



**Cabinet for Health and Family Services**

**Department for Medicaid Services**

**COMMONWEALTH of KENTUCKY**

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

**DRAFT**

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## 1.0 Introduction

The Kentucky Cabinet for Health and Family Services, Department for Medicaid Services (DMS) Managed Care Quality Strategy (MCQS) is a dynamic document. It is built on the foundation of improving not only the health of approximately 1.36 million Kentuckians that are covered by Medicaid and the Kentucky Children's Health Insurance Program (KCHIP) but also the communities in which they live. The majority (91.04%) of these individuals are enrolled in a managed care plan under the Section 1915 (b) waiver or Alternative Benefit Plan authority.

The basic premise of the MCQS is the Three-Part Aim outlined in the Center for Medicare and Medicaid Services Quality Strategy:

*to build a health care delivery system that's better, smarter and healthier—a system that delivers improved care, spends health care dollars more wisely, and one that makes our communities healthier.*

The vision for the MCQS is not only for Medicaid enrollees to experience more patient-centered, outcomes-oriented care, but for DMS efforts to serve as a catalyst for further transformation of health and health care in Kentucky. To accomplish this vision, the DMS MCQS outlines a plan for partnering with contracted Managed Care Organizations (MCOs), with enrollees and families and other partners to assess and improve the quality of health care and services and promote healthy behaviors and communities across Kentucky.

Achieving this vision in Kentucky is not without its challenges. The current healthcare system does not consistently achieve the outcomes Kentuckians would expect for its expenditures. Kentucky ranks near the bottom of the nation in several key population health metrics.

- 24.6% of Kentuckians smoke cigarettes<sup>1</sup> (second highest rate in the nation).<sup>2</sup>
- 34.2% of adults in the Commonwealth are obese<sup>3</sup> (twelfth highest rate in the nation).<sup>4</sup>
- The number of infant deaths per 1,000 live births is 6.7 (fifteenth highest in the nation).<sup>5</sup>
- Kentucky has both the highest number of cancer deaths, with 234.9 per 100,000<sup>6</sup>, as well as the highest number of annual preventable hospitalizations per 1,000 Medicare enrollees in the nation, with 76.6.<sup>7</sup>
- Kentucky also faces significant health challenges related to high rates of diabetes at 12.9%, which is the seventh highest in the nation<sup>8</sup> and heart disease, at the eighth highest rate of cardiovascular deaths in the nation at 299.7 per 100,000.<sup>9</sup>

The Commonwealth faces many economic challenges. Nearly 20% of our residents live in poverty and we are 47th in the nation for median household income. Nearly one-third of Kentuckians are on Medicaid and our workforce participation rate is less than 60%. Kentucky's rate of unemployment is 4.1%. These rates place Kentucky above the national average in poverty and unemployment, with workforce participation and wages below the national average and among the worst in the nation. Further, the State also has the ninth highest incarceration rate in the nation, far outpacing the national average with 869 per 100,000 people compared to the

<sup>1</sup> Kentucky Cabinet for Health and Family Services, Kentucky Public Health. 2019. [accessed May 6, 2019]

<https://chfs.ky.gov/agencies/dph/dmch/hpb/Documents/Tobacco%20Use%20in%20KY%202019.pdf>

<sup>2</sup> Kentucky Cabinet for Health and Family Services, Kentucky HEALTH. 2016. [accessed May 6, 2019]

<sup>3</sup> Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2016. [accessed May 6, 2019]

<https://www.cdc.gov/brfss/brfssprevalence/>

<sup>4</sup> Kentucky Cabinet for Health and Family Services, Kentucky HEALTH. 2016. [accessed May 6, 2019]

<sup>5</sup> United Health Foundation, America's Health Rankings. 2018. [accessed May 6, 2019]

<https://www.americashealthrankings.org/explore/annual/measure/IMR/state/KY>

<sup>6</sup> United Health Foundation, America's Health Rankings. 2018. [accessed May 6, 2019]

<https://www.americashealthrankings.org/explore/annual/measure/CancerDeaths/state/KY>

<sup>7</sup> United Health Foundation, America's Health Rankings. 2018. [accessed May 6, 2019]

<https://www.americashealthrankings.org/explore/annual/measure/preventable/state/KY>

<sup>8</sup> United Health Foundation, America's Health Rankings. 2018. [accessed May 6, 2019]

<https://www.americashealthrankings.org/explore/annual/measure/Diabetes/state/KY>

<sup>9</sup> United Health Foundation, America's Health Rankings. 2018. [accessed May 6, 2019]

<https://www.americashealthrankings.org/explore/annual/measure/CancerDeaths/state/KY>

national rate of 698 per 100,000 people.<sup>10</sup> These factors are known to directly impact the rate of drug use as well, as well as HIV rates. Over the past decade, the number of Kentuckians who die from drug overdoses has steadily climbed to more than 1,200 each year. Kentucky now ranks fourth highest in the nation for the number of drug related fatalities.<sup>11</sup> A June 2018 preliminary report from the Centers for Disease Control & Prevention (CDC) identified 220 counties in the nation at risk for an HIV or hepatitis C outbreak, and 54 of the total at-risk counties were located in Kentucky. Including 12 of the top 25 most vulnerable counties in the nation.<sup>12</sup> DMS through the MCQS and other avenues continue to address these issues with innovative approaches (see Section 3.0).

Addressing rising health care costs as well as our state's economic challenges are critical to better health outcomes and maintaining access for families and individuals that need services. DMS proposes a comprehensive approach to transforming Medicaid and the introduction of innovative delivery system reforms targeting substance use disorder (SUD), chronic disease management, and managed care to improve quality and outcomes.

DMS seeks to achieve this overall vision by focusing on a number of Quality Aims:

- Reduce the burden of substance use disorder (SUD) and improve behavioral health outcomes
- Reduce the burden of and improve outcomes for chronic diseases and promote evidence-based treatment for priority health conditions that affect Kentuckians;
- Increase preventive services to improve population health;
- Promote access to high-quality care and reduce unnecessary and wasteful spending; and
- Maintain timely access to high-quality, equitable care for Medicaid enrollees, especially for enrollees with special needs.

Foundational to achieving this vision are several components:

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

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

- Identification of shared goals and aims;
- Selection of interventions that achieve these goals and aims;
- Measurement and monitoring of progress toward these goals and aims;
- Definitions for the starting point and targets for performance; and
- Feedback loops and transparency

## 2.0 Managed Care in Kentucky

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

In 2011, with increasing Medicaid health care expenditures and a growing eligible population, Kentucky once again turned to risk-based managed care as a solution. Following a careful procurement process, risk-based,

<sup>10</sup> Wagner, Peter, & Sawyer, Wendy. Prison Policy Initiative. 2018. [accessed May 6, 2019]

<https://www.prisonpolicy.org/global/2018.html>

<sup>11</sup> United Health Foundation, America's Health Rankings. 2018. [accessed May 6, 2019]

<https://www.americashealthrankings.org/explore/annual/measure/Drugdeaths/state/KY/compare/WV>

<sup>12</sup> U.S. Department of Health & Human Services, Center for Disease Control. 2018. [accessed May 6, 2019]

<https://www.cdc.gov/pwid/vulnerable-counties-data.html>

state-wide, managed care was implemented. The Patient Protection and Affordable Care Act (ACA) allowed DMS to further expand Medicaid eligibility in 2014. Managed Care Program enrollment has remained relatively steady over the past 3 years, growing by 0.18% between 2016 and 2019 (Table 1). Anthem Medicaid saw the largest increase in enrollment (28.35%) while Aetna Better Health of Kentucky showed the most significant decline (22.26%). Humana CareSource (14.91%) and Passport Health Plan (6.99%) both saw modest enrollment increases over the period, while WellCare of Kentucky maintained similar enrollment (- 0.84%).

