



Kentucky Department for Medicaid Services

Managed Care Contracting

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Objectives for Procurement

- Continually enhance Kentucky's Medicaid managed care system.
- Strengthen MCO contracts to provide increased accountability and greater focus on collaboration and partnership to achieve improved quality and outcomes.
- Develop collaborative approach with MCOs and state agency partners to implement targeted approaches to improve the health of enrollees in a cost efficient and effective manner.
- Develop approach to improve provision and coordination of services for enrollees in Foster Care or receiving Adoption Assistance, Dually Committed Youth, and Former Foster Care Youth.

Key Contract Enhancements and Programmatic Changes

MCO Accountability

- Modified, streamlined, and added requirements throughout contract to increase clarity and to strengthen Department ability to hold MCOs accountable.
- Strengthened requirements for MCO oversight of subcontractors, including specificity about subcontract requirements as applicable.
- Added standard provisions that must be included in provider contracts to provide additional protections for providers as well as to support overall program accountability.
- Modified and added remedies for violation, breach, or non-performance.

Monitoring and Oversight

- DMS will conduct comprehensive readiness reviews of all MCOs, including subcontractors – setting the stage for ongoing oversight.
- DMS will conduct a collaborative process with the MCOs to develop a comprehensive reporting package that provides sophisticated data analytics.
- DMS is also reviewing internal infrastructure to support collaboration with and thorough oversight of the MCOs.
- DCBS will participate in monitoring and oversight activities for Kentucky SKY.

Payment Strategies

- Described the Department's risk adjustment model and indicated that supplemental pass-through payments and payments related to the Health Insurers' premium Fee (HIF) will not be risk-adjusted.
- Indicated the Department may, at its discretion and subject to CMS approval, implement medical loss ratio (MLR) incentive programs by which the MCO may reduce its allowable MLR.
- Added language to allow Department to develop and require the MCO to participate in a value-based payment (VBP) model.

Kentucky Health Information Exchange (KHIE) and Kentucky Health Benefit Exchange (KHBE)

- Requires that contracted network providers will sign a participation agreement with the KHIE within one month of contract signing.
- Requires contracted hospitals to submit information on admissions, discharges and transfers to KHIE to support timely patient care coordination.
- Requires the MCO to develop a collaborative relationship with enrollees of the KHBE Consumer Assistance Program.

Quality and Healthcare Outcomes

- Extensive changes to Quality Management and Health Outcomes requirements to include the following:
 - Strengthened expectations of MCO to support Kentucky in transforming the Medicaid program.
 - Added specificity and streamlined Quality Assurance and Performance Improvement Program requirements and performance measurement to achieve improved healthcare outcomes.
 - Revised Performance Improvement Project (PIP) requirements to further define accountability for completion, allow more flexibility in PIP topics, and to provide more detail about collaborative PIPS.
 - Expanded requirements to monitor performance in addressing outcomes to identify need for adjustments in approaches, projects or initiatives.

Utilization Management (UM)

- Added requirements for UM Committee and for innovative and effective UM processes and continual evaluation of cost and quality of medical services.
- Expanded requirements for content of UM Program and Review Plan and to require annual evaluation include subcontractors.
- Expanded medical necessity criteria requirements.
- Added specificity for timing of service review and authorization, including addition of specifications for telehealth and compliance with federal regulations (e.g., parity in mental health and substance use disorder benefits).

Enrollee Services and Enrollee Assignment

- Added requirements for Enrollee Handbook to follow a model Handbook that DMS will provide and to meet federal requirements.
- Added requirements for materials to be at a sixth grade reading level.
- Described enrollee reassignment method should a currently contracted MCO not continue participation.

Provider Services

- Decreasing administrative burden through changes such as:
 - Requiring a process to work with the Credentialing Verification Organization(s), at such time as contracted by the Department.
 - Clarified and expanded requirements for provider grievances and appeals policies and procedures
- Added detail for provider manual and website requirements.
- Added requirement for submission of an orientation and education plan. Added topics to listing of education requirements.
- Increased MCO contribution requirements for provider forums.
- Deleted language allowing providers to provide services prior to finalizing credentialing.

