C.3 Capitation Payments

REQUIREMENT: RFP Section 60.7.C.3
3. Capitation Payments (Section 10.0 Capitation Payment Information, Section 11.0 Rate Component)
   a. Describe proposed approaches for Physician Incentive Plans, including innovative approaches to incent provider behavior and participation.
   b. Provide examples of successful Physician Incentive Plans the Vendor has implemented, including information about their structure, measurable outcomes, challenges and lessons learned.

Our Physician Incentive Plans for Kentucky Medicaid align effective, tailored incentives that drive provider performance, quality, and population health outcomes improvements while reducing cost and operational inefficiencies.

Molina has placed a high priority on driving the transformation of the healthcare payment landscape from paying for volume to paying for value. Our face-to-face discussions with Kentucky Medicaid providers across the Commonwealth have helped lay the strong foundational understanding needed to create effective Physician Incentive Plans for the Kentucky Medicaid program.

Our collaborative value-based payment (VBP) strategy, comprised of several VBP programs, is our Physician Incentive Plan solution. It is designed to improve provider performance, support key Department quality and population health outcomes priorities, and align with our quality assurance and performance improvement (QAPI) program initiatives and quality measures for the Kentucky Medicaid program. Moreover, our proposed approaches adhere to all requirements set forth in Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 10, Capitation Payment Information and Section 11, Rate Component.
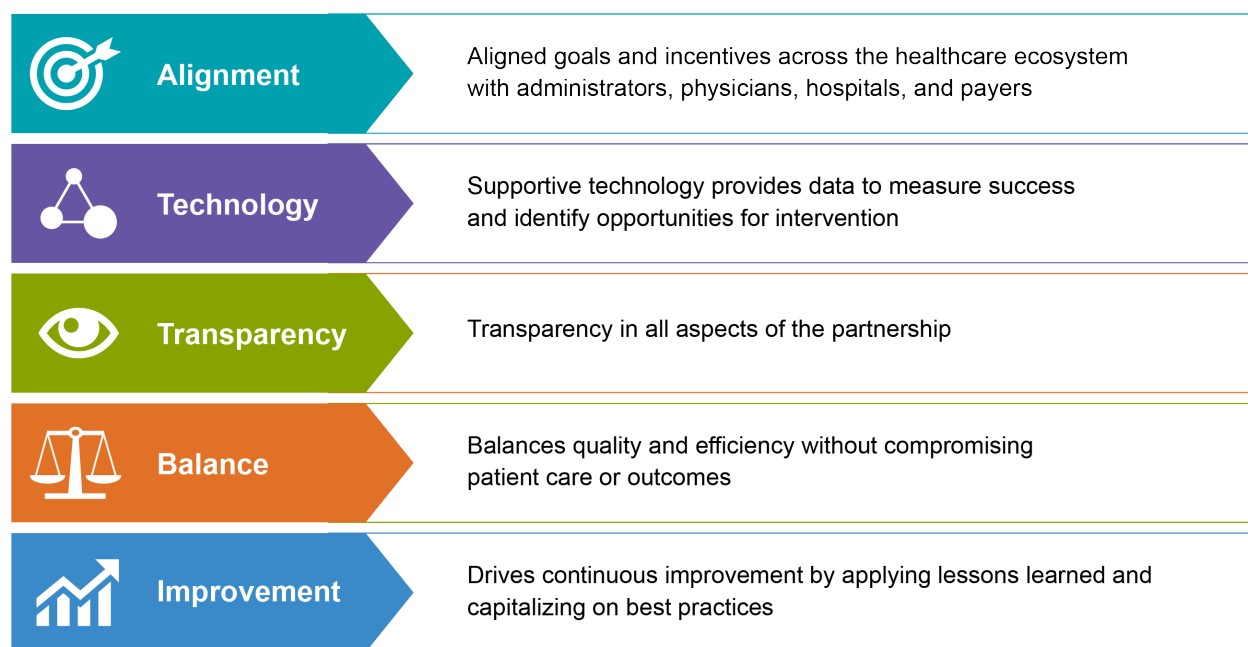
Our strategy for Kentucky will further leverage our affiliated health plans' extensive national experience with VBP, which currently comprises *more than 29,000 providers, including more than 5,000 providers operating as certified patient-centered medical homes (PCMHs), serving approximately 2.8 million members.*

VBP innovation for Kentucky Medicaid

- Innovative gain share / risk share VBP with Kentucky Primary Care Association
- VBP models supporting KHIE connection, EHR adoption
- Subcontractor partners for dental, vision, pharmacy, telehealth, maternity VBP
- Leverages Molina's enterprise wide VBP contracts with 29,000+ providers (5,000+ PCMH certified)
- 2.8 million members under VBP across all Molina affiliated health plans

As an example of our commitment to building an effective Kentucky Medicaid VBP model, our partnership with the *Kentucky Primary Care Association (KPCA) includes a technology-enabled, value-based reimbursement model incorporating clinical and provider gain share and risk share methodologies* that will support transparency and comparability, drive improved outcomes, and control costs.

Our continuum of value-based models promotes the transformation of care delivery and performance from a historically volume-based model to one focused on a clear, value-based, long-term population health management strategy that will lower costs and improve the overall quality of healthcare. We will strategically map our VBP incentives to drive improvements in provider performance, quality outcomes, and cost savings, and increase transparency around clinical outcomes and Enrollee satisfaction, as depicted in Exhibit C.3-1.

Alignment	Aligned goals and incentives across the healthcare ecosystem with administrators, physicians, hospitals, and payers	
Technology	Supportive technology provides data to measure success and identify opportunities for intervention	
Transparency	Transparency in all aspects of the partnership	
Balance	Balances quality and efficiency without compromising patient care or outcomes	
Improvement	Drives continuous improvement by applying lessons learned and capitalizing on best practices	

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Exhibit C.3-1. Key VBP Strategy Characteristics

Our value-based programs will further encourage providers to be accountable to those they serve, which will result in appropriate service utilization and the right care at the right time in the right setting. In all, nearly *70% of Molina affiliated health plan members enterprise wide are covered under some form of VBP arrangement, including:*

- *Pay-for-performance and/or PCMH contracting arrangements*
- *Pay-for-performance/pay-for-quality agreements*
- *Partial-, shared-, or full-risk VBP arrangements*
- *Formal provider risk-based agreements*
- *Diverse shared savings accountable care organization/accountable care entity and pay-for-performance agreements for nursing facilities*
- *Tiered incentive and pay-for-performance agreements for hospitals*

In the following pages, we outline our proposed approaches for Kentucky Medicaid Physician Incentive Plans and provide examples of successful Physician Incentive Plans implemented by Molina affiliated health plans in other states.

a. PROPOSED PHYSICIAN INCENTIVE PLAN APPROACHES

Molina's proposed Physician Incentive Plan approach will be driven by our variety of VBP arrangements with willing Kentucky Medicaid providers tailored to support improved provider performance, provider collaboration, and Enrollee health outcomes, as well as to "move the needle" on the Commonwealth's population health challenges.

