The Menges Group

Strategic Health Policy & Care Coordination Consulting

Assessment of Kentucky's Medicaid Managed Care Program Impacts

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I. Introduction

The purpose of this study is to assess the impacts of Kentucky's Medicaid managed care program. The key components of this assessment include:

- Cost impacts of the Medicaid managed care program across the past two decades
- Performance on key quality measures
- Opioid and medication-assisted treatment (MAT) prescription drug usage trends
- Kentucky's recent experience with COVID-19 vaccinations
- Minimum contract requirements for managed care organizations (MCOs) to participate in Kentucky's Medicaid program
- Competitive procurement dynamics

II. Cost Impacts

This study indicates that Kentucky's Medicaid managed care program has significantly reduced Medicaid program expenditures.

We assessed the progression of Kentucky's Medicaid costs across the two-decade period extending from 2000-2019. During this timeframe, the percentage of Kentucky Medicaid expenditures paid via capitation increased dramatically from 15.0% to 65.3%. A similar increase in the use of capitation contracting occurred nationally during this timeframe, rising from 13.5% in 2000 to 49.9% in 2019.

We compared Kentucky's trends with nationwide Medicaid costs and with a group of the four largest states that have predominantly relied on the fee-for-service (FFS) model throughout this two-decade timeframe (Alabama, Arkansas, North Carolina, and Oklahoma). Across these four states, capitation contracting represented just 12.9% of Medicaid expenditures during 2019, with none of this spending involving comprehensive contracting with Medicaid MCOs.[1]

We contrasted these four states with a group of four southeastern US states (Kentucky, Louisiana, Mississippi, and Tennessee) that have significantly used, and increased their use of, the Medicaid MCO contracting model across the 2000-2019 timeframe. Across the four comparison group states, capitation contracting represented 22.2% of 2000 Medicaid expenditures, with this proportion increasing to 60.4% of Medicaid expenditures as of 2019.

We removed Medicaid expansion costs within states that adopted Medicaid expansion from the tabulations to avoid the distortions that would occur by comparing cost increases in expansion and non-expansion states. Using 2019 as the endpoint in this assessment also averts distortions created by COVID-19, which has generally created reduced health care usage and costs during 2020 and 2021. The findings from these tabulations are summarized in Exhibit A.

[1] Capitation spending in these four states involve specialized programs such as behavioral health capitation in North Carolina, and primary care capitation programs in Alabama, Arkansas, and Oklahoma.

Exhibit A. Trends in Medicaid Expenditures, 2000–2019

Statistical Measure	Kentucky	USA (50 States + DC)	4 Largest States Predominantly Using FFS Model Throughout 2000-2019 (Alabama, Arkansas, North Carolina, & Oklahoma)	4 Southeastern States of Similar Size Extensively Using MCO Model as of 2019 (Kentucky, Louisiana, Mississippi, and Tennessee)
Aggregate Percent Increase in Medicaid Expenditures From 2000-2019 (2019 figures exclude Medicaid expansion costs for states adopting expansion)	138%	140%	158%	143%
Percentage of Medicaid Expenditures Paid Via Capitation, 2000	15.0%	13.5%	1.7%	22.2%
Percentage of Medicaid Expenditures Paid Via Capitation, 2019	65.3%	49.9%	12.9%	60.4%

Data source: The Menges Group tabulations using CMS Financial Management Reports (FMRs) for federal fiscal years 2000 & 2019

Between 2000 and 2019, Kentucky's Medicaid costs (excluding Medicaid expansion expenditures) more than doubled, increasing by 138% during this timeframe, or by an average of 6.6% annually. This increase was slightly lower than the corresponding nationwide Medicaid cost progression of 140%.

Importantly, a 158% increase occurred across the four largest states relying on the Medicaid FFS model. This suggests Kentucky's FFY2019 Medicaid costs were 20% lower than would have occurred if the Medicaid MCO model had not been used (and embraced on a large scale) in Kentucky.