Provider Network

- Extensive changes to provider network requirements to set expectations for supporting quality and outcomes goals, including:
 - Required submission of a comprehensive Provider Network Plan (*see detail in later slide*).
 - Allowing for network to include providers in bordering states.
 - Added specificity for provider types.
 - Updated accessibility requirements to comply with Kentucky-specific and federal regulations.
 - Added language regarding Geo Access reporting, and indicated specifications and definition for a full-time provider location and calculation of distance.

Provider Network (continued)

- Extensive changes to provider network requirements to set expectations for supporting quality and outcomes goals, including:
 - Ensuring network providers have knowingly and willingly agreed to participate, and to not require practitioners as a condition of contracting, to agree to participate or accept other products offered by the MCO.
 - Added steps MCO must take to request exceptions to network requirements.
 - Added requirements for MCO monitoring of provider compliance with access requirements (e.g., appointment and wait time standards).
 - Updated timing of notice of provider network changes to enrollees to coincide with timing of provider termination notices.
 - Added requirement to conduct exit surveys of providers who terminate participation.

Required Components of Provider Network Plan

- Overall approach to include information such as:
 - Activities to establish and maintain a network that meets required standards and addresses needs of all enrollees.
 - Methods to support and sustain network providers, including hospitals, in non-urban and other traditionally underserved areas.
 - A quantifiable and measurable process for monitoring and assuring sufficiency of network to meet health care needs of all enrollees on an ongoing basis.
 - Methods to address non-compliance with access and adequacy requirements.
- Quality assurance standards consistent with DMS' Quality Strategy.
- Demonstration of level of compliance in areas such as:
 - Appropriate range of preventive, primary care, and specialty services, that is adequate for the anticipated number of enrollees by Medicaid Region.
 - A network sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the Medicaid Region.

Provider Payments

- Added language to address stakeholder comments about need for more seamless claims processing when a claim is denied due to being submitted to the wrong entity.
- Modified language to require MCOs to make payments directly to Federally Qualified Health Centers and Rural Health Clinics at no less than the amount established under Kentucky's prospective payment system (PPS) rate.

Covered Services

- Added coverage of telehealth services.
- Added requirement to contribute to a statewide emergency Behavioral Health hotline.
- Complete revision of pharmacy benefits requirements, including compliance with SB 5, increasing transparency, cooperating with DMS on ensuring compliance, and reporting. For example:
 - Added specificity for definition of “pharmacy benefits.”
 - Enhanced requirements for use of a pharmacy benefit manager (PBM), a pharmacy benefits administrator (PBA) or related subcontractor.
 - Improved requirements on claims processing and others to ensure the state can claim and maximize rebates on physician administered drugs.
 - Strengthened Pharmacy and Therapeutics Committee (P&T) requirements.
 - Improved preferred drug list requirements.

Population Health Management (PHM)

- Added a comprehensive PHM Program to improve enrollee health through an innovative, person-centered approach addressing physical health, behavioral health, functional, and social need. Examples of requirements to address care needs include:
 - Submission of a PHM Program Plan. Include components of NCQA's programs to address Health Promotion and Wellness, Management of Chronic Conditions, and Complex Care Management.
 - Specification of conditions and populations as priority for the PHM Program based on the highest needs in Kentucky.
 - Required tools (e.g., risk stratification and service tiers, Health Risk Assessments, Enrollee Needs Assessments)
 - Care planning, including a multi-disciplinary team.
 - Ongoing program evaluation.

Kentucky SKY (Supporting Kentucky Youth)

- A single MCO will be responsible for providing and coordinating services under Kentucky SKY for enrollees in Foster Care or receiving Adoption Assistance, Dually Committed Youth, and Former Foster Care Youth.
- The Kentucky SKY MCO will have dedicated staff, care coordination teams, specific business processes and workflows, and a strong commitment to the integration of physical and behavioral health.
- DMS, DCBS, and DJJ have collaborated extensively in the design of Kentucky SKY and development of MCO contractual requirements. Partnership will continue in monitoring and oversight of the Kentucky SKY MCO.

Questions

