCOs: Aetna, Anthem, Humana, Passport, and WellCare. The report provides quality performance data, CAHPS satisfaction data, results of compliance reviews and validation of PIPs. MCO strengths and opportunities for improvement are also outlined for each MCO. Each year's technical report is required to include a section in which each MCO responds to recommendations listed for their MCO in the previous year's report. The Final Rule maintains the importance of the annual technical report and requires states to finalize and post the annual EQR report on their website by April 30 of each year.[13] The report can be found on DMS website at (KY 2021 Technical Report).

MCO Reporting Requirements

The state's current Medicaid MCO contract incorporates established standards for access to care, structure and operations and quality measurement and improvement. To monitor MCO compliance with these standards, Appendix D. of the 2021 MCO contract (Reporting Requirements and Reporting Deliverables) includes a list of monitoring reports for MCOs to submit on a monthly, quarterly, and/or annual basis. As stated in the contract, this list is subject to change based on a finalized MCO reporting package as well as throughout the contract term should DMS identify a need for different reports. All three branches in the Division of Program Quality and Outcomes (DPQO) have assigned staff responsible for reviewing specific reports to ensure that they are adequately reviewed, and information is tracked and evaluated.

Originally created in September 2011, there were 152 required reports and 11 exhibits with crosswalks, definitions, and codes. The most recently updated version of required reporting from the FY 2021 MCO contracts, which were effective January 1, 2021, contains 73 active reports (48% of the original list of 152). Required report topics cover: administration and finance; behavioral health; claims payment; enrollee services; Supporting Kentucky Youth (SKY) program; pharmacy; population health management; provider services and network ; program integrity; quality management; and utilization management.

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

During the MCO interviews, several MCOs commented on the expected challenges the MCOs will face in completing the QM-03 report and suggested that it would be helpful if DMS provided more instructions on completing some of the tabs on the report. It was also noted that there is some duplication with other reports. Considerations to lessen the reporting and review burden should continue to be discussed including reducing the frequency of report submissions and/or using other state administrative sources for some of the requested data.

Annual Compliance Reviews

Federal regulations require that every state with an MMC program conduct a full review of MCO compliance with state and federal regulations at least once every three years. The reviews can be done by the state or the EQRO. In Kentucky, the EQRO conducts the annual reviews for compliance with contract requirements and state and federal regulatory standards. According to 42 CFR§ 438.360, states can use information obtained from a national accrediting organization's review for the mandatory external quality review activities conducted by either the state or its EQRO. With this authority, states can deem NCQA standards equivalent to state requirements and thus use the information obtained through accreditation surveys to streamline their oversight process. Kentucky has preferred to use a policy for deeming based on previous plan performance rather than deeming based on accreditation. DMS remains committed to conducting compliance reviews on an annual basis.

In October 2020, IPRO used remote access tools to conduct reviews of compliance with regulatory standards and contract requirements for five MCOs: Aetna, Anthem, Humana, Passport, and WellCare. DMS commented that the process went smoothly; it was orderly and all components were completed as required. It was suggested that IPRO present the tool during the remote review to help the MCO participants follow the discussion. DMS indicated that they are considering a hybrid approach in the future, going remote for interim reviews and in-person reviews for full audits. When queried about this process during the MCO interviews, it was generally felt to be an effective way of conducting the review; some MCOs indicated that they would have no problem continuing to participate remotely in future compliance reviews. The remote review was found to be particularly convenient for MCOs with out-of-state staff wanting to participate in the compliance review interviews.

In order to make an overall compliance determination for each of the 16 domains, an average score is calculated. This is determined first by assigning a determination to each element based on the designation assigned by the reviewer. A numerical score for each domain is then calculated by adding the points achieved for each element and dividing the total by the number of elements, thus resulting in a final overall compliance determination of either Full, Substantial, Minimal, or Non-compliance.

The final findings for each MCO review are sent to the MCOs and to DMS. Two DMS divisions, the Managed Care Oversight – Quality Branch and the Managed Care Oversight – Contract Management Branch, work together to review the findings and determine if a Letter of Concern (LOC) and/or a Corrective Action Plan (CAP) request is required. The CAP/LOC Committee issues the LOCs and CAP requests to the MCOs. In general, the MCOs must provide a CAP for all minimal or non-compliance elements.

