C.9 Quality Management and Health Outcomes

REQUIREMENT: RFP Section 60.7 C.9

9. Quality Management and Health Outcomes (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.

In full alignment with Kentucky's Department for Medicaid Services objectives, Molina will deploy a local and data-driven Quality Assurance and Performance Improvement program that:

- **Actively engages Enrollees and providers**
- **Promotes measurable gains in performance metrics**
- **Adapts best practices that have been successfully demonstrated across Molina's national portfolio of Medicaid affiliates over the past 25 years**
- **Supports the transformation of the Department's Medicaid program to elevate the health outcomes for its Enrollees**

a. SUPPORTING THE DEPARTMENT TO ACHIEVE ITS GOALS

Molina has already conducted numerous focus groups with providers and Enrollees across Kentucky (both in urban and rural communities) to guide quality improvement planning.

As the Department strives to improve the quality of care, services, and outcomes for Kentucky Medicaid Enrollees, Molina will continually align our efforts with those of the Commonwealth, including the focus areas outlined in the *Kentucky State Health Improvement Plan 2017–2022*: substance use disorder, smoking, obesity, adverse childhood experiences, and integration to health access. We are enthusiastic about collaborating with the Department and other stakeholders, such as the Department for Public Health and the other Medicaid MCOs, to address key priorities, improve the health outcomes for our Enrollees, and reduce health disparities across the Commonwealth.

Our proven Quality Management and Health Outcomes approach for the Kentucky Medicaid Program will comply with all Department requirements outlined in Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 19.0 Quality Management and Health Outcomes.

To advance the Department's goal of transforming Kentucky Medicaid to empower Enrollees to engage in their healthcare, to improve health outcomes, and to reduce disparities, Molina's comprehensive Quality Assessment and Performance Improvement (QAPI) program will blend structured quality improvement process with innovative *community-based solutions* that will strengthen relationships with Enrollees and providers, enabling us to connect more personally with them to influence the system and behavior changes necessary to achieve significant quality advances. Molina's parent company and its affiliates have more than 25 years of experience improving health outcomes among Medicaid populations.

Our local QAPI program will leverage actionable data, emphasize local accountability and decision-making, and capitalize on innovative programs and interventions that have proven successful with similar populations at our affiliate health plans. Throughout this section, we provide examples of our affiliates' success, including in areas identified as focus areas by the Commonwealth. Our sole focus on government programs also promotes expertise in solutions that are specifically designed for improving outcomes in low-income populations.

Molina affiliates have an average overall rating of 3.35 in NCQA's Health Insurance Plan Ratings – 2018-2019 – Medicaid

Our QAPI program, which reflects NCQA standards, will be tailored to reflect the challenges and opportunities within each service region. Our organizational commitment to quality is evidenced by the fact that 71% of our Medicaid affiliates have obtained NCQA accreditation and that our newest affiliates will undergo the process soon. Eleven of our affiliate plans have obtained NCQA Multicultural Health Care Distinction, ***representing 22% of all MCOs that have obtained this distinction nationally,*** and four have achieved Long-Term Services and Supports Distinction.

In focus groups held by Molina across the Commonwealth, Kentucky Medicaid Enrollees and providers identified key areas in which they wanted to see improvement from Medicaid MCOs, and Molina's QAPI program incorporates key takeaways from those sessions. For example, Enrollees expressed interest in high-touch case management, solutions to provider access issues including use of telehealth, and inclusion of incentives. Providers hoped for more visible, community-based support from Provider Services representatives and more provider-friendly approaches to claims, utilization management decisions, and credentialing. ***Throughout this section, we highlight solutions to the issues that Enrollees and providers identified as important to them.***

Our experience with Population Health Management programs and applying quality improvement best practices to achieve sustainable quality advances for Medicaid Enrollees provides us with the expertise to achieve results for the Department. Throughout this section, we detail our approach to working closely with the Department and other state agencies to define priorities, establish performance targets, and continually drive our performance toward achievement of those targets.

As illustrated in Exhibit C.9-1, Molina's comprehensive and holistic QAPI program will incorporate a continuous improvement cycle that is transparent, detailed, and fully aligned with the Department's objectives.