PHYSICIAN INCENTIVE PLAN STRATEGY

Our Physician Incentive Plan strategy fundamentally recognizes the high degree of variability in risk readiness and receptivity across the Kentucky provider community. As such, we will enable providers at all levels of readiness to participate in value-based arrangements and to progress to more advanced arrangements through data-sharing, quality improvement measurement analytics, and medical cost review.
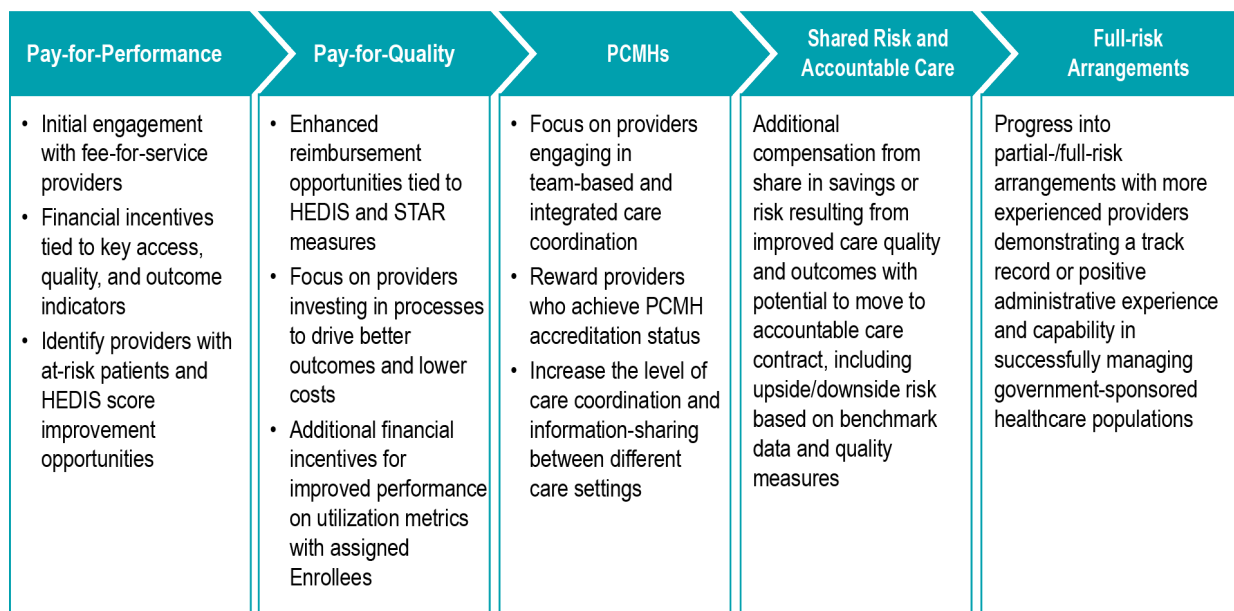
Moreover, our VBP models will be carefully tailored to specific primary and/or specialty types, risk tolerance, and the amount of control providers have over referral patterns. Our Kentucky Medicaid Physician Incentive Plan strategy therefore will encompass the following core elements, as depicted in Table C.3-1 below.

Table C.3-1. Physician Incentive Plan Core Elements

Tiered Approach	We will initially engage providers based on their level of readiness within the VBP spectrum. For providers unfamiliar with VBP, Molina can work to implement basic VBP elements (e.g., pay-for-reporting) and provide comprehensive supports required to help advance them toward more complex VBP arrangements. This effort will begin with a prioritization assessment of each provider to determine where they fall within our VBP spectrum.
Specific Identified Goals	Our VBP program will prioritize improving health outcomes by: • Reducing potentially preventable admissions • Reducing hospital readmissions • Avoiding emergency department (ED) visits • Promoting preventive care measures for Enrollees with chronic healthcare conditions • Tailoring vital care and resources to Enrollees' behavioral health needs, especially post-hospitalization follow-up and medication adherence Moreover, in our affiliated health plans, we have traditionally incentivized our VBP-contracted providers to meet and exceed the HEDIS 75th percentile and the CAHPS 75th percentile.
Continuous Development	Our approach is designed for continual development over the life of a provider contract. For providers starting out at a basic pay-for-reporting, pay-for-performance, or pay-for-quality level, our goal will be to move those providers into more complex arrangements each contract year with the final goal of developing provider partnerships that include comprehensive population-based payment arrangements. Continual improvement for the Kentucky Medicaid program will be accomplished by including VBP progress requirements in our provider contracts, developing programs that have tiered implementations, and maintaining proactive, ongoing provider VBP education and supports.

In close coordination with our Quality Improvement department, our VBP strategy will be centered on targeting and improving select HEDIS measures that have historically underperformed in Kentucky, driving our mission to "move the needle" to improve overall quality and Enrollee outcomes.

As depicted in Exhibit C.3-2, Molina's proposed Kentucky Medicaid VBP offerings will largely mirror our affiliated health plans' full VBP continuum across all lines of business (Medicaid, Medicare, Medicare-Medicaid Demonstration Programs, Marketplace), from basic pay-for-performance to more complex partial-/full-risk models.

Pay-for-Performance	Pay-for-Quality	PCMHs	Shared Risk and Accountable Care	Full-risk Arrangements
• Initial engagement with fee-for-service providers • Financial incentives tied to key access, quality, and outcome indicators • Identify providers with at-risk patients and HEDIS score improvement opportunities	• Enhanced reimbursement opportunities tied to HEDIS and STAR measures • Focus on providers investing in processes to drive better outcomes and lower costs • Additional financial incentives for improved performance on utilization metrics with assigned Enrollees	• Focus on providers engaging in team-based and integrated care coordination • Reward providers who achieve PCMH accreditation status • Increase the level of care coordination and information-sharing between different care settings	Additional compensation from share in savings or risk resulting from improved care quality and outcomes with potential to move to accountable care contract, including upside/downside risk based on benchmark data and quality measures	Progress into partial-/full-risk arrangements with more experienced providers demonstrating a track record or positive administrative experience and capability in successfully managing government-sponsored healthcare populations

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Exhibit C.3-2. Molina's VBP Continuum

In accordance with Draft Contract, Section 6.5, Capitation Agreements, Molina understands and agrees to notify the Department for review and final approval of any capitation agreement, including agreement changes or updates, with our subcontractors or providers that include the assumption of risk by the subcontractor or provider.

## A Core Focus on Effective, Tailored VBP Solutions

Our VBP models are based on a fundamental belief that properly aligned incentives can transform healthcare from a fee-for-service (FFS) volume-based model to a value-based care model in a way that lowers costs, focuses on population health management, and improves the overall quality of healthcare.

More importantly, we understand that a "one-size-fits-all" solution is not always successful; instead, *we will offer true flexibility by "meeting providers where they are" across a continuum of healthcare services and capabilities to tailor VBP arrangements that effectively incentivize provider performance and support improved Enrollee health outcomes.* This approach further promotes accountability by:

Molina Healthcare of Ohio is a leading MCO participant in the state's Comprehensive Primary Care VBP program, which includes **280 Molina-contracted practice groups and 148,000 members, 54% of the health plan's total Medicaid membership**. Moreover, **provider payments under this program totaled $462.9 million in 2018**, some **32.5% of the plan's total Medicaid spend**.

- Rewarding providers who help meet or exceed relevant quality performance measures such as HEDIS
- Investing in practices that seek to expand team-based and coordinated care models such as PCMH
- Recognizing contributions toward improved efficiency and outcomes to take advantage of greater risk sharing and accountable care payment models tied to quality performance