Results from the October 2020 Compliance Reviews indicated a high level of compliance with contract and state and federal regulations (**Table 5**). Of the 78 areas reviewed for all five MCOs overall, 33 (42.3%) received full overall compliance determinations and 44 (56.4%) received substantial overall compliance determinations. All five MCOs received full overall determinations in QAPI: Health Information Systems. There was one overall determination of minimal in the review area of Enrollee Rights and Protection: Member Education and Outreach for Anthem. Overall, 50 (2.3%) of all 2,171 elements reviewed received a minimal or non-compliance rating.

Table 5 displays the overall final compliance determinations for each domain reviewed in October 2020 for SFY 2020 (July 1, 2019–June 30, 2020) for each of the MCOs.

Table 5: Overall Final Compliance Determination by Review Domain – Reviews Conducted in October 2020

Review Area (Tool #)	Aetna	Anthem	Humana	Passport	WellCare
Behavioral Health Services (15)	Substantial	Full	Substantial	Substantial	Substantial
Case Management/Care Coordination (10)	Substantial	Substantial	Substantial	Substantial	Substantial
Enrollee Rights and Protection: Enrollee Rights (12a)	Substantial	Full	Substantial	Substantial	Full
Enrollee Rights and Protection: Member Education and Outreach	Substantial	Minimal	Substantial	Substantial	Full

Review Area (Tool #)	Aetna	Anthem	Humana	Passport	WellCare
(12b)					
EPSDT (7)	Full	Full	Full	Substantial	Full
Grievance System (2)	Substantial	Substantial	Substantial	Substantial	Substantial
Health Risk Assessment (3)	Substantial	Full	Substantial	Substantial	
Medical Records (13)	Full		Substantial	Full	Full
Pharmacy Benefits (16)	Full	Full	Substantial	Substantial	Full
Program Integrity (6)	Substantial	Full	Substantial	Substantial	Substantial
QAPI: Access (5)	Substantial	Full	Substantial	Substantial	Substantial
QAPI: Access Utilization Management (5a)	Full	Full	Substantial	Full	Full
QAPI: Measurement & Improvement (1)	Substantial	Substantial	Substantial	Substantial	Substantial
QAPI: Health Information Systems (9)	Full	Full	Full	Full	Full
QAPI: Structure and Operations – Credentialing (4)	Full	Full	Full	Substantial	Full
QAPI: Structure and Operations – Delegated Services (8)	Substantial	Full	Substantial	Full	Full
Number of Elements Requiring LOC or CAP/Total Elements Reviewed (%)	12/464 (2.6%)	4/130 (3.1%)	16/676 (2.4%)	16/691 (2.3%)	2/210 (1.0%)

Source: 2020 External Quality Review Annual Technical Report.
Grey shading: domain was not reviewed this year; deemed based on prior year results.
EPSDT: Early and Periodic Screening, Diagnostic and Treatment; QAPI: Quality Assessment and Performance Improvement; CAP: corrective action plan.

Monitoring Access to Care

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

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

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

The EQRO initiated this survey in October 2020 to evaluate access to and availability of PCPs, Behavioral Health, and Substance Use Disorder providers participating with Medicaid MCOs. This study assessed the ability to contact providers and make office hour appointments for routine, urgent, and after-hours visits employing a "secret shopper" survey methodology. Electronically submitted provider network data from each of the five MCOs (Aetna, Anthem, Humana, Passport, and WellCare) were used for this study. A total of 1,250 providers were randomly selected for this survey representing primary care providers (PCPs), pediatricians, obstetricians/gynecologists (ob/gyns), behavioral health (BH) providers, and alcohol and substance use disorder (SUD) providers.

Overall, 74.7% of the providers for the routine calls and 83.4% of the providers for the urgent calls were able to be contacted. After removing exclusions, 34.9% of the providers for the routine calls and 19.5% of the providers for the urgent calls were able to be contacted and an appointment was able to be scheduled within the corresponding timeliness standards (i.e., 30 days and 48 hours, respectively). The overall compliance rate for after-hours calls was 48.5%.

For the routine and urgent calls where an appointment was able to be made, questions were added to the survey regarding provider use of telehealth appointments and if the provider asked about COVID-19 symptoms or exposure. While 87.4% of the routine call providers and 78.4% of the urgent call providers reported they used telehealth visits, surveyors were only able to set a telehealth appointment 18.2% of the time for routine calls and 3.9% of the time for urgent calls. Only a small proportion of providers reported that they asked about COVID-19 symptoms or exposure (4.7% of the routine call appointments and 7.2% of the urgent call appointments).