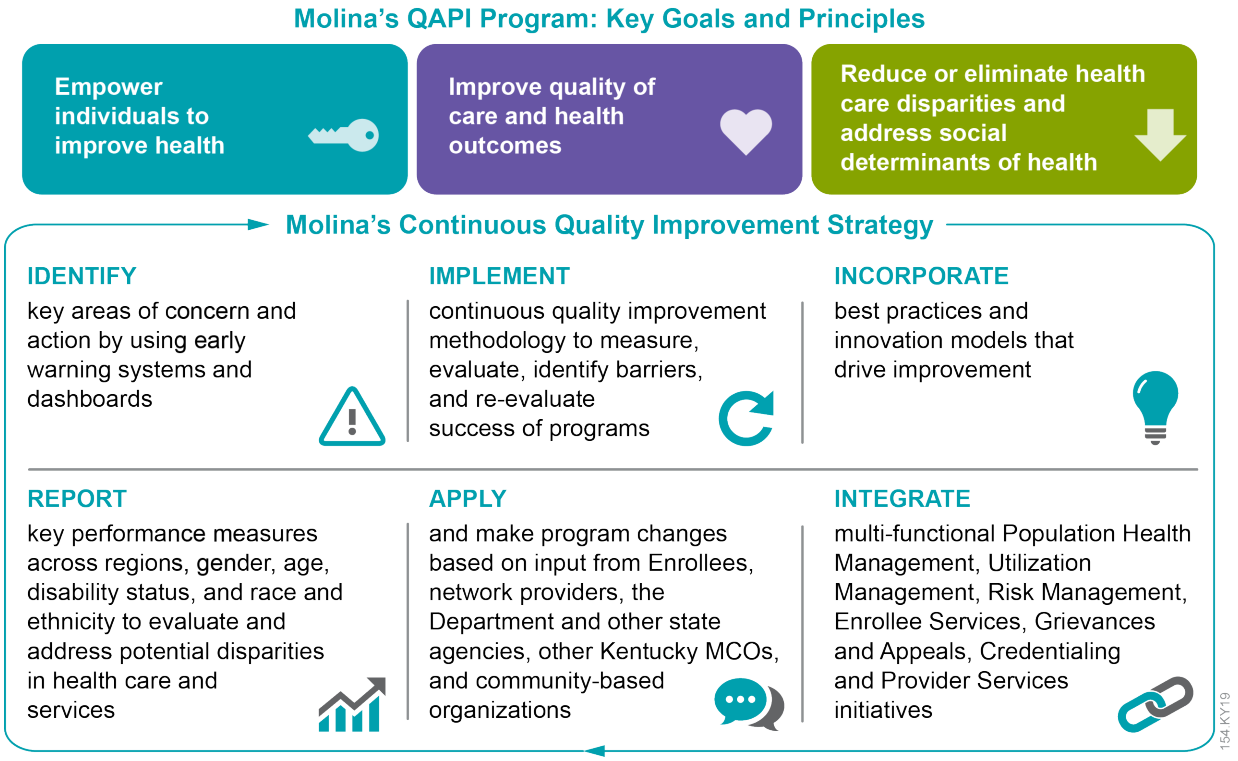


Exhibit C.9-1. Molina's QAPI Program Aligns with the Department's Goals

a.i. ORGANIZATIONAL STRUCTURE TO PROVIDE FOR A COMPREHENSIVE AND HOLISTIC APPROACH

Underscoring our commitment to implementing solutions that address Kentucky's statewide and regional communities and priorities, our Quality Improvement (QI) organizational structure emphasizes:

- Full accountability by a specialized Kentucky-based QI team including designated specialists for each region to foster deep insight into each region's quality gaps and resources
- Support from on-the-ground teams who partner with QI staff to develop and implement regional solutions
- Oversight by a QI Committee (QIC) that includes representatives from licensed Kentucky providers with support from our national QI resources

As our QAPI program will span all health plan operations, it represents a comprehensive and holistic approach. Our Kentucky Medicaid QAPI program will follow the structured framework of the Model for Improvement, developed by Associates in Process Improvement and adopted by the Institute for Healthcare Improvement. Following this model, Molina's QI team will establish performance benchmarks across the health plan that reflect the Department's goals and objectives.

Molina's organizational structure will offer the breadth and depth of resources necessary to drive meaningful gains across Kentucky. We describe our local team of QI experts and supports, our approach to strong leadership and oversight, and coordination with subcontractors and providers.