The above finding is confirmed through the comparison between the two groups of four states that were established. The rate of increase across the four southeastern states making extensive use of the MCO contracting model was 143% from 2000–2019. This cost trend as of 2019 was 15 percentage points below the group of the four largest states that did not use this model. Both comparisons suggest that Medicaid managed care has favorably "bent the trend" by nearly one percentage point per year from 2000–2019.

Between these two points of comparison, this study finds that Kentucky's Medicaid managed care program has resulted in 2019 Medicaid costs (excluding Medicaid expansion expenditures) being 15% to 20% lower than would have occurred had Kentucky relied predominantly on the FFS coverage model. **The FFY2019 total dollar savings these percentages equate to are conveyed in Exhibit B, which range from approximately $1.1 billion to $1.7 billion overall, and from $219 million to $310 million in Kentucky's share of its Medicaid costs.**

The state share of the savings primarily occurs for the non-expansion population, where the Commonwealth paid for approximately 28.25% of Medicaid costs during FFY2019. However, considerable Commonwealth savings of $36 million to $51 million occurred through serving the

Medicaid expansion population via the MCO capitation contracting model – even though the state share of the expansion population's overall Medicaid costs during FFY2019 was only 6.83%.[2]

Exhibit B. FFY2019 Savings Attributable to Kentucky's Medicaid MCO Contracting

	15% Savings	20% Savings
Total Medicaid Savings, FFY2019		
Non-Expansion Population	$648,224,033	$918,317,380
Expansion Population	$527,532,233	$747,337,330
Total	$1,175,756,266	$1,665,654,710
State Medicaid Savings, FFY2019		
Non-Expansion Population	$183,107,265	$259,401,959
Expansion Population	$36,052,735	$51,074,708
Total	$219,160,000	$310,476,667
Federal Medicaid Savings, FFY2019		
Non-Expansion Population	$465,116,767	$658,915,421
Expansion Population	$491,479,498	$696,262,623
Total	$956,596,266	$1,355,178,043

Kentucky's large-scale savings in the Medicaid managed care program have occurred with the capitation program representing roughly two-thirds of overall Medicaid expenditures. Additional savings may be achievable by enlisting Medicaid MCO management of much of Kentucky's remaining FFS expenditures. For example, a 15% savings on remaining fee-for-service Medicaid expenditures would have lowered total FFY2019 Medicaid spending by $530 million and yielded Commonwealth (state fund) savings of $150 million.

III. Quality and Access to Care Impacts

This study has assessed quality and access to care within Kentucky's Medicaid managed care program in several ways, including:

- National Committee for Quality Assurance (NCQA) accreditation
- Overall NCQA Quality Ratings
- Progression of quality scores on key Healthcare Effectiveness Data and Information Set (HEDIS) measures
- Opioid and MAT usage progression
- COVID-19 vaccinations

The findings in each of these areas are conveyed below.

A. NCQA Accreditation

NCQA is the primary entity awarding quality accreditation to health plans, and NCQA has the most rigorous criteria and processes for obtaining and maintaining health plan accreditation. All five of Kentucky's Medicaid MCOs operating during the years assessed (a sixth MCO now also participates) are

[2] These federal and state share percentages were derived from the FFY2019 FMR reports Kentucky submitted to CMS.

accredited by NCQA for their Medicaid operations. Nationwide, approximately 60% of Medicaid MCOs are currently NCQA-accredited.

B. Overall NCQA Quality Ratings for Medicaid MCOs

NCQA provides an overall quality rating for MCOs on a 0-5 scale. During NCQA's most recent rating year (2019-2020), the five participating MCOs averaged a score of 3.30. This figure closely aligns with the nationwide average for Medicaid MCOs in that rating period (3.42), even though Kentucky has far more significant social determinants of health (SDOH) barriers to overcome in achieving access than exist "on average" in the country. Kentucky is the sixth lowest state for overall health (per America's Health Rankings, 2018). The Commonwealth also has the fifth highest percentage of the population that is obese, and the nation's second highest percentage of residents who smoke tobacco. Working against this baseline, Kentucky's Medicaid MCOs' delivery of "average" quality scores on a national scale is a strong accomplishment.