With overall compliance rates for routine, urgent, and after-hours calls all substantially below the standard of 80%, IPRO recommended that DMS work with the MCOs to increase contact and appointment rates for PCPs, pediatricians, ob/gyns, BH and SUD providers in order to ensure that members are able to access providers and obtain timely appointments.

When the survey portion of this study was completed, the EQRO prepared a listing for each MCO that included the providers who could not be contacted and reasons, those where no appointment could be made and reasons, those who offered appointments that were not within the compliant time frame, and providers who offered timely, compliant appointments. Plans were given 30 days to review the files and they submitted explanations regarding the contacts and appointments that were not made. MCOs were also instructed to update their provider directory systems to edit any provider data that were found to be inaccurate.

During the interview with DMS, it was noted that access and availability surveys are not be the only way that DMS assesses data completeness and suggested that with the 2021 MCO contracts, DMS would also be using geo-access reports to provide a more complete picture.

Early and Periodic Screening, Diagnostic, and Treatment Services

Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services is a federally required Medicaid program for children that includes two major components: EPSDT screenings and EPSDT special services. The screening program provides well-child check-ups and screening tests for Medicaid-eligible children in specified age groups. EPSDT special services are only provided when medically necessary, if they are not covered in another Medicaid program, or are medically indicated and needed in excess of a program limit. DMS contracts with Kentucky's EQRO to validate that the MCOs' administration of EPSDT benefits is consistent with federal and state requirements. Findings from the October 2020 Compliance Review showed overall full compliance for the EPSDT domain for Aetna, Anthem, Humana, and WellCare, and substantial compliance for Passport. There were no elements receiving minimal or non-compliant reviews for any of the MCOs regarding EPSDT.

Care Coordination

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

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

Related results from the October 2020 Compliance Review indicate the following:

- All five MCOs had overall substantial compliance review determinations for the Case Management/Care Coordination review domain. Out of a combined total of 76 elements reviewed for EPSDT, 7 elements (9%) received minimal compliance ratings.
- Compliance with Health Risk Assessment regulations was reviewed for four of the five MCOs, resulting in an overall full compliance determination for Anthem and overall substantial determinations for Aetna, Humana, and Passport. Out of a combined total of 28 elements reviewed for HRA, 1 element (4% of the total) received a minimal compliance rating.

- Compliance with Grievance System regulations resulted in an overall substantial compliance determination for all five MCOs. Out of a combined total of 94 elements reviewed for Grievance System, 8 elements (8.5%) received minimal compliance review ratings.

State-MCO-EQRO Communication

Communication and collaboration are important in promoting effective quality monitoring and improvement. On a regular basis, and sometimes ad hoc, communication between the state, MCOs, and the EQRO has evolved over time. IPRO continues to communicate regularly with both DMS, and with each MCO, by email and telephone to gather information for EQR activities and to provide technical assistance. IPRO conducts regular follow-up meetings with the MCOs to address PIP review findings and coordinate statewide PIP workgroups via WebEx. DMS convenes several topic specific meetings with the MCOs including Operations, Information Technology (IT), and Medical Directors... DMS conducts a monthly administration conference call with the EQRO.

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

The MCOs continue to report good working relationships with the state and the EQRO. Bi-weekly, one-on-one encounter data meetings between each MCO and DMS are helpful for resolving specific MCO encounter data questions and issues such as data submission and rejection issues. A recent meeting with all MCOs to discuss issues with wraparound services was found to be particularly beneficial to the MCOs. Communication with DMS is facilitated through the shared mailbox, and the MCOs report they get timely responses to resolve questions. Input and feedback from the MCOs is often sought, and both DMS and the EQRO are responsive to MCO phone calls and questions.

Strategies and Interventions to Promote Quality Improvement

DMS, in collaboration with the EQRO, conducts activities focused on quality improvement, including performance improvement projects (PIPs) and focused studies. This section discusses the current projects completed or ongoing by the MCOs, DMS and the EQRO.