Exhibit C.3-3 further depicts the six core operational components that support and drive our VBP model development and management enterprise wide and will drive our VBP model for the Kentucky Medicaid program.
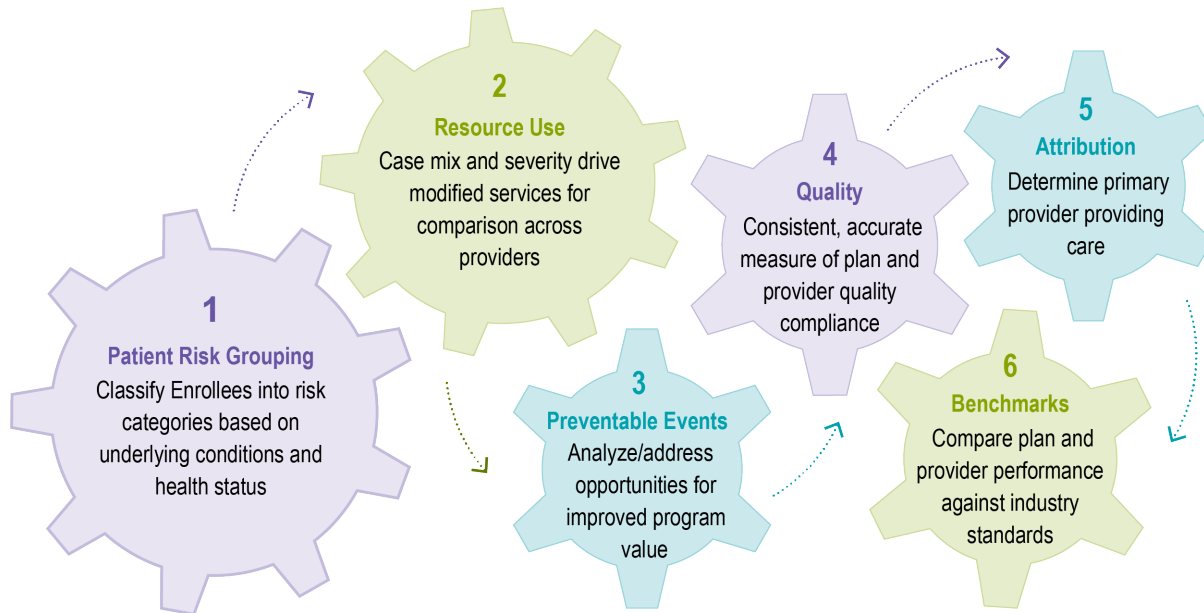
Exhibit C.3-3. VBP Core Operational Components

Aligning VBP Goals with Department Program / Population Health and Quality Goals

Molina recognizes the Commonwealth's most pressing population health needs. Rates in the Commonwealth are among the highest in the United States in heart disease, cancer, obesity, diabetes, smoking, and chronic obstructive pulmonary disease (COPD). The opioid crisis has further exacerbated the population health challenge, while conditions such as asthma continue to take a toll, particularly among children.

Our Physician Incentive Plan strategy thus will identify and address many of the Commonwealth's most immediate population health concerns by strategically aligning:

- HEDIS and other key quality and performance measures
- The Department's stated quality and healthcare outcomes priorities
- Key NCQA accreditation standards
- Molina's QAPI program and related performance improvements projects (PIPs), special initiatives, and quality measures
- Proposed Enrollee incentives
- VBP model designs applicable to specific provider types

Table C.3-2 below depicts our select quality measures which will carefully align Department population health priorities with our VBP and Enrollee incentive programs to best support the potential for improved Enrollee outcomes and related provider performance.

Table C.3-2. VBP and Enrollee Incentive Quality Measures

Department Priority Area	VBP Measure	Enrollee Incentive/Measure
Colorectal Cancer (Draft Contract priority for PIPs)	Colorectal Cancer Screening	
Cervical Cancer Screening (Draft Contract priority for PIPs)		Cervical Cancer Screening

Department Priority Area	VBP Measure	Enrollee Incentive/Measure
Obesity (Department of Public Health priority)	Weight Assessment and Counseling for Nutrition and Physical Activity—BMI percentile documentation Weight Assessment and Counseling for Nutrition and Physical Activity—counseling for nutrition Weight Assessment and Counseling for Nutrition and Physical Activity—counseling for physical activity	Well-child Visits WW (Weight Watchers) membership
Diabetes (Draft Contract priority for PIPs)	Comprehensive Diabetes Care—Eye Exam Comprehensive Diabetes Care—HbA1c testing	Comprehensive Diabetes Care—Eye Exam (retinal) Comprehensive Diabetes Care—Medical attention for nephropathy
Diabetes Medication Adherence (Department priority)	Statin Therapy for Patients with Diabetes—statin adherence 80%	
Tobacco Use Cessation/Prevention—Adolescents (Department of Public Health priority)	Adolescent Well Care	
Behavioral Health (Draft Contract priority for PIPs)	Follow-up After Hospitalization for Mental Illness—7-day follow-up Antidepressant Medication Management —effective acute phase and effective continuation phase treatment	Follow-up visit with a primary care provider (PCP) or specialist within 7 days of an inpatient hospital or behavioral health stay

Targeted Provider Types for VBP Contracting

The following are proposed VBP arrangements by provider type designed to support the Department's Kentucky Medicaid program goals.

Primary and Specialty Providers

- **Pay-for-performance.** This arrangement will include initial engagement with FFS providers. Financial incentives will be tied to key access, quality, and outcomes indicators. Moreover, this model will identify providers with at-risk patients and HEDIS score improvement opportunities. We also will collaborate with the Department and other Vendors on pay-for-performance arrangements that may include incentivizing providers to establish Kentucky Health Information Exchange (KHIE) connectivity and submission of standardized data sets as well as encourage provider adoption and use of electronic health records (EHRs).

- **Pay-for-quality.** This arrangement will include enhanced reimbursement opportunities tied to relevant HEDIS measures and will focus on providers investing in processes to drive better outcomes and lower costs. Additional financial incentives will be available for improved performance on utilization metrics with assigned Enrollees.

- **Patient-centered medical home (PCMH).** This arrangement will focus on providers who engage in team-based and integrated care coordination and will reward those who achieve NCQA, Joint Commission, or URAC PCMH accreditation status; increase the level of care coordination and information-sharing between different healthcare settings; and help improve the Enrollee experience.

- **Shared savings and accountable care.** This arrangement will include additional compensation for providers from a share in savings or risk resulting from improved care quality and outcomes (e.g., providers may be paid a portion of any share in healthcare savings when financial targets are met) with potential to move to an accountable care arrangement that includes upside/downside risk based on benchmark data and quality measures.

- **Partial-/full-risk agreements.** Providers will be able to progress into partial-/full-risk arrangements (e.g., the provider will be paid a surplus if costs are below set financial target or pays back a portion of losses higher than a set financial target) by demonstrating a track record of positive administrative experience and capability in successfully managing government-sponsored healthcare populations.

- **Bundled/Episodes of Care payments.** Tailored specifically for specialty providers, this arrangement will support a single, comprehensive payment across multiple providers in an Enrollee's episode to encourage more seamless care coordination.

> Our Ohio affiliate's Episodes of Care program includes some **1,600 unique primary and specialty practices** serving adults, women, and pediatric members, and providing **30 distinct health care services.** The program **serves more than 71,900 Ohio affiliate members** (26% of the plan's total Medicaid enrollment), with **provider payments totaling $62.4 million in 2018.**

Hospital-based Providers

- **Pay-for-performance.** We will offer enhanced reimbursement opportunities tied to relevant measures such as Appropriate ED Utilization, Preventable Readmission Rates, Leapfrog Score, Patient Satisfaction, and Discharge Planning and Transitions of Care. Molina may also offer a ***pay-for-performance incentive for hospital partners to submit/use standardized KHIE-defined data in the KHIE system.***

- **Pay-for-quality.** This arrangement will include enhanced reimbursement opportunities tied to relevant HEDIS measures and will focus on providers investing in processes to drive better outcomes and lower costs. Additional financial incentives will be available for improved performance on utilization metrics with assigned Enrollees.

- **Shared risk and accountable care.** Providers will receive additional compensation from a share in savings or risk resulting from improved care quality and outcomes with potential to move to an accountable care arrangement that includes upside/downside risk based on benchmark data and quality measures.

Several of our affiliated health plans currently offer these types of hospital-focused VBP arrangements—ranging from tailored pay-for-performance/pay-for-quality arrangements to shared savings / gain sharing models—and could provide a viable framework for similar VBPs for the Kentucky Medicaid program.