C. Progression of Quality Scores on Key HEDIS Measures

Working with NCQA's Quality Compass data set across multiple years, we assessed the progression of average quality scores on more than 20 key HEDIS measures. Virtually all these measures provide insight into health service access.

We analyzed all measures that were either defined as key measures by NCQA (by virtue of factoring into each MCO's overall quality scores awarded by NCQA), and/or were defined by Kentucky's Department of Medicaid Services as being "core quality measures." For 24 of these measures, data were available in Quality Compass for all five Kentucky Medicaid MCOs for both 2016 and 2019, and 21 of these measures are core Kentucky measures.

The average scores for each of these quality measures across the five Kentucky MCOs operating during this timeframe are presented in Exhibit C below. From 2016-2019, the **Kentucky Medicaid MCOs' quality score improved by an average of 3.27 points across the 21 core Kentucky measures.** These scores also improved by an average of 3.03 points across all 24 key measures.

Among the 21 core Kentucky measures, the MCOs' average score improved from 2016-2019 on 16 measures (76%). Across all 24 key measures, the MCOs' average score improved from 2016-2019 on 18 measures (75%).

These data demonstrate both the degree to which Kentucky closely tracks quality performance, and the degree to which Kentucky's Medicaid MCOs are collectively "moving the needle" favorably in terms of achieving steadily improved quality. While these percentage point improvements may appear modest, these are important achievements. A 3% increase in these average scores translates to tens of thousands of additional Kentucky Medicaid enrollees accessing preventive services and indicated treatments for their health conditions in 2019 relative to 2016.

Exhibit C. Progression of Average Kentucky Medicaid MCO Quality Scores on Key HEDIS Measures, 2016-2019

HEDIS MEASURE	Abbreviation	2016 Average Score, Kentucky Medicaid MCOs	2019 Average Score, Kentucky Medicaid MCOs	Increase or Decrease in Average Score
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)	WCC	62.25	79.32	17.07
Prenatal and Postpartum Care - Postpartum Care	PPC - Post	59.30	68.25	8.95
Childhood Immunization Status - Combo 10	CIS Combo 10	22.06	30.56	8.50
Adult BMI Assessment	ABA	83.91	91.43	7.52
Well-Child Visits in the first 15 Months of Life (6 or more visits)	W15 - 6+ Visits	59.59	66.89	7.30
Controlling High Blood Pressure - Total	CBP	51.51	57.57	6.06
Comprehensive Diabetes Care - Eye Exam	CDC - Eye Exam	44.42	50.46	6.04
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	CDC - Blood Pressure	55.62	60.42	4.81
Use of Imaging Studies for Low Back Pain	LBP	60.90	65.17	4.27
Appropriate Testing for Pharyngitis (Total)	CWP	54.62	57.96	3.34
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	W34	63.40	66.36	2.96
Prenatal and Postpartum Care - Timeliness of Prenatal Care	PPC - Pre	81.66	84.24	2.58
Medication Management for People With Asthma - Medication Compliance 75% (Total)	MMA	41.31	43.87	2.56
Annual Dental Visit (Total)	ADV	54.96	57.37	2.41
Well-Child Visits in the first 15 Months of Life (0 visits), low score is desired	W15 - 0 Visits	2.01	1.37	0.64
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	PCE - SC	68.85	69.45	0.60
Comprehensive Diabetes Care - HbA1c Control (<8%)	CDC - HbA1c	45.41	45.15	-0.27
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	PCE - B	81.28	78.20	-3.08
Antidepressant Medication Management - Effective Continuation Phase Treatment	AMM	38.87	34.97	-3.90
Follow Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	ADD	66.34	62.28	-4.06
Spirometry - COPD	SPR	34.88	29.28	-5.60
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	81.37	84.54	3.17
Asthma Medication Ratio	AMR	64.60	65.51	0.92
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	SAA	58.61	58.44	-0.17
AVERAGE, ALL 24 MEASURES WHERE DATA WERE AVAILABLE				**3.03**
AVERAGE, ALL 21 KENTUCKY CORE MEASURES WHERE DATA WERE AVAILABLE				**3.27**