Kentucky Quality Improvement Team

Demonstrating our commitment to quality, our QI director will report directly to our Kentucky chief executive officer (CEO) and receive support and oversight from our Kentucky medical director and behavioral health director. The QI department will comprise a diverse array of expertise, including appropriately credentialed registered nurses, healthcare professionals, and ancillary personnel. Our Kentucky QI staff will coordinate all quality improvement policies and planned quality improvement activities that reflect the Department's priorities.

Regional collaborative teams will enable Molina to more rapidly identify and respond in communities with low quality scores.

The QI department will include the following teams:

- **Regulatory and Kentucky quality experts** that will include our QI director and QI specialists who support and implement interventions for our Performance Improvement Projects (PIPs); implement interventions to improve Enrollee and provider satisfaction surveys; lead development and submission of reports and documents that meet Kentucky regulatory requirements and deliverables; organize, facilitate, and document QIC activities; and participate in Commonwealth-led meetings, population health coalitions, and collaboratives.
- **QI intervention specialists** who, working with cross-functional teams and with community-based staff as part of our Provider Engagement Teams, will develop and test innovative solutions that drive quality gains to enhance health outcomes. QI specialists will also meet with providers to help advance quality and performance.
- **Quality analytics team**, dedicated to supporting our Kentucky QAPI, that will develop and manage our protocols for monitoring outcomes and process measures (such as HEDIS and CAHPS) and analyzing data to provide insight for program or initiative development and also produces DMS-required reports.

Dedicated to Regional Solutions

Emphasizing a community-based, regional approach to quality***, a Molina QI specialist will be assigned to each Kentucky region and will cultivate a deep understanding of regional data trends, including understanding Enrollee demographics, culture, public health statistics, and concerns.*** Extending the reach of our QI team into the community, QI specialists will team with community-based provider services representatives and community engagement representatives (located in our Molina One-Stop Help Centers across the Commonwealth) to collaborate on quality interventions to address performance measures (including clinical outcomes, health disparities, and Enrollee and provider satisfaction) within their assigned regions.

Provider services representatives will have relationships with providers within their area, and community engagement representatives will maintain strong working relationships with schools, community-based organizations, and other key stakeholders., such as the Kentucky Department for Public Health. During monthly work group meetings, the team will

review below-target measures (as defined in our QAPI Work Plan, described below) and strategize to engage providers and stakeholders to improve results in their region.

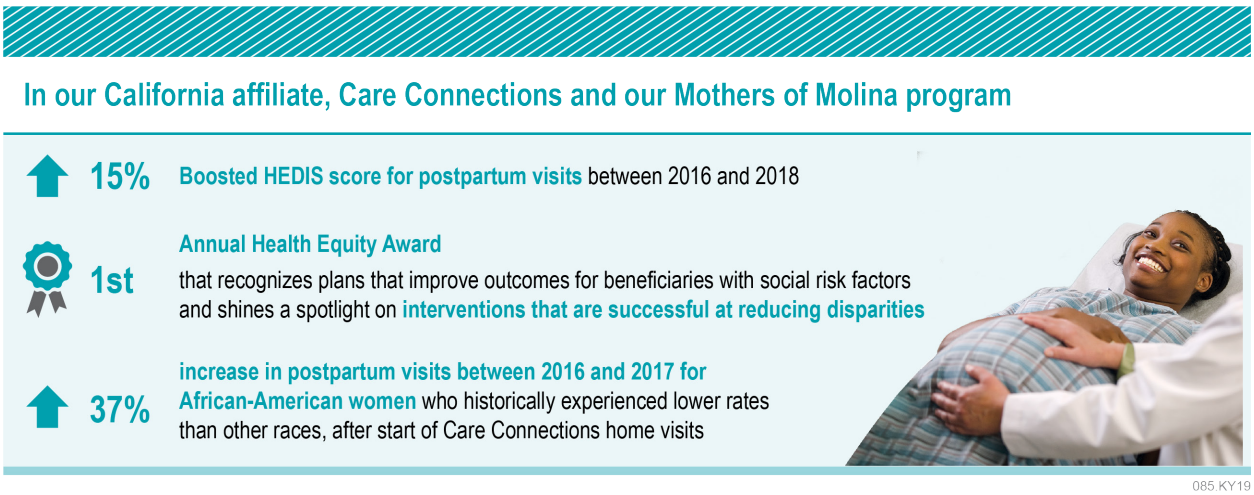
For example, should the QI specialist identify below target Comprehensive Diabetes Care – HbA1c testing for Enrollees in contiguous ZIP codes, during the monthly work group meeting he or she will explore with the provider services representative and community engagement representative the opportunity to work with a local provider to initiate a Molina Day, for well visits, immunizations, HbA1c testing, other diabetes screenings, and other preventive services. At the Molina Day event we will also provide helpful educational materials about healthy eating, the importance of physical activity, preventive screening recommendations, and our diabetes care management program.