Behavioral Health Providers

We are ready to work with the Department and other MCOs to develop and implement innovative behavioral health (mental health / substance use disorder) VBP models designed to address the Commonwealth's significant mental health and opioid use disorder crises. These models could include, but may not be limited to:

- **Pay-for-performance.** This arrangement includes initial engagement with FFS providers. Financial incentives will be tied to key access, quality, and outcomes indicators. Moreover, this model will identify providers with at-risk Enrollees and HEDIS score improvement opportunities.

- **Pay-for-quality.** This arrangement will include enhanced reimbursement opportunities tied to relevant HEDIS measures and will focus on providers investing in processes to drive better outcomes and lower costs. Additional financial incentives will be available for improved performance on utilization metrics with assigned Enrollees.

Molina Healthcare of Ohio: Innovative Behavioral Health-focused VBP

With the state of Ohio facing many of the same behavioral health challenges as Kentucky, including alarming rates of opioid abuse, overdoses, related ED visits, and drug-related deaths, our affiliated health plan in Ohio has taken a lead role in developing behavioral health-focused VPB models that could also be leveraged for the Kentucky Medicaid program including:

- **Pay-for-performance.** In partnership with its key community mental health providers, our Ohio affiliate offers *a pay-for-performance program that rewards these providers for completing needed 7- and 30-day HEDIS follow-up visits following hospital discharge*. This program has been successful in incentivizing mental health community providers to focus on connecting with members quickly after discharge to ensure needed visits are completed in a timely manner.

- **Behavioral Health Home.** Working in close collaboration with the Ohio Department of Medicaid, our Ohio affiliate and other Medicaid MCOs are launching a *Behavioral Healthcare Coordination program focused on members with significant mental health and/or substance abuse issues.* With a July 2020 go-live, *the program will create a behavioral health-focused PCMH network* in which community behavioral health providers can voluntarily participate and receive funding to perform a variety of activities (including care coordination) to help members access resources and manage their physical health and behavioral health needs while remaining in their community. The goal is to increase care coordination and provider collaboration to reduce behavioral health-related ED visits and inpatient stays and improve health outcomes.

Molina's Preferred Provider PA Program

During our focus groups, we heard frustrations from providers around prior authorization requirements. We understand and are sensitive to the administrative burden placed on hospital systems and provider groups, particularly as it relates to prior authorization. As a matter of practice, Molina's affiliated health plans systematically review their approach to prior authorization codes to discern the utilization, approval rates, and impact on both quality and cost. They regularly perform an extensive review of all codes that require prior authorization to identify those that they may be able to build into their value-based programs to relax, or in some instances, eliminate the requirements of prior authorization. The goal is to remove barriers to member care and to improve provider relationships.

Molina will incorporate a Preferred Provider PA Program in partnership with Kentucky's highest functioning health systems and provider groups that have demonstrated quality outcomes in identifying certain codes that create administrative burden to providers. We will develop a collaborative approach to relax or eliminate the need for prior authorization of those codes. After implementation with these selected preferred providers, Molina and the providers will hold quarterly Joint Operating Committee meetings to review utilization, quality, and cost metrics to determine if adjustments to the program are warranted, which can be made at Molina's sole discretion if necessary.

KHIE Connectivity / EHR / Telehealth Adoption

Molina recognizes and supports the important role that meaningful clinical data exchange plays across the continuum of care. As such, we applaud the Commonwealth's mission to drive KHIE connectivity, with some 95% of Kentucky hospitals and their providers currently connected to the system. Moreover, EHR adoption rates in Kentucky are equally impressive, with 96% of hospitals adopting certified EHR and 83% of physicians adopting some form of EHR.[1]

However, a key challenge for health information exchange systems nationwide, including KHIE, is that participating providers often submit disparate, non-standardized quality, claims, and encounters data, negatively impacting the health information exchange's ability to achieve "meaningful use" and negatively impacting system utilization and efficacy.

Molina therefore will collaborate with the Department and other MCOs on a KHIE VBP model that drives improved meaningful use and data value by *incentivizing provider adoption and utilization of standardized KHIE-defined data sets to include key HEDIS and other quality and outcomes measures of highest priority to the Department*. These KHIE-defined data elements will include, but not be limited to:

- Provider Search
- Admission/Discharge/Transfer (ADT) Exchange
- Lab Results Exchange
- Reportable Labs Exchange (XDS.b) Repository, Clinical Repository
- Continuity of Care Document (CCD)
- Radiology Report Exchange
- Medical Claims
- Immunizations
- Other Custom Data/Reports
- Syndromic Surveillance (ADT & Diagnosis)

Common data-sharing and data set guidelines will allow KHIE to facilitate better communication between MCOs and providers. Better communication, better data, and better collaboration will help incentivize providers in VBP arrangements to deliver better care, generating better HEDIS scores and better financial rewards.

We will use value-based pay-for-performance tools and educate providers about how the benefits of EHRs better position them to take full advantage of more complex and rewarding value-based contracts. Our value-based contracting methodologies will encourage providers to identify and resolve gaps in care, which is best accomplished when providers make optimal use of EHRs.

We further understand that EHR implementation costs (including technology and maintenance) can be cost prohibitive for providers. *To increase participation, especially among rural providers, Molina will incentivize providers not currently on an EHR to connect to the Epic Community Connect EHR platform by paying 80% of their ongoing maintenance fees, if they agree to meet quality performance metrics*. Community Connect provides a cost affordable mechanism to simplify access to EHRs, supporting better visibility into patient care and allowing for clinical data to be integrated into a single secure database that allows physicians to access and share clinical information across care settings.

Efforts by our affiliate health plans to promote the adoption and use of EHRs have included pay-for-performance initiatives based on providers using electronic tools to manage their practices and exchanges of information. We also have designed value-based contracting methodologies that align with the Medicare Access and CHIP Reauthorization Act (MACRA) and state guidelines that encourage providers to identify and resolve gaps in care, which are best accomplished when providers optimize their use of EHRs.

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[1] Office of the National Coordinator for Health Information Technology, Health IT Dashboard

Telehealth Adoption

We will partner with providers on VBP incentives to ramp up telehealth infrastructure, including financial assistance with related costs, to improve access and health outcomes for Medicaid enrollees residing in rural areas of the commonwealth. MHI's telehealth benefit vendor, Teladoc, will offer covered general medical and behavioral health telemedicine services, supporting 24/7 Enrollee access to services via web, phone, and Teladoc's award-winning mobile app. Though Teladoc does not currently offer VBP models in Kentucky, the company is willing and able to collaborate with Molina, the Department, and other MCOs to develop a VBP model that includes select telehealth services-related quality and/or performance measures for Kentucky Medicaid.

Additional Potential VBP Arrangements

Further building on the potential for a truly robust Kentucky Medicaid VBP model, we have secured commitments from our subcontractors to partner with us, the Department, and other MCOs to develop and implement value-based programs focused on dental, vision, pharmacy, and high-risk OB services.

Avesis. As our dental services subcontractor, Avesis is currently contracted with four of the five Kentucky Medicaid MCOs and has more than twice the number of contracted dental providers in the Commonwealth than any other dental vendor. The company is willing and able to collaborate with Molina, the Department, and other MCOs to develop a VBP model that includes select dental services-related quality and/or performance measures for Kentucky Medicaid.

Avesis does offer VBP programs in the state of Georgia that could serve as models for potential development and implementation for Kentucky Medicaid. The company is also in negotiations to build similar VBP offerings for its dental network in Arizona.

March Vision Care. Our vision benefits subcontractor, March Vision Care, administers vision benefits for Medicaid and Medicare beneficiaries in 27 states, including Kentucky. March has partnered with our affiliated health plans since 2001 and currently administers vision services for D-SNP plans in the Commonwealth, which include Medicare- and Medicaid-eligible Enrollees. The company is willing and able to collaborate with Molina, the Department, and other MCOs to develop a VBP model that includes select vision services-related quality and/or performance measures for Kentucky Medicaid.