Data source: The Menges Group tabulations using NCQA Quality Compass data files

D. Opioid and MAT Usage Progression

Kentucky's Medicaid MCOs pay for most the state's Medicaid prescriptions, including more than 99% of both opioid and MAT prescriptions. It is widely recognized that Kentucky has been particularly hard-hit by the opioid epidemic, and this dynamic is evident in Exhibit D. **Kentucky's share of nationwide Medicaid opioid prescriptions doubled from 2012-2019, from 2.4% to 4.8%.** These percentages, particularly the 2019 figure, are above Kentucky's share of overall Medicaid prescription volume.

Exhibit D. Kentucky's Share of Nationwide Medicaid Prescriptions

	2012	2019
All Prescriptions	2.24%	3.25%
Opioids	2.39%	4.79%
MAT	3.51%	7.55%

Data source: The Menges Group tabulations using CMS State Drug Utilization Files

As a component of the Medicaid MCOs' efforts to counter this epidemic, Kentucky is a national leader in providing its Medicaid population with access to MAT. As shown in the bottom row of Exhibit D, Kentucky's share of nationwide MAT prescriptions, 7.6% in 2019, is far above Kentucky's share of all Medicaid prescriptions and its share of all opioid Medicaid prescriptions. Kentucky's MAT treatment efforts are further evident in Exhibit E, which conveys MAT prescriptions as a percentage of opioid Medicaid prescriptions each year. While this ratio has improved (with relatively more MAT prescriptions

occurring) nationally and in Kentucky *every year* from 2012-2019, Kentucky's ratio is far above the nationwide figure each year.

Exhibit E. Annual MAT Medicaid Prescription Volume as Percentage of Opioid Medicaid Prescription Volume, 2012 - 2019

Geographic Area	2012	2013	2014	2015	2016	2017	2018	2019
Kentucky	8.6%	17.0%	23.3%	24.3%	22.1%	35.9%	45.4%	54.6%
USA	5.9%	6.7%	7.5%	8.9%	11.8%	16.4%	24.9%	34.6%

Data source: The Menges Group tabulations using CMS State Drug Utilization Data files

E. COVID-19 Vaccinations

As with other states in the region, Kentucky's population has considerable hesitancy regarding accessing available COVID-19 vaccines. Low-income subgroups are at particular risk for contracting COVID-19 and are also at heightened risk of significant complications and death should they contract the virus. Kentucky's Medicaid MCOs have worked diligently to overcome barriers to COVID-19 vaccination for their enrollees. A few examples of these efforts are conveyed below:

- Multi-channel outreach from Kentucky MCOs to their enrollees via calling, texting, and mailing information
- Gift card incentives ranging from $25 to $100 to encourage individuals aged 12 and older to complete vaccinations
- In-home vaccinations

Available vaccination data demonstrate that Kentucky is faring quite well in achieving protection against COVID. As of November 12, 2021, Kentucky ranks 37th among all states regarding the percentage of its population that has been at least partially vaccinated. This percentage is higher than five of the seven states contiguous to Kentucky, with the only two neighboring states having higher vaccination rates (Illinois and Virginia).

Exhibit F compares vaccination percentages as of November 12 in four non-senior adult age cohorts between Kentucky and selected neighboring states. In almost every instance, Kentucky's vaccination percentage is above the neighboring state's figure.