**Table 1. List of Kentucky Medicaid MCOs by Enrollment**

MCO	Enrollment 4/2016	Enrollment 4/2017	Enrollment 4/2018	Enrollment 5/2019	Percent Change 2016–2019
Anthem Medicaid	100,849	117,133	126,733	129,436	+28.35%
Aetna Better Health of Kentucky	276,052	249,501	230,100	214,613	-22.26%
Humana-CareSource	125,658	139,259	146,530	144,391	+14.91%
Passport Health Plan	287,255	303,146	312,781	307,322	+6.99%
WellCare of Kentucky	441,691	441,187	449,519	437,962	-0.84%
<b>Total</b>	<b>1,231,505</b>	<b>1,250,226</b>	<b>1,265,663</b>	<b>1,233,724</b>	<b>+0.18%</b>

Source: Cabinet for Health and Family Services, KY Data Warehouse Monthly Membership Counts by County; run date June 2019.

In January 2018, a five-year 1115 demonstration waiver was approved by CMS entitled Kentucky HEALTH (Helping to Engage and Achieve Long Term Health). With this project, the Commonwealth of Kentucky intended to transform the Kentucky Medicaid program by empowering individuals to improve their health, engage enrollees in the community and prepare them for employment and provide enrollees the tools to successfully use commercial market health insurance and eventually transition off Medicaid. The Kentucky HEALTH program included implementing an innovative delivery system reform targeting SUD and chronic disease management. The Kentucky HEALTH implementation was to become effective Sunday, July 1, 2018, but was suspended due to a legal decision at the federal level. However, the SUD portion of the 1115 waiver was authorized and is moving forward. The Commonwealth of Kentucky and the DMS continue to collaborate with MCOs, stakeholders and other state agencies in order to continue to improve the overall health and well-being of Medicaid enrollees.

**Note: The Kentucky MCQS is drafted with the expectation that the Kentucky HEALTH 1115 will eventually be implemented in some form. The document reflects high-level interventions and initiatives proposed in the Kentucky HEALTH waiver but omits detail until legal challenges are resolved. DMS anticipates issuing a revised MCQS after the resolution of legal challenges.**

### 3.0 Quality Strategy Overview

Through oversight and direction by the Division of Program Quality and Outcomes, Quality Branch, DMS seeks to accelerate quality, value and population health improvement in Kentucky by leveraging relationships with Managed Care Organizations (MCOs), health care provider organizations, Medicaid enrollees, families and community partners. Kentucky's quality goals are focused on achieving the Three-part Aim outlined in the Centers for Medicare and Medicaid Services Quality Strategy: better care, smarter spending and healthier people. The MCOs are required to have or obtain within two (2) to four (4) years and maintain National Committee for Quality Assurance (NCQA) accreditation. NCQA provides a framework for essential quality improvement and measurement. The MCOs are also required to submit a full set of HEDIS and CAHPS data annually.

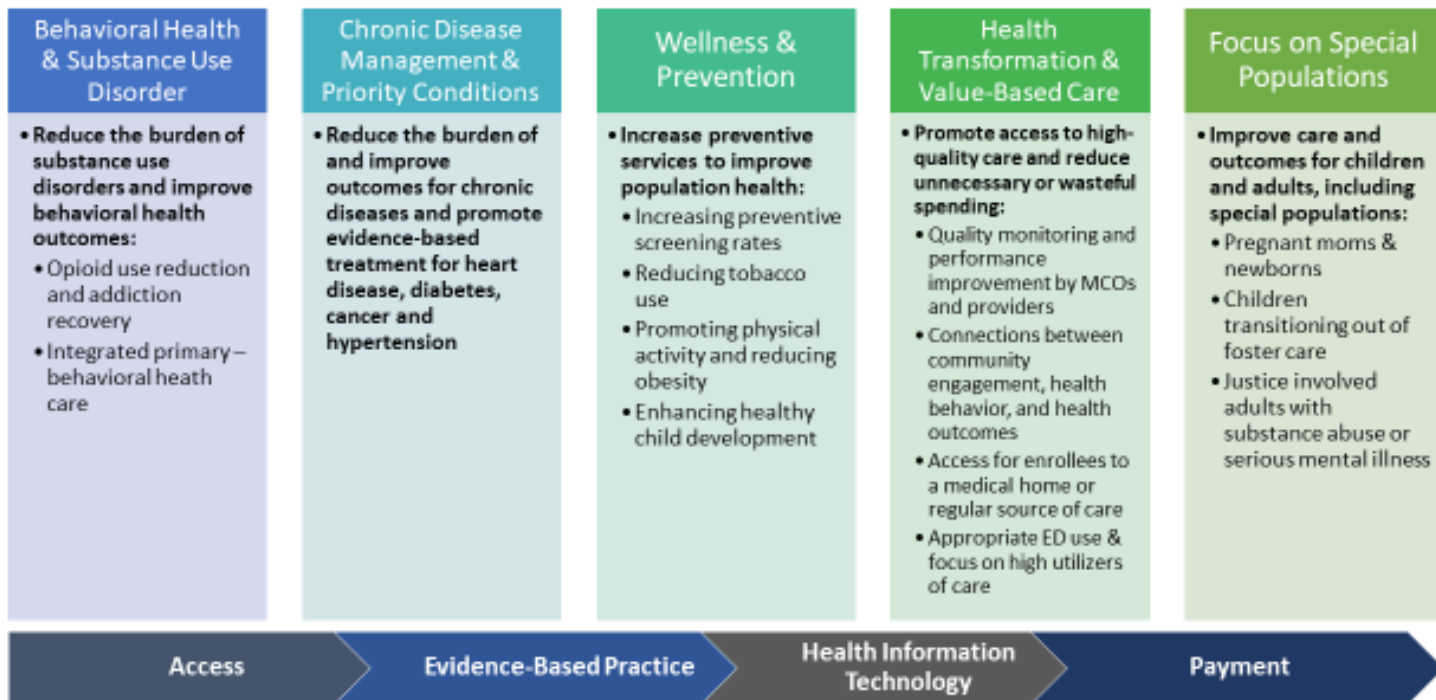
DMS seeks to accelerate health care performance improvement in Kentucky by leveraging relationships with MCOs, the state's public schools of medicine, dentistry nursing and public health at the University of Kentucky and the University of Louisville (each a "State University") and state university teaching hospitals. This collaborative approach also includes partnerships with enrollees, stakeholders, providers, governmental departments, contractors, community groups and legislators. The partnerships will accelerate value to enrollees to encourage the development of population-based innovative care delivery models that improve medical and behavioral health outcomes and ensure timely access to treatment. Figure 1 below provides additional detail on

the quality aims and interventions as well as delivery system reforms that DMS will pursue in concert with its MCO, university partners, enrollees and families and other stakeholders across Kentucky.

### 3.1 Delivery System Reforms

## Figure 1. Kentucky Medicaid Quality Aims

*Improve care and care experience for enrollees, reduce cost, improve the health of populations and advance health equity across the Commonwealth*



DMS plans to undertake a significant delivery system reform to improve quality and outcomes. Initiatives and interventions include efforts related to SUD, chronic disease management, and general managed care reforms. Further, to support each of these delivery system initiatives, DMS will continue to strengthen its data collection efforts. DMS will implement an initiative to improve data collection, including appropriate interoperability of data and ensure that data driven decisions are aligned with overall goals to further improve quality and outcomes across the delivery system.

#### 3.1.1 Behavioral Health and Substance Use Disorder (SUD)

It is estimated that nearly 100,000 Medicaid enrollees in the Medicaid Expansion population may have a SUD requiring treatment. In 2014 with the expansion of Medicaid, Kentucky greatly expanded coverage of behavioral health and SUD treatment options, allowing Medicaid enrollees to receive coverage for the full spectrum of inpatient and outpatient SUD services. DMS plans to maintain all current behavioral health and substance use disorder benefits and elevate the standard of care for drug treatment to aggressively combat this epidemic.