CVS Health. Our PBM, CVS Health, has experience managing similar value-based arrangements in other states and is willing and able to collaborate with Molina, the Department, and other MCOs to develop a VBP model that includes select pharmacy-related quality and/or performance measures for Kentucky Medicaid.

Lucina Analytics. Headquartered in Louisville, Lucina Analytics is our high-risk maternity data analytics and risk assessment technology subcontractor. The company is willing and able to assist in collaboration with Molina, the Department, and other MCOs to develop a VBP model that includes birth outcomes improvement quality and/or performance metrics for Kentucky Medicaid.

Furthermore, through our parent company's telehealth benefit vendor, **Teladoc**, Enrollees will be able to access covered general physical health and behavioral health telehealth services, supporting 24/7 Enrollee access to services via web, phone, and Teladoc's award-winning mobile app. The company is willing and able to collaborate with Molina, the Department, and other MCOs to develop a VBP model that includes select telehealth services-related quality and/or performance measures for Kentucky Medicaid.

Initial VBP Arrangements with Key Kentucky Providers

Kentucky Primary Care Association

As an example of our commitment to driving VBP in Kentucky, we have formed a partnership with the Kentucky Primary Care Association (KPCA) that includes terms of delegated credentialing, data-sharing, and other provisions of a care coordination partnership.

The partnership includes *a value-based provider reimbursement framework, incorporating clinical and provider gain share methodologies that support transparency, comparability, and innovation; drive improved outcomes; and control costs*.

KPCA's network will provide Kentucky Medicaid Enrollees with *access to more than 1,000 sites across the Commonwealth, comprising more than 430 total clinic sites, 350 Federally Qualified Health Centers, more than 80 rural health clinics, and more than 170 school-based health sites*.

Molina and KPCA's joint interdisciplinary partnership will drive a shared agenda focused on increasing care coordination and close collaboration to achieve a seamless Enrollee experience with an emphasis on:

- Joint Enrollee outreach and education
- Creating interventions for Enrollees with a recent avoidable ED visit
- Enrollee follow-up post-inpatient discharge
- Leveraging resources to remove barriers associated with social determinants of health
- Increasing data-sharing capabilities by leveraging KPCA's proprietary CHARLI platform, which supports timely exchange of patient information to inform and develop more effective interventions

Under this partnership, KPCA will be eligible to receive a percentage of shared savings if the actual Medicaid medical cost ratio is less than benchmark and one or all agreed-upon standardized quality incentive measures are achieved.

Assessment and Oversight of Provider Readiness for Value-based Contracts

As a standard practice enterprise wide, Molina's affiliated health plans drive a comprehensive assessment and oversight approach to determine provider readiness to successfully participate in value-based partnerships. This approach allows our affiliated plans and providers to evaluate core capabilities and systems that are critical for providers to succeed under VBP contracts.

This wide-ranging assessment includes consideration of a provider's organizational size and the number of empaneled Molina affiliated health plan members, as well as the provider's level of sophistication in managing clinical, financial, operational performance, data integration and data integrity, and levels of risk. Exhibit C.3-4 illustrates core elements of our standard VBP readiness assessment.

Clinical Considerations	Organizational Support	Financial	Operational
• Care Standardization • Decision-support Tools • Patient-centered Care / Chronic Care Management • QI and Data Monitoring • HIT/HIE • PCMH Accreditation (as applicable)	• Commitment from Leadership • Staffing • Data Resources	• Understanding Patient Cost of Care Through Data Aggregation and Analysis • Coding Accuracy • Stable Revenue Cycle Management • Provider Performance Incentive Distribution Capabilities	• Monitoring Provider Productivity • Improving Cost Efficiencies • Identifying Patients Covered Under VBP

Services and Partnerships: To Facilitate Care Coordination and Data-sharing Across Multiple Providers
• Formal/Informal Relationships   • Services Under Provider's Scope / Continuum of Care   • Data-sharing Capabilities

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Exhibit C.3-4. VBP Readiness Assessment

Upon completion of the assessment, we begin collaboration and negotiation with each provider on VBP model design, readiness, and implementation. In the Commonwealth, the VBP agreements we will develop will include clear definition of the path to participation in programs in higher-level Health Care Payment Learning & Action Network (HCPLAN) alternative payment model framework categories, timelines, quality metrics, performance expectations, and enrollment thresholds.

To develop provider readiness and evolution along the VBP continuum, we will provide ongoing provider education, readiness development, and technical support through data exchanges, Joint Operating Committee meetings, data collection, analysis and sharing, and even embed care managers when applicable (e.g., partner hospitals). Table C.3-3 outlines the support and assistance we will share with all providers in VBP programs to develop and support their capability to evolve along the continuum.

Table C.3-3. VBP Readiness Support

Method of Support	Description
Data Collection and Analysis	- Molina will collect and process quality, claims, and other related provider performance data in our claims processing system. - Data will be compared to a quality performance matrix, which will include baseline, targeted, and actual performance as well as variance from target and projected financial status.
Data Exchanges	- Providers will have real-time access through our provider Web portal to retrieve eligibility, claims, and reports and obtain HIPAA-compliant performance monthly reports, including variance to target. They also will have access to data and analytics through the Web portal, enabling the provider to manage financial risk and understand their monthly risk position and provider performance. - We will use customizable dashboards and functionality in our secure online Clinical CareAdvance care management platform to review areas such as Enrollee eligibility, claims status and creation, service requests and authorization, Enrollee rosters, HEDIS profiles and "Missed Services" alerts, reports, links, forms, and account tools.. - We will provide real-time access to provider's electronic medical records to ease the burden of referral/authorization/discharge planning as well as access to quality data and insight into potential care gaps.
Joint Operating Committee Meetings	We will conduct in-person meetings with providers to review operations, quality metrics, and education. These meetings will be monthly or quarterly depending on HCPLAN alternative payment model category and provider preference. Reviews will include but will not be limited to: - Overall enrollment and current enrollment demographics - Quality, which will help identify gaps in Enrollee care and the potential to earn through VBP agreements - Pharmacy data - Claims processing and denial trends - Utilization at the Enrollee level, including top ED and inpatient utilizers
Care Management	We will embed care managers / care coordinators in provider offices with high volumes of our Enrollees to assist Enrollees and help providers with referrals, authorizations, and care management.

Method of Support	Description
Financial	The following are a few examples of how Molina provides financial support for providers to move beyond basic pay-for-performance arrangements and into pay-for-quality programs, as well as demonstrate readiness for additional compensation opportunities further along the continuum, up to accountable care arrangements that include upside/downside risk based on benchmark data and quality measures. **Coordination of Services Quality Incentive Program.** We will offer prepaid funding opportunities (i.e., PMPM payments) for participating providers to invest in dedicated team-based provider coordinators. These coordinators will assist care management teams with patient outreach and education and promote integrated care coordination across treating providers and vendors providing community benefits, along with treatment planning and compliance, which will drive better outcomes and lower costs. **PCMH Quality Incentive Program.** We strongly support the PCMH care model, which promotes team-based and integrated care coordination in a shared-information practice environment. Grant investments will be available for participating providers to cover PCMH accreditation consultant expenses, along with ongoing prepaid funding opportunities (i.e., PMPM payments) for achieving and maintaining recognized accreditation modules (i.e., NCQA).

We will provide comprehensive support to our providers to encourage and enable progression through the VBP continuum. Our strategy will consider factors such as scope of practice, practice size, availability of cash reserves, and geography, which can all impact the amount of risk providers are willing and able to assume.