Exhibit F. Vaccination Percentages in Kentucky and Selected Comparison States: Non-Senior Adults

First Vaccination Dose Administered by State by Age					
Age Bracket	**Kentucky** *9% Medicaid Population in FFS/other*	**West Virginia** *23% Medicaid Population in FFS/other*	**Indiana** *22% Medicaid Population in FFS/other*	**Tennessee** *0% Medicaid Population in FFS/other*	**Ohio** *6% Medicaid Population in FFS/other*
18-24	49%	50% (16-20) & 51% (21-25)	47% (20-24)	46% (21-30)	51% (20-29)
25-39	57%	47% (26-30) & 55% (31-40)	50%	55% (31-40)	58% (30-39)
40-49	66%	61% (41-50)	59%	61% (41-50)	63% (40-49)
50-64	76%	69% (51-60)	70%	67% (51-60)	73%

Data source: The Menges Group tabulations using state dashboard COVID-19 vaccination data

These relatively successful vaccination rates in Kentucky may be at least partially attributable to the large degree to which Kentucky's overall population is enrolled in Medicaid (Kentucky ranks fourth in the nation), coupled with the large degree to which its Medicaid population is served via MCOs that systematically track and facilitate access to care. As shown in the column headings in Exhibit F, Kentucky's Medicaid population is much more extensively enrolled in MCOs than in Indiana and West

Virginia. Kentucky has a significantly larger proportion of its population enrolled in Medicaid (35%) than Ohio (26%) and Tennessee (23%).

IV. Kentucky's Contract Requirements for Medicaid MCOs

Kentucky's Department for Medicaid Services (DMS) has established a detailed and rigorous set of contract requirements for any organization that will serve as a Medicaid MCO in the Commonwealth. These requirements begin on page 43 of the Medicaid Managed Care Contract document and extend for 130 pages (through page 173). Twelve examples of the rigor of these requirements are conveyed below.

1. **National Committee for Quality Assurance (NCQA) Accreditation:** The Contractor shall have NCQA accreditation. The Contractor shall authorize the accrediting entity to provide the Department a copy of its most recent accreditation review, including:
    a. Accreditation status, survey type, and level (as applicable);
    b. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and
    c. Expiration date of the accreditation.

    The Contractor shall provide the Department a copy of its complete survey report every three years.

2. **Administrative Costs:** The Contractor agrees that its administrative costs shall not exceed ten percent (10%) of the total Medicaid managed care contract cost.[3] Note that actual administrative allocations to the MCOs in their capitation rates are averaging below this established ceiling – approximately 8%. Note also that similar to the administrative cost requirements, in setting capitation rates for Kentucky's program DMS seeks to build in only a 1.0% profit margin for the health plans.

3. **Access to Contractor's MIS:** The Contractor shall provide the Department with log-in credentials to allow access to Contractor's Claims and customer service systems on a read-only basis at the Contractor's primary place of business during normal business hours.

4. **Licensure of Providers:** Prior to the start date of operations and at all times during the period of the Contract, the Contractor shall ensure that each provider, including individuals and facilities and their staff, providing health care services to Enrollees is validly licensed or, where required, certified to provide those services in the Commonwealth or the state in which services are provided, including certification under CLIA, if applicable. Each provider in has a valid Drug Enforcement Agency ("DEA") registration number, if applicable. Each provider shall have a valid NPI and Taxonomy, if applicable.

[3]It is important for policymakers to not consider administrative spending as inherently inferior to direct provider payments. Administrative efforts, as with medical spending, can be exceptionally valuable or excessive depending on the nature of any given expenditure. Extensive administrative investments to systematically assess enrollees' needs and facilitate access to appropriate care, for example, are critically needed in the Medicaid arena.

5. **Key Personnel:** The Contractor's Executive Team members are considered key personnel... All key personnel shall be dedicated full-time to this Contract and shall be available to meet at the Department's requested location within twenty-four (24) hours' notice from the Department.

6. **Health Outcomes:** The Department will set specific quantitative performance targets and goals, and the Contractor shall be expected to achieve demonstrable and sustained improvement for each measure. Minimum performance levels shall be specified for each performance improvement area derived from regional or national standards or from standards established by an appropriate practice organization.