Performance Improvement Projects

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

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

The PIP assessments are conducted using tools developed by IPRO and consistent with the CMS EQR protocol for PIP validation. The EQRO reviews PIPs for compliance at interim and final re-measurement **(Table 6).** For all final reports, the interim PIP score is re-evaluated based upon the extent to which the MCO addressed the interim PIP review comments. Additional points are earned for sustained improvement, as well as a corresponding interpretation of which goals were/were not met, lessons learned and follow-up activities.

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

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

Table 6 lists the final validation result scores for the statewide collaborative PIP completed in 2020.

Table 6: Final PIP Results – Reducing Potentially Preventable Hospitalizations and ED Visits for ACSCs, 2017–2020

MCO	Final Score	Final Compliance Level
Aetna	87.2	2
Anthem	81.4	2
Humana	85.4	2
Passport	58.3	3
WellCare	97.5	1

PIP: performance improvement project; ED: emergency department; ACSC: ambulatory care sensitive conditions; MCO: managed care organization.

For the one PIP completed in 2020, four MCOs attained acceptable compliance levels: WellCare received a Level 1 compliance rating and Aetna, Anthem, and Humana each received Level 2 compliance ratings. Passport, with a Level 3 compliance rating, was required to respond to an inquiry.

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

- Improving Diabetes Management (January 1, 2020, to December 31, 2022);
- Improving Assessment, Referral and Follow-up for Social Determinants of Health (SDoH) (January 1, 2020, to December 31, 2022);

- Aetna will also be conducting a third PIP, entitled "Improving Weight Assessment, Counseling for Nutrition and Physical Activity, and Referrals for Overweight and Obesity Management in Children and Adolescents in the Supporting Kentucky Youth (SKY) Program."

Statewide Collaborative PIPs

Beginning in 2014, Kentucky initiated its first statewide collaborative PIP, followed by a new topic in each of the following years:

- Safe and Judicious Antipsychotic Medication Use in Children and Adolescents, 2014–2017;
- Effectiveness of Coordinated Care Management on Physical Health Risk Screenings in the Seriously Mentally Ill (SMI) Population, 2015–2018;
- Prenatal Smoking, 2016–2019; and
- Reducing Potentially Preventable Hospitalizations and ED Visits for Ambulatory Care Sensitive Conditions (ACSCs), 2017–2020.

The statewide collaborative PIP model offers an opportunity for shared learning and an avenue to address the same message to all MMC providers and members. During the course of a statewide PIP, each MCO has individual conference calls with the EQRO and DMS to discuss study progress and barriers. All MCOs together also participate in periodic group conference calls with DMS and the EQRO. These sessions provide valuable insight on PIP progress, especially via intervention tracking measures that help quantify opportunities for improvement. For the new PIPs beginning in 2021, DMS suggests continuing the quarterly MCO meetings with IPRO on the call to facilitate the agenda and PIP discussion. The state would like to see more MCO management staff involved with the PIP process and IPRO suggested that DMS consider hosting an all-plan meeting at the conclusion of each PIP during which MCOs would share their PIP findings, successes, and challenges.

Focused Studies of Healthcare Quality

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

The following studies are in progress for FY 2021:

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

Strengths, Opportunities for Improvement and Recommendations

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

Strengths

- Kentucky has a contract in place for EQR that includes review of compliance with state and federal regulations, validation of PIPs, and several optional EQR activities. The EQRO also prepares the annual External Quality Review Technical Report as required by regulation.
- Within the past two years, Kentucky DMS updated their Quality Strategy entitled *Strategy for Assessing and Improving the Quality of Medicaid Managed Care Services*.[15] It is currently posted on the DMS website.
- Compared to national benchmarks, 8 of the 41 (20%) Quality Strategy measures met or exceeded the national 50th percentile, including 1 measure (2%) that met or exceeded the national 90th percentile and 4 measures (10%) that met or exceeded the national 75th percentile but were below the national 90th percentile.
- Of the 35 HEDIS 2020 measures aligned with the Quality Strategy goals that could be trended, 19 measures (54%) showed improvement in rates between HEDIS 2018 and HEDIS 2020.
- MCOs participated in the October 2020 Compliance Review, with results indicating a high level of compliance with contract, state, and federal regulations. Of the 78 areas reviewed for all 5 MCOs overall, 33 (42%) received full overall compliance determinations and 44 (56%) received substantial overall compliance determinations. All five MCOs received full overall determinations in QAPI: Health Information Systems.
- DMS continues to strive to maintain and improve communications as evidenced by regularly scheduled meetings for workgroups, EQR activities and MCO operations.
- In 2021, Kentucky MCOs each submitted final PIP reports for their fourth statewide collaborative PIP on the topic Reducing Potentially Preventable Hospitalizations and ED Visits for ACSCs, with four of the five MCOs meriting acceptable compliance level results.
- Two focused studies were in progress during FY 2021 on the following topics: Access to Colorectal Cancer Screening and Care Management for Kentucky Medicaid Managed Care Enrollees; and COVID-19 Hospital Encounters, Mortality and Access to Telehealth Services among Kentucky Medicaid Managed Care (MMC) Enrollees.