Integrated health systems in Kentucky with a large scope and diversity of care will have greater influence over the total cost of care for their population. This means they will be able to assume more financial risk and be early candidates for VBP programs in HCPLAN alternative payment model framework categories 3 and 4. We may provide additional development and support to smaller and more rural practices facing challenges with establishing coordinated networks of care over large geographical regions. This support may include development of virtual delivery systems to enable them to move into more progressive amounts of financial risk.

Our VBP program will be built on our sound understanding of Kentucky's diverse Medicaid population and the health and social determinants challenges they face. Moreover, it will be a key driver of our overarching strategy to improve healthcare access and health outcomes across the Commonwealth, especially in rural and historically underserved areas.

Provider VBP Support Through our Provider Engagement Team
Molina's dedicated Provider Engagement Team will be another critical resource for our VBP-contracted provider partners to achieve performance goals and financial rewards. Our Provider Engagement Team is a cross-functional group that works in collaboration with our Quality Improvement, Network Management, Utilization Management, and other key health plan departments. This multidisciplinary approach drives more effective and more fully informed provider engagement to improve quality outcomes and promote efficiencies via implementation and support of new programs/initiatives. Exhibit C.3-5 depicts ways in which our Provider Engagement Team will collaborate with—and offer vital support to—providers with VBP contracts, helping achieve targeted performance and quality metrics.

Additional Data and Reporting Support	Implementation Support Resources	Improvement Initiatives / Best Practices
• VBP metrics over time and compared with benchmarks • High-cost Enrollee list • Quality/HEDIS missing service list	• Quality Improvement team • Healthcare Services team • Care management, disease management • Health Homes • Molina Community Health Workers • ED diversion and transition of care support	• Shared best practices • New technologies

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Exhibit C.3-5. Provider Engagement Team VBP Provider Supports

Our Provider Engagement Team will regularly meet with providers, typically monthly to semi-annually depending on the size of the health system or provider practice. These meetings can include, but will not be limited to:

- VBP quality and performance dashboard reviews (benchmarked against peers)
- Provider education to include free physical health and behavioral health continuing medical education credits for attendees
- Sharing of best practices (e.g., VBP performance supports, opioid reduction initiatives, discharge planning for Enrollees with complex behavioral health needs, and physical health / behavioral health provider collaboration efforts)
- Review of clinical outcomes improvements (ED utilization, new/effective clinical protocols)

For example, our Illinois affiliate engages in regularly scheduled meetings with VBP-contracted providers, including quarterly with larger provider groups and health systems (Tier 1), and bimonthly to semi-annually with smaller practices (Tier 2).

Additionally, the Provider Engagement Team holds monthly meetings with Tier 1 providers focusing on quality data challenges and successes and to develop potential process improvements, as needed. Overall in 2019, our Illinois affiliate's Provider Engagement Team conducted 40 such collaboration meetings with 10 Tier 1 providers serving some 100,000 assigned Molina members and 31 meetings with 11 Tier 2 providers serving more than 34,000 assigned Molina members.

In the last four months of 2019, *our Illinois affiliate's Provider Engagement Team also secured new VBP-based contracts with 18 large provider groups covering a combined 114,000 members for 2020. Moreover, the plan is currently in VBP contract talks with two other major provider groups covering an additional 5,000 Molina members*. This level of proactive engagement also has helped improve overall provider satisfaction with the health plan.

Our Provider Engagement Team will further support VBP-contracted providers in Kentucky by providing access to and evaluation of comprehensive cost, utilization, and quality data, and identifying and proposing performance improvement opportunities and related resources. It will also send participating providers a pay-for-performance quality dashboard, a corresponding Missing Services Report, and other reports as needed for more complex risk-based arrangements. This quality reporting and documentation also will be uploaded and made available 24/7 to providers via the secure provider Web portal.

Additional Kentucky Medicaid Provider VBP Supports

Molina's strategy to support the Kentucky Medicaid program and provider community across the Commonwealth, including proactive, comprehensive provider engagement supports for providers under VBP arrangements, will further encompass investment in key infrastructure, resources, and provider and Enrollee-facing supports.

Molina One-Stop Help Centers. Molina will establish up to *six Molina One-Stop Help Centers throughout the Commonwealth (one in our main office in Louisville and five in regional areas throughout Kentucky)*. These centers will offer the full complement of provider services as required by Attachment C, Draft Medicaid Managed Care Contract and Appendices, and will include, but will not be limited to:

- Provider access to our Provider Services and Provider Engagement Team staff, such as VBP quality and performance reviews, claims/encounters training, KHIE/EHR assistance, and more
- Meeting spaces
- Initial provider orientation, and regular ongoing and specialized trainings to include free continuing medical education credits

Evaluating VBP Program Effectiveness

To align with the Department's VBP goals for Kentucky Medicaid, we will identify specific performance measurement methodologies that will provide the most meaningful calculation of healthcare delivery performance. For example, our provider incentives will focus on, among other measures:

- Improving Enrollee health outcomes by avoiding potentially preventable admissions, readmissions, and ED visits
- Emphasizing preventive care measures for Enrollees who have chronic healthcare issues
- Supporting maternal and fetal health to better manage overall healthcare outcomes

We will establish baseline performance metrics and evaluate provider performance relative to these metrics. Once specific quality metrics are met, providers will become eligible for enhanced reimbursement tied directly to achieving results relative to the baseline for these measures.

We will then identify specific provider types that are best positioned to meet these measures and design programs that specifically reward quality performance and improvement. We will accomplish this through analysis of past calendar year performance on critical HEDIS measures to update benchmarks on a group-by-group basis, encouraging continuous quality improvement.

Ensuring access to accurate and actionable data will be critical to VBP performance evaluation which, in turn, will help us successfully and effectively manage Enrollee care and advance population health initiatives. Recent affiliated health plan successes with improved data-sharing include:

- Sharing real-time ED and hospital (inpatient admission, observation, and discharge) data with providers via secure online access
- Securing online access for VBP-contracted providers to their performance reports, which are updated monthly via secure file transfer protocols

We will further *enhance our VBP arrangements by implementing 3M Transformation Suite technology* and proprietary groupers to provide new analytics tools and levers that will positively impact our ability to evaluate VBP effectiveness, track costs, promote innovative population health and disease management, and report on quality metrics related to health outcomes.

Table C.3-4 depicts ways the 3M Transformation Suite will allow Molina to enhance provider and stakeholder engagement in Kentucky, and, in turn, improve cost and quality outcomes tied to VBP.

Table C.3-4. 3M Transformation Suite Features

3M Transformation Suite VBP Design and Analytics Competencies
• Leverages proprietary groupers that include potentially preventable readmissions, population-focused preventables, and potentially preventable events
• Features analytics tools that accurately capture relevant utilization datasets (e.g., complications, admissions, readmissions, ED visits, ambulatory services)
• Provides detailed and expert analysis of risk-adjusted claims data, starting with analysis of Molina affiliated health plans' current VBP arrangements, to set a meaningful baseline and comparison among populations
• Uses 3M proprietary methodology combined with Molina's more than 25 years of government healthcare program expertise to implement innovative evidenced-based VBP models designed to reduce potentially preventable events by developing a comprehensive analysis of healthcare data across providers and populations
• Reflects upon process of care and transitions between care settings to better understand the requirements for improving acute care outcomes, access to care, and avoidable services outside the inpatient setting
• Allows stakeholders to identify performance gaps and generate appropriate plans of action to make improvements
• Identifies members at high risk as well as members who exhibit early signs of being at a substantial risk of emerging as persistently high-need, projecting utilization and setting equitable (risk-adjusted) VBP goals and incentives

The 3M Suite's innovative dashboards and business intelligence-based VBP reporting tools further drive better informed VBP design and decision-making by:

- Improving patient care by identifying opportunities to lower resource utilization, track costs, coordinate care, and reward quality improvements
- Supporting bundled payment with sophisticated algorithms that include risk adjustment, outlier thresholds, and empirically derived relative payment weights based on actual historical expenditures
- Comparing provider costs by calculating expected resource use with consideration for the clinical risk of a patient's chronic illness and co-morbid conditions
- Expressing episodes and health risk in a clinically meaningful way, so clinicians and other health professionals can understand and act on information

Exhibit C.3-6 below depicts screenshots from the 3M Transformation Suite platform.