7. **Value-based Payment:** The Contractor shall collaborate with the Department and other MCOs to implement a Value-Based Payment (VBP) model that aligns incentives for Enrollees, Providers, the Contractors, and the Commonwealth to achieve the Medicaid program's overarching goals for improvement in quality and healthcare outcomes. The impact of initiatives will be measured in terms of access, outcomes, quality of care, and savings.

8. **Enrollee Call Center:** The Contractor shall have an Enrollee Services function that includes a call center which is staffed and available by telephone Monday through Friday 7:00 am to 7:00 pm Eastern Time (ET). The call center shall meet the current American Accreditation Health Care Commission/URAC-designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer…

9. **Outreach to Homeless Persons:** The Contractor shall assess the homeless population by implementing and maintaining a customized outreach plan for Homeless Persons population, including victims of domestic violence. Victims of domestic violence should be a target for outreach as they are frequently homeless. Assistance with transportation to access health care may be provided via bus tokens, taxi vouchers or other arrangements when applicable.

10. **Coordination of Primary Care and Behavioral Health Care:** The Contractor shall provide training to network PCPs on how to screen for and identify behavioral health disorders, the Contractor's referral process for Behavioral Health Services and clinical coordination requirements for such services. The Contractor shall include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.

11. **Population Health Management (PHM):** The Contractor shall submit its written PHM Program Plan to the Department for review and approval within thirty (30) Days of Contract Execution, annually, and prior to implementing any material revisions. The PHM Program Plan must address all program elements set forth in this Section and others based on the specific components of the Contractor's Program.

12. **Care Planning:** For Enrollees identified as needing Care Plans, the Contractor shall use a collaborative multidisciplinary team to develop an individualized and person-centered Care Plan with the Enrollee receiving care management services. The Contractor shall assign a care manager to the Enrollee who will facilitate development of the care team and Care Plan,

The DMS requirements for MCOs regarding serving enrollees with special needs are particularly stringent, including in particular the separate contract for the MCO serving children in foster care (named the Kentucky SKY Program).

The volume and rigor of the contract requirements, including the program oversight requirements, position Kentucky and DMS to partner only with Medicaid MCOs that are exceptionally qualified to deliver comprehensive care coordination services tailored to the Commonwealth's Medicaid population. The contract procurement process, described in the next section of the report, furthers Kentucky's ability to identify optimal MCO contracting partners – and to leverage the competition for DMS contract awards to push the health plans to offer features "above the compliance bar" DMS has established through its core contract requirements.

V. Competitive Procurement Dynamics in Kentucky's Medicaid Managed Care Program

Kentucky's competitive procurement for MCO contracts pushes health plans to "one-up" one another with the level of their programmatic commitments and innovative features in the effort to be one of the selected Medicaid MCO program participants. Through its procurement process throughout the past decade, DMS has been successful in attracting a large set of highly qualified applicants, leveraging its Request for Proposal (RFP) process to contract with the highest-qualified MCOs.

Like its efforts to create rigorous baseline contract requirements as described in the previous section, DMS has been strategic in framing its RFP questions to motivate MCOs to compete and innovate in the programmatic areas of greatest importance to DMS. The core RFP questions in the most recent DMS Medicaid MCO RFP covered 30 operational areas, with the questions themselves extending across 25 pages of the RFP. The questions for the Kentucky SKY procurement spanned 22 pages. An excerpt of questions in the core RFP (taken from just one of the 30 operational areas covered) is provided in Exhibit G below.