Molina Day is a community-based mini-wellness fair held at the provider's office to encourage Enrollees with diabetes assigned to that provider and other Enrollees missing preventive services to come in for well visits, immunizations, HbA1c testing and other diabetes screenings, and other preventive services.

In addition to leading the effort to schedule the Molina Day, conduct telephonic outreach to Enrollees with care gaps to schedule appointments (using our Enrollee Call Center staff), and assist with transportation, we would invite community organizations to attend. Organizations that focus on workforce development or food insecurity may engage with Enrollees and share information to enhance their experience. In addition, we may invite a Department for Public Health representative to promote its local Diabetes Self-Management Program.

QI specialists also work with provider service representatives to target providers for outreach as part of a Provider Engagement Team. Cross-functional teams with representation from Medical Affairs, QI, Health Care Services, and Provider Engagement Teams work with key provider offices to identify and address barriers to improved health outcomes, access, and Enrollee or provider satisfaction. Molina's Kentucky Provider Engagement Teams will work closely with high-volume providers to interpret and act on their quality data to improve Enrollee outcomes (both HEDIS and CAHPS scores). ***In Ohio, aggregate HEDIS scores for providers who worked with Provider Engagement Teams exceeded aggregate scores for those who did not for most priority measures, such as Controlling High Blood Pressure (14% higher score), Adult BMI Assessment (6% higher), and Cervical Cancer Screening (7% higher).***

The regional team may also identify opportunities to coordinate community-based services provided by our Care Connections staff. ***Kentucky Medicaid Enrollees who participated in our focus group identified high-touch, community-based support as an important issue.*** Co-located at high-volume provider offices or community-based organizations, Care Connections nurse practitioners will support Enrollees and deliver comprehensive wellness assessments and address gaps in care. They will provide valuable face-to-face support (for example, helping Enrollees obtain preventive services and key clinical tests and exams), coordinate appointments with primary care providers (PCPs) to avoid inappropriate emergency department (ED) use, link Enrollees with care managers, or connect Enrollees with supports to address social determinants of health, such as housing or employment. Care Connections will also play an important role in expanding access to quality care through home visits, mobile clinics, and pop-up clinics, which will be particularly impactful in communities with limited access to traditional care providers.



Promoting a QAPI program that reflects the healthcare landscape in Kentucky, our QI director will collaborate closely with our Behavioral Health Director, Dr. LaTonia Sweet. Dr. Sweet is a lifelong Kentuckian and is board certified by the American Board of Psychiatry and Neurology in *both* General Psychiatry and Addiction Psychiatry. Named the *2016 Physician of the Year* by Kentucky Medical News, Dr. Sweet is prominent within the Kentucky healthcare community and received the *2016 Kentucky Medical Association Community Connector Award* as well as the *2017 Kentucky Medical Association Leadership Institute Award*. In addition, she holds positions on the boards of directors for several Kentucky organizations, including the Kentucky Foundation for Medical Care, a charitable organization committed to improving the health of Kentuckians through medical education and public health initiatives. Dr. Sweet's deep knowledge of Kentucky's healthcare ecosystem and her experience as a provider, leader, and consumer provides Molina with a strong local voice to guide us toward sustainable solutions that drive measurable quality gains in a comprehensive and holistic manner.

Committed to a Holistic and Comprehensive Approach

Our QI team will lead cross-functional workgroups when appropriate, following the Model for Improvement, to deploy rapid cycle testing so that we remain nimble in implementing, monitoring, and refining our QAPI interventions. Work groups, led by QI and reflecting participation from relevant functional areas across Molina based on the specific topic, will support QI by engaging in intervention planning, implementation, and evaluation.