Exhibit C.3-6. 3M Transformation Suite Screenshots

With our successful onboarding of 3M's proprietary methodologies, we will be able to develop, support, and deliver smarter VBP goals and incentives that align with Kentucky Medicaid program and Department population health goals, as well as provider needs and Enrollee care objectives. We also will

share robust data with our providers via our secure provider Web portal, allowing access to dashboards and actionable reports for greater transparency. For more information about the 3M Transformation Suite and its support of Molina's VBP evolution, please refer to Proposal Section C.9, Quality Management and Health Outcomes.

b. EXAMPLES OF SUCCESSFUL PHYSICIAN INCENTIVE PLANS

Our parent company's decades-long commitment to—and expertise in—Medicaid nationally has informed our approach to developing value-based programs across our affiliated health plans. We have established a wide range of non-risk and shared/partial/full-risk VBP models that address populations where Medicaid is typically the primary payer, including, but not limited to, Medicaid and CHIP program members, members in long-term care facilities or requiring long-term services and supports, and members with complex behavioral health conditions.

An approach that includes VBP variety, coupled with MCO agility to meet unique provider needs, is crucial to implementing an effective VBP model. Many of our providers come from mission-driven organizations that nonetheless do not have the resources to invest in complex billing systems or staff that understand complex payment methodologies.

Arrangements for these providers require us to be more flexible, a duty we embrace because of its ultimate importance to our members' healthcare needs. Our programs encourage providers to be highly accountable to those they serve, helping drive appropriate services utilization and the right care at the right time in the right setting. The following are key examples of VBP successes from two of our affiliated health plans in Ohio and Washington.

MOLINA HEALTHCARE OF OHIO—STATE INNOVATION MODEL PROGRAM: OHIO COMPREHENSIVE PRIMARY CARE

Program Structure

Molina Healthcare of Ohio is an MCO leader in the Ohio Department of Medicaid's Comprehensive Primary Care VBP program. The Comprehensive Primary Care model is a robust PCMH construct that incentivizes PCPs to comprehensively manage their patients' health needs, thereby improving quality of care and lowering costs. Provider participation is voluntary; practices receive quarterly PMPM payments and are eligible for annual shared-savings payments.

Participating providers are held to minimum activity requirements with annually increasing thresholds in 20 HEDIS quality measures across areas of practices serving adults, children, and individuals with behavioral health needs, as well as four efficiency metrics.

The Comprehensive Primary Care VBP program currently comprises *280 Molina-contracted practice groups and 148,000 members, some 54% of our Ohio affiliate's total Medicaid membership. Moreover, recently released full year 2018 Comprehensive Primary Care program performance results found provider payments under this program totaled $462.9 million in 2018, approximately 32.5% of the plan's total Medicaid spend*.

Measurable Outcomes

Molina Healthcare of Ohio (and the Comprehensive Primary Care program in general) has experienced a lower trend in healthcare spending and higher quality performance by participating PCPs versus non-participating PCPs.

Quality

- From the latest currently available results covering performance year 2017 to 2018, the Ohio Department of Medicaid increased Comprehensive Primary Care quality metric thresholds to more closely align with HEDIS standards. Despite this increase in the benchmark standard, ***Molina Healthcare of Ohio's participating providers maintained their average overall pass rate and improved their average scores in 80% of the individual quality measures being evaluated for the program***. The health plan's standout areas of achievement include ***an overall 18% improvement on behavioral health measures, a 4% improvement on adult health measures, and a 3% improvement on women's health measures***.

- As part of the quality improvements demonstrated by participating Ohio Comprehensive Primary Care providers, Molina Healthcare of Ohio has also made significant positive impacts on utilization of CPT II codes for measures specifically targeted by the Ohio Department of Medicaid as areas where additional coding changes had to be made at the provider level. Our Ohio affiliate's Provider Engagement Team worked closely with Ohio Comprehensive Primary Care providers to implement these changes, ***resulting in a 15% increase in quality on applicable measures***.

Efficiency

- In the separate category of Ohio Comprehensive Primary Care Program Efficiency (measured separately as a combination of improved performance benchmarked against adjustments to Ohio Department of Medicaid performance thresholds), our Ohio affiliate's participating providers have shown substantial progress on 50% of program metrics, including:

  - Average provider pass rate for ED visits/1000 improved by 59%
  - Average generic dispense rate improved by 9%

Challenges / Lessons Learned

With the implementation of the Comprehensive Primary Care program, Molina Healthcare of Ohio identified and addressed key opportunities:

- **An aligned VBP requires aligned and coordinated MCOs.** Recognizing the need for a consistent approach and messaging to Ohio Comprehensive Primary Care practices, Molina Healthcare of Ohio and other Ohio Medicaid MCOs have implemented regular touch-points to stay aligned on this program. This coordination significantly improves the provider experience by ensuring consistent messaging with providers and minimizing disparate, often disjointed provider touch-points with multiple MCOs. This approach is also leveraged in the health plan's ongoing partnership with the Ohio Medicaid Department to identify and implement best practices that are driving improvements to the program.

- **Ohio Comprehensive Primary Care practices need access to more and better data for practice transformation.** Benefiting from the lessons learned from other PCMH models, Molina Healthcare of Ohio and other Ohio Medicaid MCOs recognized the scope of information that practices need to increase visibility to and variations in practice patterns. In response, our Ohio affiliate contracted with a data intermediary, The Health Collaborative, which is supporting the Medicare CPC+ program in Ohio and northern Kentucky. By engaging The Health Collaborative in partnership with other MCOs to expand the tool to Ohio Comprehensive Primary Care metrics, participating providers now have access to a single dynamic tool for critical information to support practice transformation and progress in both the state and federal VBP programs.

MOLINA HEALTHCARE OF OHIO—STATE INNOVATION MODEL PROGRAM: EPISODES OF CARE

Program Structure

Molina Healthcare of Ohio's condition-specific, population-based Episodes of Care program provides financial incentives (which may be positive or negative) to the primary accountable provider for a specific care episode to deliver quality and savings relative to peer benchmarks for the cost per episode on a retrospective basis. Provider participation is mandatory for this VBP program as a condition of participation in Ohio Medicaid.

To qualify for the program's gain-sharing incentive, providers must achieve all quality measures for specified episode types. Episodes are supported by a range of one-to-eight quality measures each and include such targeted metrics as:

- Antibiotic fill rate in the absence of strep tests for upper respiratory infections
- Follow-up visits after ED/inpatient visits
- Infection rate after surgery
- New barbiturate fill rate

The Episodes of Care program includes Molina Healthcare of Ohio-contracted primary and specialty providers serving both adults and children, and providing 30 distinct services for conditions including, but not limited to, COPD, asthma, perinatal/neonatal care, joint replacement, urinary tract infection, attention deficit / hyperactivity disorder, upper respiratory infection, and percutaneous coronary intervention. ***The program comprises nearly 1,600 unique practices serving more than 71,900 Ohio affiliate members, about 26% of the health plan's total Medicaid enrollment. Provider payments under this program totaled $62.4 million in 2018.***

Measurable Outcomes

Launched in 2016, the Episodes of Care program has grown significantly in the number of episodes while demonstrating notable improvements from the first year of performance. From 2016 to 2018, the program expanded from three to nine episode types linked to financial incentives, while the overall volume of episodes has experienced a twelve-fold increase. In evaluating the performance of the original three episodes (perinatal, COPD, and asthma) between 2016 and 2018, ***providers have generated efficiencies equating to 188% in increased gain-sharing payments***. Additionally, providers improved quality performance during the same period, making more incentive payments payable. Between 2016 and 2018, ***the amount of possible gain sharing increased 64%***, while ***the amount of possible gain sharing not paid out due to unmet required quality metrics decreased by 32%***. These metrics indicate there is significantly more episode spend below the program's "Commendable" spend threshold, with more providers meeting required Episodes of Care quality metrics.