Exhibit G. Excerpted Questions from Kentucky's Medicaid MCO Procurement

Section 19.0 Quality Management and Health Outcomes:

a. Provide a detailed description of how the Vendor will support the Department in achieving its goals to transform the Medicaid program to empower individuals to improve their health and engage in their healthcare and to significantly improve quality of care and healthcare outcomes, and to reduce or eliminate health disparities. At a minimum, the Vendor's response should address:

> *i. How it will structure its organization to provide for a comprehensive and holistic approach to meet these goals, including coordination with Subcontractors and providers.*
>
> *ii. Strategic solutions the Vendor will use in quality management, measurement, and improvement.*
>
> *iii. Innovative strategies and enhanced services, if any, that the Vendor proposes to implement to enhance the health and well-being of Enrollees and to improve health outcomes, including examples of successes with similar Medicaid populations.*

iv. Internal tools and technology infrastructure the Vendor will use to support improvements in health outcomes and to identify, analyze, track, and improve quality and performance metrics as well as the quality of services provided by Network Providers at the regional and statewide levels.

v. Methods to ensure a data-driven, outcomes-based continuous quality improvement process, including an overview of data that is shared with providers to support their understanding of progress in achieving improved outcomes.

b. Indicate if the Vendor has received NCQA accreditation for the Kentucky Medicaid market, and if not, the proposed timeline for achieving accreditation.

c. Provide the Vendor's proposed use of the Quality Improvement Committee (QIC) to improve the Kentucky Medicaid managed care program.

d. Provide the Vendor's proposed use of the Quality and Member Access Committee (QMAC) to improve the Kentucky Medicaid managed care program, including the following information:

i. Proposed stakeholder representation.

ii. Innovative strategies the Vendor will use to encourage Enrollee participation.

iii. Examples of successful strategies the Vendor has implemented to obtain active participation in similar committees.

e. Provide a comprehensive description of the Vendor's proposed Quality Assessment and Performance Improvement (QAPI) Program that meets all requirements of this Contract.

f. For each of the below quality measures, demonstrate how the Vendor will work to make improvements in Kentucky's Medicaid population. Include discussion of strategies and interventions specific to each measure, partners that will be necessary to achieve improvement, data analytics, and anticipated timeframes for success in achieving improvements. Describe potential challenges the Vendor anticipates, if any, and how those will be addressed. Provide examples of successes in other state Medicaid programs, and how that success will be leveraged in the Kentucky Medicaid market.

i. Medication Adherence for Diabetes Medications

ii. Tobacco Use and Help with Quitting Among Adolescents

iii. Colorectal Cancer Screening

g. Describe the Vendor's proposed approach to collaborating with the Department, other MCOs, and providers to ensure Performance Improvement Projects (PIPs) are effective in addressing identified focus areas and improving outcomes and quality of care for Enrollees, including the following:

i. Lessons learned, challenges, and successes the Vendor has experienced while conducting PIPs, and how the Vendor will consider those experiences in collaboration with the Department on identified PIPs.

ii. Recommended focus areas, including those for regional collaborative PIPs, for the first two years of the Contract resulting from this RFP and rationale for these focus areas.

iii. Methods for monitoring and ongoing evaluation of progress and effectiveness.

h. Provide a description of opportunities the Vendor has identified to collaborate with the Department for Public Health to support improvement in public health outcomes. Where does the Vendor anticipate that collaborating on

initiatives would have the most impact in addressing quality care and outcomes for Medicaid Enrollees? Explain the Vendor's rationale.

i. Describe the Vendor's approach to monitoring and evaluating progress in improving the quality of health care and outcomes on an ongoing basis. Describe the following:

i. How the Vendor will use data to inform and prioritize initiatives to address Enrollee needs.

ii. Methods for measuring provider performance against practice guidelines and standards adopted by the QIC, and follow up activities to be conducted with providers based on ongoing review of findings.

iii. A summary of the Vendor's approach to annual evaluation of the overall effectiveness of the QAPI program and how the Vendor will use findings for continuous quality improvement efforts.

j. Provide a summary of how the Vendor will collaborate with the Department and other Vendors in developing and implementing a value-based payment (VBP) program. Include proposed approaches for the following at a minimum:

i. The Vendor's lessons learned in developing and implementing VBP models, examples of models that

have been most effective in improving performance and outcomes.

ii. Recommended goals and focus areas in the first two years of implementation of the VBP program.

iii. Proposed approaches to collaborate with the Department and other MCOs to develop the VBP program and to implement a coordinated approach to achieve statewide improvement in outcomes.