The DMS is aligning SUD treatment services outpatient and inpatient/residential with the national best practice criteria set forth by the American Society of Addiction Medicine (ASAM). Beginning with residential SUD treatment providers will be certified by DMS to their appropriate treatment level of care with the intentions of each provider obtaining ASAM/CARF certification by July, 1, 2021. The certification allows for residential treatment providers a waiver of the IMD exclusion up to 96 beds for treatment coverage. This waiver on residential treatment is in the efforts to expand access to treatment. By aligning standards for treatment, Kentucky is looking to increase quality and outcomes for individuals seeking SUD treatment services throughout the continuum of care. This also includes an effort to minimize time without Medicaid coverage for the justice involved re-entry population needing to continue their SUD treatment services in the community. As an increase

to access with medication for Opioid Use Disorder coverage of Methadone treatment has been added as a covered service.

The MCOs work collaboratively with the DMS and the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to assure that enrollees receive quality behavioral services. The MCOs incorporate the core values of the enrollees to have the right to retain the fullest control possible over their behavior health treatment. The behavioral health services shall be responsive, organized and accessible to those who require behavioral healthcare. The most normative care in the least restrictive setting will be provided in the community to the greatest extent possible. Enrollee satisfaction with the services will be measured. The behavioral health services are recovery and resiliency focused. The MCO and its providers use the most current version of DSM classification. The MCOs maintain an emergency and crisis Behavioral Health Services Hotline that is staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days a year throughout the Commonwealth. Face to face emergency services are available twenty-four (24) hours a day, seven (7) days a week.

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

### **3.1.2 Chronic Disease Management**

Kentucky faces a series of public health challenges. Not only does the State have exceedingly high infant mortality, obesity, diabetes, heart disease, and smoking rates, it ranks highest in the nation with respect to cancer deaths and preventable hospital conditions. While these health indicators are demonstrative of residents' overall health status, they also lead to higher utilization of healthcare services and increased healthcare expenditures, particularly among the State's most vulnerable populations. As such, DMS will align various program components in support of the State's existing public health infrastructure and current efforts to improve chronic disease prevention and management. Further, DMS will work with Kentucky's MCOs to implement best practices from nationally recognized disease management programs, such as the National Diabetes Prevention Program.

If implemented, several Kentucky HEALTH program components are designed to support existing statewide efforts to improve chronic disease prevention and management. For example, the Kentucky HEALTH *My Rewards Account*, described in *Section 4.1.2*, will incentivize enrollees to participate in a variety of health activities including health risk assessments, chronic disease or weight management courses, and smoking cessation programs, many of which are already offered through State and local health departments across Kentucky.

DMS will also explore, through its MCO contracts, participation in existing initiatives designed to drive public health outcomes and focused on Kentucky Department for Public Health (DPH) key priorities. These outcomes include, but are not limited to, diabetes, obesity, cardiovascular disease, lung cancer, and substance use disorder. State-based programs include, but are not limited to, the Kentucky Diabetes Prevention and Control Program and the Kentucky Tobacco Prevention and Cessation Program. In addition, the State will continue participation in existing federal programs, such as the National Diabetes Prevention Program (DPP), a Centers for Disease Control and Prevention (CDC)-supported program aimed at preventing or delaying type two diabetes for at-risk individuals.

### **3.1.3 Wellness and Prevention**

DMS will continue to work with MCOs, DPH, its state university partners and other stakeholders to increase preventive services to improve population health for Medicaid enrollees. Improving wellness and prevention for Medicaid enrollees will include efforts focused on:

- Increasing preventive screening rates,
- Reducing tobacco use,
- Promoting physical activity and reducing obesity, and
- Enhancing healthy child development.

MCOs have programs and process in place to address preventive healthcare needs of its population. MCOs conduct health screening assessments, including mental health and substance use disorders screening of new enrollees who have not been enrolled with them in the prior twelve month period for the purpose of accessing

the enrollees' health care needs within ninety days of enrollment. Information that is collected includes demographic information, current health and behavioral health status to determine the enrollee's need for care management, disease management, behavioral health services and/or any other health or community services.

### **3.1.4 Health Transformation and Value-Based Care**

DMS will continue to work with its stakeholders and other organizations to align incentives across the delivery system by introducing mechanisms to control spending. DMS will work to implement innovative and strategic solutions to quality improvement and collaborate with MCOs to develop a data-driven, outcomes-based continuous quality improvement processes. DMS will work with each MCO on its quality management and performance improvement approach and require MCOs to incorporate quality and outcomes measurement against relevant targets and benchmarks. HEDIS measures will be collected and reported annually with benchmarks, trending and performance goals included. DMS will analyze MCO performance against benchmarks and goals will be analyzed and MCOs will develop performance improvement plans based on areas of focus identified by DMS such as access, quality of care, population health improvements and reduction of unnecessary costs.

In addition, DMS will work with MCOs to develop innovative value-based model(s) aimed at transitioning from a reimbursement model that rewards providers based on volume, to a model that aligns payment incentives with quality, performance and outcomes. DMS in partnership with MCOs will tie a meaningful portion of Medicaid payments to value-based purchasing arrangements designed to achieve improvements in population health outcomes and decrease the total cost of care for Medicaid enrollees.

Further, DMS will pursue additional managed care system reforms aimed at improving the efficiency and responsiveness of the current managed care delivery system. DMS will include contract provisions designed to align processes and establish consistency in administrative requirements across the contracted MCOs.

### **3.1.5 Focus on Special Populations**

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

- Children in/or receiving Foster Care or adoption assistance;
- Blind/Disabled Children under age 19 and Related Populations eligible for SSI;
- Adults over the age of 65;
- Homeless (upon identification);
- Individuals with chronic physical health illnesses;
- Individuals with chronic behavioral health illnesses;
- Children receiving EPSDT Special Services;
- Children receiving services in a Pediatric Prescribed Extended Care facility or unit.

MCOs have written policies and procedures in place, which govern how enrollees with these multiple and complex physical and behavioral health care needs are screened, identified, treated and supported. They assess each enrollee identified as ISHCN in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. MCOs develop and distribute to ISHCN enrollees, caregivers, parents and/or legal guardians, information and materials specific to the needs of the enrollee, as appropriate. This information shall include health educational material as appropriate to assist ISHCN and /or caregivers in understanding their chronic condition. MCOs produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring. MCOs develop practice guidelines and other criteria that consider that needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population. In addition, because DMS covers more than half of all births in Kentucky, DMS, in partnership with MCOs and other Cabinet Departments, has several programs aimed at improving outcomes for pregnant mothers, babies



and children. The DPH-operated Kentucky Health Access Nurturing Development Services (HANDS) program is a voluntary home visitation program that supports families through pregnancy and the first two years of life. DMS and MCOs also help support children and families through Early and Period Screening, Diagnostic and Treatment (EPSDT). In Kentucky, EPSDT is divided into two components: EPSDT Screenings and EPSDT Special Services. The EPSDT Screening Program provides routine physicals or well-child check-ups for eligible children at specified ages. Children are checked for medical problems early including: preventive check-ups; growth and development assessments; vision; hearing; teeth; immunizations; and laboratory tests. If conditions are discovered through screening, additional services and supports may be available.

FACES – Foster Adoptive Caregiver Exchange System – is another initiative aimed at improving care and support for Kentucky’s foster children and families. DCBS, DMS and MCOs play an active role in providing health care coverage for foster children and work actively to ensure foster children and families have the care and support they need to thrive.