Challenges / Lessons Learned

The Episodes of Care program was the first state-aligned VBP launched in Ohio in 2016. When this model was originally launched for Ohio Medicaid, our Ohio affiliate, the four other Medicaid MCOs, and Ohio Medicaid FFS providers implemented the model-logic in their respective unique systems. While the model definitions were very complex and documented, there were key areas of question/interpretation in the nuances of the model development which resulted in some variation of results across MCOs.

As a result, in 2018, the Ohio Department of Medicaid agreed to align the calculations across plans and generate the model calculations and provider reports from MCO encounter information. This change to a single convener (Ohio Department of Medicaid) on behalf of all MCOs aligned the calculations, allowing the state to develop a single, streamlined provider report incorporating the results of all Ohio Medicaid MCOs and FFS providers, instead of the original six distinct reports providers used to receive.

MOLINA HEALTHCARE OF WASHINGTON—MEDICAID VBP SUITE

A leader in one of our most mature Medicaid VBP markets nationally, Molina Healthcare of Washington offers a selection of VBP programs designed to:

- Improve member health and satisfaction
- Incentivize improvements in both medical costs and quality of care
- Incentivize provider engagement with the health plan and move providers along the VBP continuum to greater levels of risk

The majority of the health plan's VBP contracts are shared savings- / quality-based. *Our Washington affiliate also met its internal target of expanding the number of its VBP contracts statewide by nearly 50% for the full year 2019.* Total provider reimbursements under VBP were $3.5 million in 2018, and, while most recent full-year results are still being assessed, the health plan is *estimating VBP-driven reimbursements totaling $10.87 million for 2019.* Moreover, the health plan is projecting *some $14.4 million in VBP-related reimbursements and an increase of at least 20% in the number of VBP contracts in 2020.*

Program Structure

Molina Healthcare of Washington offers a suite of VBP models designed to best ensure provider performance success and drive member outcomes improvements.

Shared Savings

- Shared savings model is based on total cost of care medical cost ratio targets (typically 50%, although some are at 35% share to provider)
- Provider payout opportunity is typically capped at 1% to 3% of the premium, regardless of medical cost ratio performance
- Quality targets must be met to access savings, if a provider's medical cost ratio performance is favorable to the target
- Shared savings are assessed in proportion to quality targets met (typically 5 to 6 quality measures, each with equal weights, e.g., 20% for each measure if there are five measures)
- All Medicaid programs are covered in one value-based care model, although medical cost ratio targets usually vary by Medicaid line, with a roll-up to an average overall medical cost ratio

Shared Risk and Quality

This model is the same as the shared savings approach, with a provider potentially achieving a higher shared savings percentage in exchange for taking downside actuarial risk.

Global Percent of Premium with Delegated Functions

- Providers receive a percentage of global premium and take actuarial risk for total cost of care. Molina Healthcare of Washington is currently the only MCO offering this model.
- Utilization management and claims are delegated together.
- A negotiated percent of premium is dedicated to quality performance.

Pay for Quality

Providers are paid only for quality performance with no tie to medical costs. Though in practice in other states, this pure pay-for-quality model is rare among MCOs in Washington.

Quality Measures

Our Washington affiliate asks participating providers to focus on selected premium withhold measures aligned with key HEDIS metrics as adopted by the Washington State Healthcare Authority, as depicted in Table C.3-5 below.

Table C.3-5. Molina Healthcare of Washington—VBC Premium Withhold Measures

Premium Withhold Measure Aligned with HEDIS Metrics	
CDC	Comprehensive Diabetes Care—Poor HbA1c Control (>9%)
CDC	Comprehensive Diabetes Care—Blood Pressure Control (<140/90)
CBP	Controlling High Blood Pressure (<140/90)
AMM	Antidepressant Medication Management—Effective Acute Phase Treatment
AMM	Antidepressant Medication Management—Effective Continuation Phase Treatment (6 Months)
CIS	Childhood Immunization Status—Combo 10
W34	Well-child Visits in the 3rd, 4th, 5th and 6th Years of Life
MMA	Medication Management for People with Asthma: Medication Compliance 75% (Ages 5–11)
MMA	Medication Management for People with Asthma: Medication Compliance 75% (Ages 12–18)

Targets are ideally (and typically) set at HEDIS 75th percentile. In select instances, if the health plan believes a provider is unable to reach these targets in a given contract year, a two-tiered approach may be employed. This approach essentially rewards a level of performance (if medical cost ratio targets are met) below the 75th percentile that still represents meaningful improvement for the provider. This tier is typically valued at 50% of payout if less than the 75th percentile is achieved. If a provider achieves the 75th percentile, they receive the second 50%. Moreover, our Washington affiliate is increasingly requiring HEDIS-compliant data feeds for all non-administrative-only measures.

Finally, to further drive outcomes improvements for Washington State Healthcare Authority's progressive statewide Integrated Managed Care program, behavioral health screening measures are being added to the MCO withhold in 2020. Molina Healthcare of Washington is actively working on a plan to incorporate these new measures into its current and future VBP arrangements within required implementation timeframes for the Integrated Managed Care program.

Measurable Outcomes

- Overall medical cost ratio for members served by providers under VBP arrangements has been lower than for providers not under VBP arrangements
- Average cost for high-needs members (>$100K annual cost) served by VBP-contracted providers has been lower and has decreased at a higher rate than for members under non-VBP provider care
- Rates of Avoidable ED Utilization/1,000 members have been lower for members served by VBP-contracted providers than for members served by non-VBP-contracted providers
- Rates of Avoidable Admissions/1,000 members have been lower for members served by VBP-contracted providers than for members served by non-VBP-contracted providers
- Member and provider performance for HEDIS Antidepressants measure has improved under VBP arrangements

Challenges / Lessons Learned

Among Medicaid MCOs in Washington, Molina Healthcare of Washington has earned a solid reputation from the provider community and the Washington State Healthcare Authority for its VBP competency. This reputation has helped build momentum toward provider adoption and enhanced market share growth.

The health plan has also developed an interdisciplinary "ecosystem" that facilitates consistent communication between health plan functional areas (such as Quality, Finance, Contracting / Provider Engagement, Healthcare Services). This model emphasizes proactive provider engagement, communication, and solutioning, helping drive the plan's 'best in class' reputation for supporting provider needs. This includes providing timely, accurate, and actionable performance data, support

through exceptionally knowledgeable and talented staff, and regularly scheduled multidisciplinary engagements with providers, among other strengths designed to better ensure provider success and improved member outcomes.

Washington has one of the most mature Medicaid VBP markets in the nation, with most providers on the continuum of VBP adoption. This is due to a large degree to the Washington State Healthcare Authority making VBP a cornerstone of its healthcare policies in the past five years, including coverage for agency employees and their dependents.

Nevertheless, some providers, especially small practices in rural areas, still struggle to manage VBP arrangements successfully. Unlike larger provider groups and health systems, many of these smaller providers lack any VBP experience and staff devoted to VBP administration and management. Supporting these providers to become successful under VBP arrangements through proactive provider engagement, education, and tailored incentives, continues to be a top priority for our Washington affiliate.