iv. Potential challenges specific to Kentucky and the Vendor's proposed methods for addressing identified challenges.

v. Regardless of the model implemented, the Vendor's approaches to analyzing performance against targets, frequency of analyses, reporting results to DMS, and use of analyses to modify interventions that are not making progress towards achieving targets.

k. Will the Vendor and Subcontractors implement VBP arrangements with providers? If so, describe the following:

i. The types of VBP arrangements the Vendor and Subcontractors plan to use and why these models were selected. As part of your description, map your proposed VBP arrangement to the HCP-LAN APM Framework maturity level.

ii. How improvement in health outcomes will be addressed through the VBP arrangements implemented.

iii. Methods for evaluating the effectiveness of VBP, including tracking of costs and improvement in health outcomes.

l. Provide results of any provider satisfaction survey reflecting the Vendor's performance in Kentucky or any other state Medicaid program over the last three (3) years. Where results identified provider dissatisfaction, describe strategies the Vendor has implemented to address improvement, and examples of how those strategies have been effective.

VI. Summary of Key Findings

Kentucky's Medicaid managed care program is an asset to the Commonwealth of Kentucky, its Medicaid population, and its taxpayers. The program's regulatory framework includes a comprehensive set of core contract requirements for any Medicaid MCO, coupled with a competitive bidding process that

fosters innovations and performance commitments above the program's core contract requirements. Within this framework, Kentucky has attracted a capable field of MCO applicants during each procurement, resulting in the state's selection of the most advantageous contracting partners.

This study finds that these health plans, in partnership with Kentucky's DMS, Kentucky's provider community, and a wide array of community agencies, have delivered on the program's core objectives. These accomplishments are summarized below.

A. Cost Effectiveness

Based on cost trends in Kentucky relative to other states from 2000-2019, costs under Kentucky's Medicaid managed care program in 2019 were 15% to 20% lower than would have occurred had Kentucky relied predominantly on the FFS coverage model. **These percentages equate to FFY2019 overall Medicaid savings of $1.2 billion to $1.7 billion in Kentucky, and savings of $219 to $310 million in Kentucky's share of its Medicaid costs.**

B. Quality and Access

Several important achievements regarding quality and access to care have occurred.

- All Kentucky Medicaid MCOs secure NCQA accreditation. The Kentucky MCOs' overall quality scores have been closely in line with nationwide Medicaid MCO averages even though Kentucky's population has a more challenging baseline of health status and lifestyle dynamics to overcome.

- From 2016-2019 across 21 core Kentucky quality and access measures, the **Kentucky Medicaid MCOs' composite quality scores improved by an average of 3.27 points.** This improvement translates to tens of thousands of additional Medicaid enrollees accessing indicated services.

- As one prong of their efforts to address Kentucky's opioid epidemic, the MCOs have been highly successful in facilitating access to MAT. During 2019, Kentucky's Medicaid program had 55 MAT prescriptions for every 100 opioid prescriptions, far above the nationwide ratio of 35 MAT prescriptions per 100 opioid prescriptions.

- Kentucky's adult population has accessed COVID vaccinations to a much greater degree than has occurred in most of its neighboring states. As of November 12, 2021, Kentucky ranks higher than five of the seven states contiguous to Kentucky for share of its population at least partially vaccinated. These successes seem at least partially attributable to the state's unusually high Medicaid enrollment, as well as the presence of experienced Medicaid-focused health plans that systematically track and facilitate access to needed health services.

While the scope of this assessment has been limited to the components described above, the above achievements indicated what can occur under a system of care coordination tailored to address the Medicaid population's diverse and complex health needs. The FFS coverage model does not systematically track or reward quality, facilitate access to care, or steer care to cost-effective treatments. The support rendered to the Medicaid population by the health plans during most of their lives when they are not directly obtaining health services is critical to enrollees' potential to achieve and

maintain optimal health and quality of life. Kentucky's Medicaid managed care program represents a comprehensive means of achieving all these important objectives.