Finally, led by Kentucky’s Department for Behavioral Health, Developmental and Intellectual Disabilities, with support from DMS and MCOs, the Kentucky Opioid Response Effort (KORE) is designed to be a comprehensive targeted response to Kentucky’s opioid crisis by expanding access to a full continuum of high quality, evidence-based opioid prevention, treatment, recovery, and harm reduction services and supports in high-risk geographic regions of the state. KORE’s target populations include persons who have survived an opioid-related overdose, pregnant and parenting women, justice-involved individuals, children, transition-age youth, and families.

### **3.2 Performance Measures**

#### **3.2.1 Alignment and the Kentucky Core Healthcare Measures Set**

DMS has already taken the first step toward aligning incentives around areas that matter to enrollees, plans, purchasers and providers. DMS, in coordination with more than 70 expert volunteers from varying backgrounds and geographic regions in the state, worked to align and prioritize the quality and cost metrics used by Medicaid, Medicare and commercial insurers to rank and incentivize provider performance. The Kentucky Performance Measures Alignment Committee (PMAC) working with four subcommittees reviewed dozens of measures and provided recommendations for a final set of aligned priority metrics. The multi-stakeholder subcommittees engaged in consensus-based discussions over several months and eventually presented their recommendations to the PMAC oversight committee.

The result was the selection of the Kentucky Core Healthcare Measures Set, which is intended to align measurement efforts across payers and highlight shared areas of focus. The set includes 32 primary care measures, 21 of which are considered high priority, focused in the areas of prevention, pediatrics, chronic and acute care management, behavioral health, and cost/utilization. This is less than half of 89 currently incented measures in Kentucky by various programs.

#### **3.2.2 Quality Measurement and Reporting**

The MCOs incorporates outcomes measurement against relevant targets and benchmarks. DMS specifies performance and outcomes measures that MCOs must address, including HEDIS and Kentucky-specific measures. Please see section 3.3 below for additional detail on MCO claims-based quality reporting.

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

**Table 1. Overview of Comprehensive Kentucky Medicaid Quality Strategy 2019-2022**

Goals & Aims	Interventions	Core Measures	Monitoring, Feedback & Transparency
<p><b>Goal 1.</b> Reduce burden of SUD and engage enrollees to improve behavioral health outcomes  <b>Aim 1.1</b> Reduce Opioid Use through access to addiction recovery services  <b>Aim 1.2</b> Enhance BH care through integrated primary care-BH care  <b>Aim 1.3</b> Increase the number of screenings for OUD</p>	<p>Waiver of IMD Exclusion (Pilot) to enhance access (1.1); Pilot or care coordination programs to integrate primary care and BH care (1.2)                      Core measures for MCOs include: BH and SUD treatment Pharmacy and provider 'lock in' program</p>	<p><b>HEDIS Measures:</b></p> <ul style="list-style-type: none"> <li>• Antidepressant Medication Management (AMM) (2 measures)</li> <li>• Initiation and Engagement of Alcohol and other Drug (IET)</li> </ul> <p><b>Clinical Measures:</b></p> <ul style="list-style-type: none"> <li>• Use of Opioids at High Dosage (NCQA proposed);</li> <li>• Screening for Clinical Depression and Follow Up Plan (NQF 418)</li> </ul>	<p>Quarterly reports from MCOs; reviewed internally to evaluate progress and possible changes to interventions publicly shared after an evaluation period of no less than 3 years</p>
<p><b>Goal 2.</b> Reduce burden of and outcomes for chronic diseases  <b>Aim 2.1</b> Promote evidence-based treatments for CAD, Hypertension, Diabetes &amp; Cancer</p>	<p>Enrollee participation in MCO Case Management and Disease Management programs for chronic diseases</p>	<p><b>HEDIS Measures:</b></p> <ul style="list-style-type: none"> <li>• Controlling High Blood Pressure (CBP)</li> <li>• Comprehensive Diabetes Care (CDC) (6 measures)</li> <li>• Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)</li> <li>• Pharmacotherapy Management of COPD Exacerbation (PCE) (2 measures)</li> <li>• Appropriate Medications for People with Asthma (ASM)</li> <li>• Medication Management for People With Asthma (MMA)</li> </ul> <p><b>Clinical Measures:</b></p> <ul style="list-style-type: none"> <li>• Statin Therapy for Patients with Cardiovascular Disease(CMS 347v1 eCQM);</li> <li>• Diabetes Care: Hemoglobin (HbA1c) Poor Control (&gt;9.0%) (NQF 59);</li> <li>• Controlling High Blood Pressure (Hypertension) (NQF 18);</li> <li>• See cancer screening measures below</li> </ul>	<p>Quarterly reports from MCOs; reviewed internally to evaluate progress and possible changes to interventions publicly shared after an evaluation period of no less than 3 years</p>
<p><b>Goal 3.</b> Increase preventive service use  <b>Aim 3.1</b> Increase screening  <b>Aim 3.2</b> Reduce tobacco use  <b>Aim 3.3</b> Promote physical activity  <b>Aim 3.4</b> Enhance healthy child development</p>	<p>**KY HEALTH – My Rewards account will provide enrollee incentives for 3.2, 3.3 Core measures include use of screening counseling, immunizations*                      3.2 Quit Now Kentucky – free, evidence-based tobacco cessation service – increase/improve on education of enrollees and providers</p>	<p><b>HEDIS Measures:</b></p> <ul style="list-style-type: none"> <li>• Adult BMI Assessment (ABA)</li> <li>• Cervical Cancer Screening (CCS)</li> <li>• Weight Assessment &amp; Counseling for Nutrition &amp; Physical Activity for Children/Adolescents (WCC) (3 measures)</li> <li>• Childhood Immunization Status (CIS) (2 measures)</li> <li>• Breast Cancer Screening (BCS)</li> <li>• Cervical Cancer Screening (CCS)</li> <li>• Chlamydia Screening in Women (CHL)</li> <li>• Human Papillomavirus Vaccine for Female Adolescents (HPV) - NOW under IMA - Immunization for Adolescents</li> <li>• Annual Dental Visits (ADV)</li> </ul>	<p>Quarterly reports from MCOs; reviewed internally to evaluate progress and possible changes to interventions publicly shared after an evaluation period of no less than 3 years</p>