Opportunities for Improvement

- Statewide average rates for 16 (46%) of the 35 trendable HEDIS measures listed in the 2019 Quality Strategy did not improve between HEDIS 2018–2020.
- HEDIS 2020 statewide average rates were below the national 50th percentile for 33 (80%) of the 41 discrete core measures., including 19 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.
- Not all core measures from the 2019 Quality Strategy were included in this analysis. In addition to HEDIS measures, the strategy includes clinical measures, many of which are drawn from the National Quality Forum (NQF) data set. Where possible, HEDIS measures that are equivalent to the NQF measures were included, but there were no HEDIS equivalent measures for three of the NQF measures and there were an additional two measures that were not collected in Kentucky in RY 2020; these measures are therefore not represented in this evaluation.
- There was one overall determination of minimal compliance in the 2020 Compliance Review in the area of Enrollee Rights and Protection: Member Education and Outreach for Anthem. Overall, 50 (2.3%) of all 2,171 elements reviewed received a minimal or non-compliance rating.
- Opportunities for improvement exist based on findings from several EQR monitoring and validation reports:
    - Validation of provider network submissions continued to identify the need to enhance the accuracy and completion of critical data fields, and to consider expanding the data dictionary to include more specificity in the definition of data elements. It was also suggested that DMS consider adding the following data elements to the Managed Care Assignment Processing System (MCAPS): wheelchair access, hours at site, and provider usage of health information technology (HIT).
    - Results from the web-based provider directory validation indicated that there is still opportunity to enhance the accuracy and completeness of the web directories regarding critical fields in the MCO provider files, especially with respect to phone numbers and addresses.

- Results of the FY 2021 Access and Availability Survey of PCPs, Behavioral Health and Substance Use Disorder providers indicated that overall compliance rates of 34.9% (scheduling routine), 19.5% (urgent calls), and 48.5% (after-hours calls) are well below the standard of 80%.

- Reporting requirements continue to represent a major effort for the MCOs in coordinating the collection of data and submitting the reports on schedule, as well as for DMS in reviewing and analyzing the results.

Recommendations

In collaboration with the EQRO and the MCOs, it is recommended that Kentucky DMS address the above listed opportunities for improvement.

- The updated Quality Strategy entitled *Strategy for Assessing and Improving the Quality of Medicaid Managed Care Services* provides a well-constructed framework to enhance quality monitoring and improvement as Kentucky's MMC program seeks to achieve its five program goals. Limitations discussed in this evaluation regarding the strategy's Core Measures are being addressed by the inclusion of performance measure data in the newly created QM-03 report. DMS should also consider establishing state-level baselines for all reported measures and setting state-level performance thresholds for each measure in order to better evaluate the effectiveness of the MMC program in achieving the goals set forth in the Quality Strategy. Thresholds should be quantifiable, actionable, and able to be sustained over time. Benchmarks targeting national Medicaid performance, such as NCQA's national *Quality Compass*, as well as incremental improvement over baseline rates offer potential sources for future evaluation.
- DMS should continue to engage the MCOs in discussions related to contract reporting requirements in order to determine what needs to be monitored through MCO reporting and how best to obtain this information on a regular basis. Considerations to lessen the reporting and review burden could include reducing the frequency of report submissions and/or using other state administrative sources for some of the requested data.
- DMS, in collaboration with the EQRO, may want to consider taking a more proactive role in initiatives to promote quality improvement such as providing feedback to the MCOs regarding HEDIS rate improvement, including face-to-face or WebEx conferences and trainings based on lessons learned from focused 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.

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