	<p>Promote 100% tobacco free schools and smoke-free policies 3.4</p>	<p><b>Clinical Measures:</b></p> <ul style="list-style-type: none"> <li>• Breast Cancer Screening (NQF 2372);</li> <li>• Colorectal Cancer Screening (NQF 32);</li> <li>• Tobacco Use: Screening and Cessation (NQF 28);</li> <li>• Body Mass Index (BMI) Screening and Follow-Up (NQF 42);</li> <li>• Childhood Immunization Status (NQF 38);</li> <li>• Well Child Visits, 3-6 years and first 15 months (NQF 1516);</li> <li>• Well Child Visits, First 15 months (NQF 1392)</li> </ul>	
<p><b>Goal 4.</b> Promote access to high-quality care and reduce unnecessary spending  <b>Aim 4.1</b> Quality and performance monitoring  <b>Aim 4.2</b> Enhance connections between community engagement, health behavior and health outcomes  <b>Aim 4.3</b> Increase access to PCMH  <b>Aim 4.4</b> Reduce inappropriate ED use</p>	<p>**KY HEALTH – Deductible Account will provide enrollee incentives for 4.4; My Rewards will provide incentives for 4.2; Additional measures may include non-urgent ED use, performance improvement plans focusing on ambulatory sensitive conditions and optimizing inpatient service utilization</p>	<p><b>HEDIS Measures:</b></p> <ul style="list-style-type: none"> <li>• Follow-Up after Hospitalization (FUH)</li> <li>• Appropriate Testing for Children with Pharyngitis (CWP)</li> <li>• Appropriate Treatment for Children with Upper Respiratory Infection (URI)</li> <li>• Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</li> <li>• Use of Imaging Studies for Low Back Pain (LBP)</li> </ul> <p><b>Clinical Measures:</b></p> <ul style="list-style-type: none"> <li>• Medication Reconciliation Post-Discharge (NQF 97);</li> <li>• 30 day All Cause Readmissions (NQF 1768)</li> </ul>	<p>Quarterly reports from MCOs; reviewed internally to evaluate progress and possible changes to interventions publicly shared after an evaluation period of no less than 3 years</p>
<p><b>Goal 5.</b> Improve care and outcomes for children and adults, including special populations  <b>Aim 5.1</b> ↑ care/outcomes for pregnant moms &amp; newborns  <b>Aim 5.2</b> ↑ care/outcomes for children transitioning out of foster care  <b>Aim 5.3</b> Improve coordination of care for adults who are justice-involved and need health services related to substance use disorder or serious mental illness  <b>Aim 5.4</b> Increase access and quality of community based services for children and adults with SED and SMI</p>	<p>KI-HIPP provides a pathway for enrollees to transition to employer-sponsored insurance; My Rewards provides resources for buying additional services  Core measures address immunizations, well-child visits, contraceptive care, ADHD follow-up, tobacco use in adolescents  Additional measures will be drawn from KY Core Healthcare Measures set; MCO Maternity Care Management programs; SUD 1115 Waiver</p>	<p><b>HEDIS Measures:</b></p> <ul style="list-style-type: none"> <li>• Follow-up Care for Children Prescribed ADHD Medication (ADD) (2 Measures)</li> <li>• Prenatal and Postpartum Care (PPC) (2 Measures)</li> <li>• Frequency of Ongoing Prenatal Care (FPC)</li> </ul> <p><b>Clinical Measures:</b></p> <ul style="list-style-type: none"> <li>• Childhood Immunization Status (NQF 38);</li> <li>• Well Child Visits, 3-6 years and First 15 months (NQF 1516);</li> <li>• Well Child Visits, First 15 months (NQF 1392)</li> </ul>	<p>Quarterly reports from MCOs; reviewed internally to evaluate progress and possible changes to interventions publicly shared after an evaluation period of no less than 3 years</p>

\*MCOs will be encouraged to provide value-based incentives to providers, focusing on core measures

\*\* Applicable if Kentucky HEALTH implemented

### **3.3 Quality Strategy Development, Review and Revision**

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

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

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

Quality Strategy documents are posted on the DMS website for public comment. Each MCO established and maintains an ongoing Quality and Member Access Committee (QMAC) composed of enrollees, individuals from consumer advocacy groups or the community who represent the interests of the enrollee population and public health representatives. The DMS will annually seek and utilize input from the MCO's QMAC; the Medicaid Advisory Council established under 42 CFR 431.12; and the Medicaid Technical Advisory Committee's (TACs) with consumer representation. This enrollee and stakeholder input and public comment will be utilized as appropriate in the DMS's annual review and update of this quality improvement strategy document and the state's quality initiatives.

#### **3.3.1 EQR Technical Report**

Kentucky requires the contracted EQRO to perform the mandatory and optional EQR activities utilizing the nine protocol documents. Annually, the EQRO will review MCO compliance with state and federal regulations and state contract requirements and prepare a final, detailed technical report inclusive of all EQR and EQR related activities. This report will be made available by the DMS to any interested parties.

The EQRO provides monitoring of contracted MCOs. Specifically, the EQRO conducts on-site MCO annual compliance reviews, access and availability, validation of performance measures, validation of performance improvement projects, and NCQA HEDIS compliance audits. An annual Technical Report is submitted to DMS, outlining review focus and findings as well as recommendations to each MCO on opportunities to improve DMS enrollee healthcare quality for the coming year. The most recent Technical Report was completed and submitted in April 2019. The EQR technical report provides detailed information regarding the regulatory compliance of MCOs as well as results of Performance Improvement Projects (PIPs), Performance Measures (PMs), and optional quality-focused activities. Report results provide information regarding the effectiveness of the managed care organizations program, identify strengths and weaknesses and provide information about problems or opportunities for improvement. This information is incorporated in the Quality Strategy and used to initiate and develop quality improvement projects.

#### **3.3.2 Development and Implementation of Quality Improvement Plan**

MCOs continuously monitor their performance on a variety of dimensions of care and services for enrollees, identify areas for potential improvement, carry out individual Performance Improvement Projects (PIPs), undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. PIPs are developed and implemented to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and enrollee satisfaction. Clinical PIPs should address preventive and chronic healthcare needs of enrollees, including the enrollee population as a whole and subpopulations, including, but not limited to Medicaid eligibility category, type of disability or special healthcare need, race, ethnicity, gender and age. PIPs should also address the specific clinical needs of enrollees with conditions and illnesses that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality, availability, and accessibility of services provided by the MCO to enrollees and

providers. Such aspects of service should include, but not be limited to availability, accessibility, cultural competency of services, and complaints, grievances, and appeals. While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

The MCOs overall quality management and performance improvement approach incorporates outcomes measurement against relevant targets and benchmarks. All health goals, outcomes, and indicators comply with Federal requirements established under 42 C.F.R. 438.240 (C) (1) and (C) (2) relating to MCO performance and reporting. DMS specifies required performance and outcomes measures that the MCO addresses, including HEDIS and Kentucky-specific measures. MCOs implement and operate a continuous internal Quality Improvement (QI) Program that provides for the evaluation of access to care, continuity of care, health care outcomes, and services provided for or arranged by the MCOs. MCOs also submit quarterly reports of all enrollee grievances and appeals and their disposition. DMS reviews these reports as an input to evaluate whether the MCO is following prescribed rules and regulations.

Each MCO conducts an annual survey of enrollee and provider satisfaction, focusing on quality of services provided and ability to access to services. DMS reviews and approves both the enrollee and provider survey instruments, and annual survey results are reported to DMS. A description of the methodology to be used in conducting provider surveys and the percentage of providers to be surveyed must also be submitted. In their annual reports to DMS, MCOs also provide GeoNetwork reports and maps and complete utilization trend and pattern reports. MCOs use the results of these annual surveys and access analyses as input to their annual review, evaluation, and modification of their overall Quality Improvement Program.

MCOs report to DMS quarterly completed activities and corrective actions, which are recommended or in progress, and the results of all clinical, administrative, provider and enrollee satisfaction surveys conducted during the preceding year. DMS reviews annual quality improvement program reports for completeness and the reasonableness of any implemented and/or planned PIPs and corrective action plans contained within. Minor discrepancies are brought to the attention of the MCO through regularly scheduled meetings, and in writing for more serious issues or concerns. DMS also assesses whether the resulting reports conform to submission requirements, and the degree to which the MCOs utilized the results in their Annual QI Plan submission.

MCOs also collect and report HEDIS data annually. After completion of the MCO's annual HEDIS data collection, reporting and performance measure audit, the MCOs submit to the Final Auditor's Report issued by the NCQA certified audit organization and an electronic copy of the interactive data submission system tool no later than August 31st of each year.

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

### **3.3.3 Role of Utilization Management**

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

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

The MCOs UM program also monitors and evaluates the appropriateness of care and services on an ongoing basis. The MCO develops or adopts written medical necessity review criteria that are based on sound medical evidence or judgement. These criteria are reviewed periodically and updated as needed by the MCO. The DMS reviews and approves the criteria prior to use and requires adequate notification to the providers of any change in criteria. The MCO includes practicing physicians and other providers in the MCO's provider network in the review and adoption of medical necessity criteria. The MCO has in place mechanisms to check the consistency of application of review criteria.

### **3.3.4 Quality and Performance Monitoring of Individual Providers**

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

The MCOs monitor provider actions to ensure he/she complies with the DMS policies that include:

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

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

### **3.3.5 Frequency of State Reviews of the Effectiveness of the Quality Strategy**

The DMS or its contracted agent will have the right to conduct periodic audits of the MCOs during which DMS will identify and collect management and quality data on the use of services or other information as determined by the DMS. Among other items, these assessments include evaluation of the MCO's QI Program description, QI plan and the MCO's annual evaluation description, policy and procedures, and implementation of the procedures. The contracted EQRO will perform an annual review of MCOs compliance with state and federal regulations. This activity includes documentation review and interviews with MCO staff.

The DMS performs an assessment and analysis of both the MCOs' quarterly and annual reports along with the results from the implementation of this quality plan. This assessment will evaluate the overall quality of service provided and planned improvements by the MCOs. Minor discrepancies are brought to the attention of the MCO through regularly scheduled meetings and in writing for more serious issue or concern. Identified significant deficiencies will result in request(s) for corrective action plan(s) from the MCO as described within the MCO contract.

### **3.3.6 Significant Changes to the Quality Strategy**

Significant changes to the quality strategy include any written change to policy or procedure that results in a required change to the QI program and plan, which will trigger stakeholder input regarding its implementation. Examples might include: changes in federal or state laws and regulations, results of annual reports from the MCOs including consumer surveys, excessive complaints, grievances and appeals, or results from oversight activity performed by the Commonwealth or the EQRO. Avenues for stakeholder input include submitted complaints (in writing and through telephone calls), written surveys, questionnaires posted on the DMS website, and in extreme cases direct communication by the DMS. The Commonwealth will submit a revised Managed Care (MC) Quality Improvement (QI) Strategy to CMS when significant changes are made.

## **4.0 MCO Standards**

As part of Kentucky's Medicaid Quality Strategy, MCO standards supporting quality of care are highlighted.

### **4.1 Enrollment and Disenrollment**

To be eligible for MCO enrollment, an individual must have qualified to receive medical assistance under one of the Medicaid assistance categories and be a resident of the MCO service area. MCOs provide for continuous open enrollment throughout the term of their contract, and they must accept all enrollees, regardless of overall plan enrollment. Except for newborns, and presumptive eligibility, enrolleeship begins at 12:01 a.m. on the first day of the first calendar month for which the enrollee's name appears on the HIPAA 834, and is automatically renewed until the enrollee is disenrolled. Only DMS may disenroll an enrollee from the plan.

### **4.2 Availability of Services**

MCOs maintain and monitor a network of appropriate providers (including hospitals, home health providers, dentists, vision providers, hospice, pharmacy, prevention, primary care, and at least one provider of maternity care), representing the complete array of provider types including primary care providers, primary care centers, federally qualified health centers and rural health clinics, local health departments and the Kentucky Commission for Children with Special Health Care Needs, among other requirements. MCOs also comply with the following service availability requirements:

- All covered services are as accessible to enrollees as generally available to commercial insurance enrollees, and no incentive for providers to withhold medically necessary services;
- If the MCO is unable to provide necessary medical services covered under the contract, it will timely and adequately cover these services out of network, coordinating appropriate payment and ensuring that cost to the enrollee is no greater than it would be if provided in-network;
- Direct access of female enrollees to qualified women's health specialists is ensured within network.
- Second opinions related to surgical procedures and the diagnosis and treatment of complex and/or chronic conditions will be provided within or outside network;
- Providers may advise beneficiary about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under Medicaid; and
- MCOs promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

### **4.3 Assurances of Adequate Capacity and Services**

MCOs offer an appropriate range of medically necessary preventive, primary care, specialty and emergency services as required by federal and state regulations, guidelines, transmittals, and procedures. Medically necessary services are those considered by the DMS to be reasonable and necessary to establish a diagnosis and provide preventive, palliative, curative or restorative treatment for physical or mental conditions in accordance with the standards of health care generally accepted at the time services are provided, including but not limited to services for children in accordance with 42 USC 1396d(r). Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

#### **4.4 Provider Selection**

MCOs have written policies and procedures regarding the selection and retention of their provider network. These procedures must not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon a provider's licensure or certification. They must also comply with the Any Willing Provider provisions set forth in 907 KAR 1:672 and KRS 304.17A-270. MCO provider networks must offer sufficient types, numbers, and specialties in each county to assure quality and access to health care services.

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

#### **4.5 Subcontracts and Delegation**

With approval from DMS, MCOs may enter into subcontracts for the performance of its administrative functions or the provision of specified covered services to enrollees. All MCO subcontractors are eligible for participation in the Medicaid program. The form and content of each subcontract, and any amendment to the subcontract, is approved by the DMS in writing prior to the effective date. The MCO will notify the DMS in writing of all subcontracts on a quarterly basis and of the termination of any approved subcontract within ten (10) days following termination. No subcontract will in any way relieve the MCO of any responsibility for the performance of its duties under their Contract.

#### **4.6 Practice Guidelines**

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

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

#### **4.7 Coordination and Continuity of Care**

##### **4.7.1 Primary Care Provider (PCP)**

MCOs ensure that each enrollee has an ongoing source of primary care through a PCP. PCP means a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced registered nurse practitioner, including a nurse practitioner, nurse midwife and clinical specialist, physician assistant, or clinic, including a primary care center and rural health clinic, that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours a day, seven (7) days a week primary health care services to individuals. For an enrollee who has gynecological or obstetrical health care needs, disability or chronic illness, the PCP can be a specialist who agrees to provide and arrange for all appropriate primary and preventive care. MCOs have procedures for serving enrollees from enrollment date, whether or not they have selected a PCP.



MCOs are required to send enrollees a written explanation of the PCP selection process within five (5) business days of enrollment to include: time frame for PCP selection, explanation of the PCP selection/assignment process, and where to call for assistance. MCOs are responsible for explaining and facilitating the selection of or change in Primary Care Provider through telephone or face-to-face contact where appropriate. They assist enrollees in making the most appropriate PCP selection based on previous or current PCP relationship, providers of other family enrollees, medical history, language needs, provider location or any other factors that are important to the enrollee.

#### 4.7.2 Coordination of All Services that Enrollees Receive

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

#### 4.7.3 Prevention of Duplication of Services for Individuals with Special Health Care Needs

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

MCOs also assure and facilitate direct access to specialty physicians for individuals who have been identified as having Special Healthcare Needs and who require a course of treatment or regular healthcare monitoring. This access can be achieved through standing referrals from the PCP or by the specialty physician being permitted to serve as the PCP.

### 4.8 State Transition of Care Policy

When an enrollee transfers from one MCO (Former MCO) to another MCO (New MCO), the Former MCO is responsible for contacting the New MCO, the enrollee and the enrollee's providers to transition existing care. Other provisions include:

- **Prior Authorization (PA)** PAs shall be honored by the New MCO for 90 days or until the enrollee or provider is contacted by the New MCO regarding the PA. If the enrollee and provider are not contacted by the New MCO, the existing Medicaid PA shall be honored until expired.
- **Inpatient Status** If the Enrollee is an inpatient at the time of transition, the entity responsible for the Enrollee's care at the time of admission shall continue to provide coverage at that facility, including all Professional Services, until the enrollee is discharged from the facility for the current admission. An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis is considered a "current admission." Same diagnosis is defined as the first five digits of a diagnosis code.
- **Outpatient Care** The New MCO will be responsible for outpatient services both facility and non-facility, effective on the transition date.

**Transition to Long Term Care or 1915(c) Home and Community Based Services (HCBS) Waiver Program** Eligible enrollees receive a Level of Care (LOC) determination to ensure the enrollee meets medical criteria for Nursing Facility or HCBS services. That LOC is passed electronically to the DCBS eligibility worker, triggering the eligibility determination for additional benefits, and is generally completed within thirty (30) days. *Once LTC or HCBS eligible, worker entries exempt the enrollee from managed care effective with the next feasible month.* If the worker action is completed prior to cut off (eight business days before the end of the month), managed care ends at the last day of current month. If the action is after the cut off, managed care ends the last day of

the following month. During this transition, the MCO will be responsible for all services except the additional Waiver Benefits, which will be paid by DMS on a fee for service basis. Once exempt from managed care, DMS will be responsible for all eligible services associated with this enrollee.

**Enrollees with Transplants** Follow up care provided on or after the Enrollee's Transition that is billed outside the Global Charges, will be the responsibility of the New MCO.

**Loss of Eligibility Issues** When an enrollee loses eligibility during an inpatient stay, the MCO is responsible for the care through discharge if the hospital is compensated under a DRG methodology or through the day of ineligibility if the hospital is compensated under a per diem methodology.

#### 4.9 Coverage and Authorization of Services

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

#### 4.10 Identifying Special Populations

**Individuals needing long term services and supports (LTSS)** are beneficiaries of all ages who have functional limitations and/or chronic illnesses and require services and supports whose primary purpose is to support the enrollee's ability to live or work in the setting of their choice. These settings may include enrollee home, worksite, provider-owned or controlled residential setting, nursing facility, or other institutional setting.

**Individuals with Special Health Care Needs (ISHCN)** are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their condition(s). The primary purpose of the definition is to identify these individuals so that MCOs can facilitate access to appropriate services. DMS has defined the following categories of individuals who shall be identified as ISHCN.

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

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

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

#### 4.11 Health Information Systems

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

Additional requirements:

- MCOs must ensure that all medical information is kept confidential through appropriate security and privacy protocols.
- MCOs must ensure that data received from providers is accurate and complete by collecting service information in standardized formats whenever feasible and appropriate, verifying the accuracy and timeliness of reported data (through audits and edits consistent with NCCI), screening data for completeness, logic and consistency, and storing all claims and encounter data in a data warehouse.
- MCOs must make all collected data available to the DMS and provide additional data and reports as requested by the DMS. At a minimum, MCOs must electronically provide encounter data to DMS on a monthly basis. Encounter data must follow the format, data elements, and method of transmission specified by the DMS. If the MCO knowingly fails to submit data derived from processed claims or encounter data as required by the terms of the contract or data from processed claims otherwise specified by the DMS under the contract, the DMS may assess penalties.
- Encounter data is used by DMS to 1) evaluate access to care, availability of services, quality of care; 2) evaluate contractual performance; 3) validate required reporting of utilization of services; 4) develop and evaluate proposed or existing capitation rates; 5) meet CMS Medicaid reporting requirements.
- The contracted EQRO will perform encounter data validation to determine the accuracy and adequacy of claims submitted by the MCO.
- MCOs, and their subcontractors, must make all of their books, documents, papers, provider records, medical records, data, surveys and computer databases (collectively "Records") available for examination and audit by the DMS, the Attorney General of the Commonwealth of Kentucky, the Office of Insurance of the Commonwealth of Kentucky, authorized federal or Commonwealth personnel, or the authorized representatives of the governments of the United States and the Commonwealth of Kentucky including, without limitation, any employee, or agent of the DMS, Cabinet for Health Services and CMS.

#### **4.12 Confidentiality**

MCOs have the responsibility to protect enrollee information from unauthorized disclosure for any reason. MCOs maintain that confidentiality through written policies and procedures designed to protect the rights of enrollees including, but not limited to, the right to respect, dignity, privacy, confidentiality and nondiscrimination. MCOs agree to abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. Confidentiality of all enrollee information is mandatory, and a breach of confidentiality is considered as a basis for immediate revocation of the MCO Contract.

#### **4.13 Grievances and Appeals**

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

Every grievance received will be documented in an MCO's management information system. MCOs maintain written policies and procedures for the receipt, handling and disposition of grievances that comply with 42 CFR 438 Subpart F and 42 CFR 431. These policies and procedures include a process for evaluating patterns of grievances for impact on formulation of policy and procedures, access and utilization. They also outline procedures for maintaining grievance records separate from medical case records to protect the confidentiality of enrollees who file a grievance or appeal.

MCOs submit quarterly reports of all enrollee grievances and appeals and their disposition to DMS and their QMAC. These reports include number of grievances and appeals (including expedited appeal requests), nature of grievances and appeals, resolution, and timeframe for resolution. DMS or its contracted agent may conduct reviews or onsite visits to follow up on patterns of repeated grievances or appeals. Any patterns of suspected fraud or abuse identified through the data will be immediately referred to the MCO's Program Integrity Unit.

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

## **5.0 Quality Measurement & Improvement Standards**

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

The EQRO conducts an annual validation of these performance measures by evaluating the accuracy of the performance measures reported by the MCO and determining the extent that the Medicaid specific performance measures follow the specifications established by the DMS for the calculation of the performance measures. The EQRO also conducts an annual analysis of utilization patterns of services and delivery sites to determine shifts in access to care, e.g., under-utilization or inadequate access to healthcare providers. Finally, the EQRO annually reviews MCO compliance with state and federal standards and state MCO contract requirements. The EQRO produces a report that describes the manner in which data from all EQR and EQR related activities were aggregated and analyzed, and conclusions drawn as to the quality, timeliness and access to care furnished by the MCOs.

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

### **5.1 Assessment of quality and appropriateness for enrollees with special needs**

The MCO regularly reports data and other summary reports to assess the quality and appropriateness of care and services supplied under the MCO Contract to all enrollees, including those populations previously identified in this document as special populations (See Section 4.10 Identification of Special Populations).

Quarterly and annually, the MCO submits a report on quality assurance activities during the reporting period. A description of the activities such as current or proposed quality improvement projects, updates on these projects including any relevant attachments, results of medical record review(s) or chart abstraction activities for establishing baselines. Also included is a discussion of the MCO's use of encounter data in monitoring utilization and quality and identification of any problems regarding the completeness and accuracy of the data. The MCO will also report on activities during the reporting period associated with sub-populations and individuals with special healthcare needs.

## **5.2 Mandatory External Quality Review (EQR)**

The DMS maintains a contract with an External Quality Review Organization (EQRO) to perform external quality review functions. The EQRO performs the federally required reviews of access to care, quality of care and the effect of care coordination. EQR is the analysis and evaluation by an EQRO of aggregated information on quality, timeliness, and access to the health care services that an MCO or their subcontractors furnish to Medicaid enrollees. Requirements and procedures for EQR of Medicaid MCOs are established in the Code of Federal Regulations (42 CFR Parts 433 and 438) Final Rule. Three mandatory activities are conducted to provide information for EQR are identified in 42 CFR 438.358, which include the following:

- the review of compliance with structural and operational standards;
- the validation of performance measures; and
- the validation of performance improvement projects.

The DMS may determine which optional activities are included in the EQR and what types of performance measures and performance improvement projects to require of their contracting MCO. The Final Rule also requires that aggregated information are obtained from activities that are consistent with protocols, as defined in the rule, to ensure that data to be analyzed are collected using sound methods widely used in the industry. The DMS has contracted with a single EQRO to perform the mandatory and optional EQR activities.

Quarterly Reports containing a summary of EQR activities for the quarter and are provided to DMS on a quarterly schedule. An Annual Report is provided containing a detailed technical report describing the manner in which the data from all EQR and EQR related activities were aggregated and analyzed, and conclusions drawn as to the quality, timeliness, and access to care furnished by each MCO. The report will include an assessment of the MCO's strengths and weaknesses and recommendations for improvement for each of the activities conducted. This report is made available as requested.

## **5.3 Health Equity**

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

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

- Education and Awareness – Increase awareness of the significance of health disparities, their impact on the state, and the actions necessary to improve the health outcomes for racial and ethnic minorities, rural, and low-income populations of Kentucky.

- Cultural Competency – Improve the health and health care outcomes for racial and ethnic minority and underserved communities through evidence-based tailored approaches that account for differences in culture and language.
- Research – Improve the coordination and utilization of research to advance health equity for racial and ethnic minority and underserved communities.
- Evaluation – Improve the coordination and utilization of evaluation outcomes to advance health equity for racial and ethnic minority and underserved communities.
- Strengthening Partnerships – Strengthen and broaden leadership in Kentucky for addressing health disparities at all levels.

Current Projects for the Kentucky OHE include:

- Continuing Education (LGBT, Cultural Competency)
- UAB TCC Mini-grant - The Department for Public Health Office of Health Equity (OHE) and the Kentucky Heart Disease and Stroke program (KHDSF) are collaborating to promote heart healthy interventions such as smoking cessation, physical activity, healthy eating, and prevention, as well as working to improve quality of care and address inequities within the health care system and local communities. The collaboration will focus on improving the health outcomes for racial and ethnic minorities, rural, and low-income populations of Kentucky. This work is supported by the University of Alabama at Birmingham's Mid-South Transdisciplinary Collaborative Center for Health Disparities project, an NIMHD funded initiative (U54MD008176).
- Bless Your Heart/CARE Collaborative - The Bless Your Heart initiative is part of a three-piece Million Hearts Initiative comprised of a tool-kit that helps church health ministry's design a program that will encourage its enrollees to live a heart-healthy life. The Chronic Disease Branch Heart Disease and Stroke Prevention Program's CARE collaborative; (Cardiovascular Assessment, Risk Reduction and Education) is designed to provide blood pressure awareness educational encounters within communities. The Bless Your Heart/Care Collaborative is a project that communities can implement to improve the health of communities across the commonwealth. The Bless Your Heart/CARE Collaborative addresses key goals and strategies in addressing significant health disparities across the commonwealth. Those objectives of the Bless Your Heart/CARE Collaborative project are:
  - Increase awareness of the risk factors of heart disease and stroke
  - Educate the community on healthy living and disease prevention
  - Increase capacity within the faith-based communities to address health issues through established coalitions or networks
  - Increase access to care for those identified as needing additional follow-up to care

#### **5.4 Intermediate Sanctions**

The description describes the methodology for using sanctions as a means for addressing identified quality of care problems. These intermediate sanctions meet the requirements specified in 42 CFR 438 Subpart I.

##### **5.4.1 Requirement of Corrective Action**

The DMS may require corrective action in the event that any report, filing, examination, audit, survey, inspection, or investigation should indicate that the MCO, or any subcontractor or supplier is not in compliance with any provision of the contract, or in the event that the DMS receives a substantiated grievance or appeal respecting the standard of care rendered by the MCO, or any subcontractor or supplier. The DMS may also require the modification of any policies or procedures of the MCO relating to the fulfillment of its obligations under the contract. Should the DMS desire to take any such corrective action the DMS will issue a written deficiency notice and require a corrective action plan to be filed by the MCO within fifteen (15) days following the date of the notice. A corrective action plan delineates the time and manner in which each deficiency is to be corrected. The plan is subject to approval by the DMS, which may accept the plan as submitted, accept the plan with specified modifications, or reject the plan. The DMS may extend or reduce the time allowed for corrective action depending upon the nature of the deficiency.

#### **5.4.2 Notice of MCO Breach**

If the MCO fails to cure a default in accordance with a plan of correction or comply with Sections 1932, 1903(m) and 1905(t) of the Act, the DMS issues a written notice to the MCO indicating the violation(s) and advising the MCO that failure to cure the violation(s) within a defined time period not less than thirty (30) days, to the satisfaction of the DMS, may lead to the imposition of any sanction or combination of sanctions provided by the terms of the contract, or otherwise provided by law, including but not limited to the following: (a) suspension of further enrollment for a defined time period; (b) suspension of capitation payments; (c) suspension or recoupment of the capitated rate paid for any month for any enrollee who was denied the full extent of covered services meeting the standards set by the contract, or who received or is receiving substandard services; (d) assessment of liquidated damages under the contract; or (e) termination of the contract.

#### **5.4.3 Health Care Data Sanctions**

If the MCO knowingly fails to submit health care data derived from processed claims or encounter data as required by the terms of the contract, the DMS may withhold an amount commensurate with harm but not to exceed ten (10%) % of the MCO's capitation payment for the month following non-submission of data. The amount withheld will be retained by the DMS until the data is received and accepted by DMS. Any other health care data requested by the DMS or required under the contract, including social and demographic data, will be submitted in accordance with time frames developed by the DMS.

#### **5.4.4 Intermediate Sanction and Civil Money Penalties**

In the event the MCO fails to comply with the terms and conditions of 42 United States Code Section 1396b(m), the DMS may do any of the following: (a) Appoint temporary management to oversee the MCO if there is a substantial risk to the health of enrollees; (b) Permit individuals to disenroll without cause; (c) Suspend default enrollment; or (d) Suspend payment for new enrollees. Prior to imposing the intermediate sanctions, the DMS must give the MCO timely written notice that explains the basis and nature of the sanction, and any other due process protections that the State elects to provide.

Before terminating the contract under 42 CFR 438.708, the DMS provides the MCO with a pre-termination hearing. The State gives the MCO written notice of its intent to terminate, the reason for termination, and the time and place of the hearing. The DMS gives the MCO, after the hearing, written notice of the decision either affirming or reversing the proposed termination of the contract and for an affirming decision, the effective date of termination of the contract. The DMS also gives enrollees notice of the termination, and information consistent with 42 CFR 438.10, on their options for receiving Medicaid services following the effective date of termination.

The DMS may impose civil money penalties for the circumstances set forth below if the MCO does any of the following: (a) Fails substantially to provide medically necessary items and services that are required under law and under applicable Contracts; (b) Imposes excess premiums and charges; (c) Acts to discriminate among enrollees; (d) Misrepresents or falsifies information; (e) Violates marketing guidelines.

### **6.0 Conclusions and Opportunities**

As the largest payer of healthcare services in Kentucky, the DMS continuously seeks ways to improve healthcare quality. The Quality Strategy specifies areas of focus that serve to define time-bound, explicit goals and responsibilities for MCOs as they fulfill their missions of improved care, spending healthcare dollars more wisely, and making Kentucky communities healthier.

There are numerous opportunities that the DMS and its partners will need to capture to successfully achieve what is documented in its Quality Strategy. Aligning with CMS' Quality Strategy, DMS recognizes that opportunities can be categorized using these domains: eliminating racial and ethnic disparities, strengthening infrastructure and data systems across all settings of care, enabling local innovations, and fostering learning organizations. Specifically considering Medicaid in Kentucky, there are several notable advances that should support healthcare quality improvement. These include:

- Procurement of new Medicaid electronic data warehouse and electronic management system technology
- Connecting governmental data resources, and consolidating government human services teams by virtue of Medicaid 1115 waiver proposals
- Strong collaborative relationships across multiple sectors of state government, particularly with regards to new Medicaid specific partnerships and pilot projects with the Justice and Safety Cabinet, the Office for Drug Control Policy, the Office of the Inspector General, and the Education and Workforce Development Cabinet
- Significant expansion of Medicaid State University Partnership contracts to conduct analytic and programmatic development initiatives that directly support MCO quality improvement activities
- Legislative support that refines policies pertaining to telehealth; treatment of substance use disorder; and diabetes prevention.

As DMS pursues its internal action plan for operationalizing the Quality Strategy in the coming years, this document and its indicators of success will serve as a guidepost for new and ongoing efforts towards optimizing quality measurement and public reporting for quality improvement.

For additional information regarding MCO requirements, the MCO contract may be found at:  
<https://chfs.ky.gov>

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