In addition, we will engage all Kentucky staff in QI through quarterly town hall staff meetings, led by our CEO, to review QI goals, activities, and progress, such as our most recent HEDIS, CAHPS and provider satisfaction results. In addition, our intranet will update employees about all improvement initiatives, orienting the entire health plan toward achievement of the Department's goals.

Supported by National Resources

Our Kentucky team will also receive support from our national Quality Program Management and Oversight and HEDIS operations teams (that will include staff dedicated to Kentucky) that lead enterprise-wide initiatives (like NCQA accreditation, CAHPS and provider satisfaction survey data collection, and HEDIS data collection and reporting), enabling our Kentucky team to focus on the local, regional, and statewide needs of our Enrollees and providers. National experts facilitate and co-chair the national QIC, share best practices and lessons learned from our affiliate plans, and augment local staff for

some QAPI functions. Our national team has experts in NCQA accreditation, delegated vendor management, comparative data analysis, HEDIS operations and analytics, and training. Ongoing collaborative forums that link QI peers in our affiliates will enable our Kentucky QI team to learn about and share their own successes and best practices, identify trends across health plans, and develop solutions to address strategic challenges.

In addition, our quality analytics team will rely on our national analytics team for assistance and support, promoting adoption of best practices from affiliate health plans, such as development of tailored dashboards to support our Kentucky team in monitoring Enrollee outcomes for Department priority metrics.

Aligned with QAPI Program Management

Throughout the QI process, our organizational structure and resource deployment will align with our Kentucky QAPI Program Plan, which summarizes program goals, objective, activities scope, strategy, oversight and resources, delegation activities, and oversight process. Annually, we will also produce a QAPI Work Plan that summarizes all the performance measures that we will use in Kentucky, including Department-specific measures and targets for each measure (such as NCQA's Quality Compass 50th or 75th percentile) and monitor progress throughout the year. In addition to ongoing monitoring of results as part of our rapid cycle testing process, annually the QI team will conduct a comprehensive evaluation of our QAPI program. We provide more detail on these processes in Proposal Section C. 9.e that describes our proposed QAPI program in detail.

QAPI Program Organizational Oversight

Emphasizing the importance of a Kentucky focus, our Kentucky QAPI program will receive oversight and direction from local leadership and stakeholders, who are ultimately accountable for results and decision-making, promoting a sole focus on the needs of the Department and our Kentucky stakeholders.

Our Kentucky board of directors, led by our CEO, will retain ultimate authority and responsibility for the quality of care and services we deliver. The board will delegate authority to the QIC, which will be co-chaired by the medical director and QI director. We describe our QIC in detail in Proposal Section C.9.c.

Our Kentucky QIC will be responsible for designing, approving, implementing, monitoring, and modifying the activities within our QAPI program. Kentucky physical and behavioral health practitioners and Molina staff across the health plan will actively participate in all QAPI initiatives through committees and strategically formed cross-functional work groups. ***We will invite provider feedback on QAPI program elements such as proposed practice guidelines, performance measure results, clinical protocols, QAPI study designs and interventions, and strategies through participation in the QIC or the Health Care Services or Professional Review Committees.*** Through our regional Quality and Member Access Committees (QMAC) (described in detail in Proposal Section C.9.d), we will solicit input from Enrollees and stakeholders so that our program continues to reflect what is meaningful and important to the communities we serve.

Supporting our local efforts, Molina's Kentucky team will receive support from our national QIC. The national QIC includes chief medical officers and leaders from Health Care Services and Quality from all Molina affiliates. These individuals are highly trained clinical personnel and quality experts with experience serving Medicaid populations in other states. For example, with this expert team's support, we have established a national set of evidence-based clinical practice and preventive health guidelines for management of physical and behavioral health conditions. At least annually (and as needed), the national QIC discusses additional guidelines that would support our providers and are relevant for our Enrollees. Upon approval by the national QIC, our Kentucky QIC will provide additional review and approval and for consideration of local needs. Our Kentucky medical director, care management director, and QI director will all serve on both the national and Kentucky QIC, fostering a strong linkage of national and local initiatives. Exhibit C.9-2 illustrates our committees and subcommittees and lines of accountability.

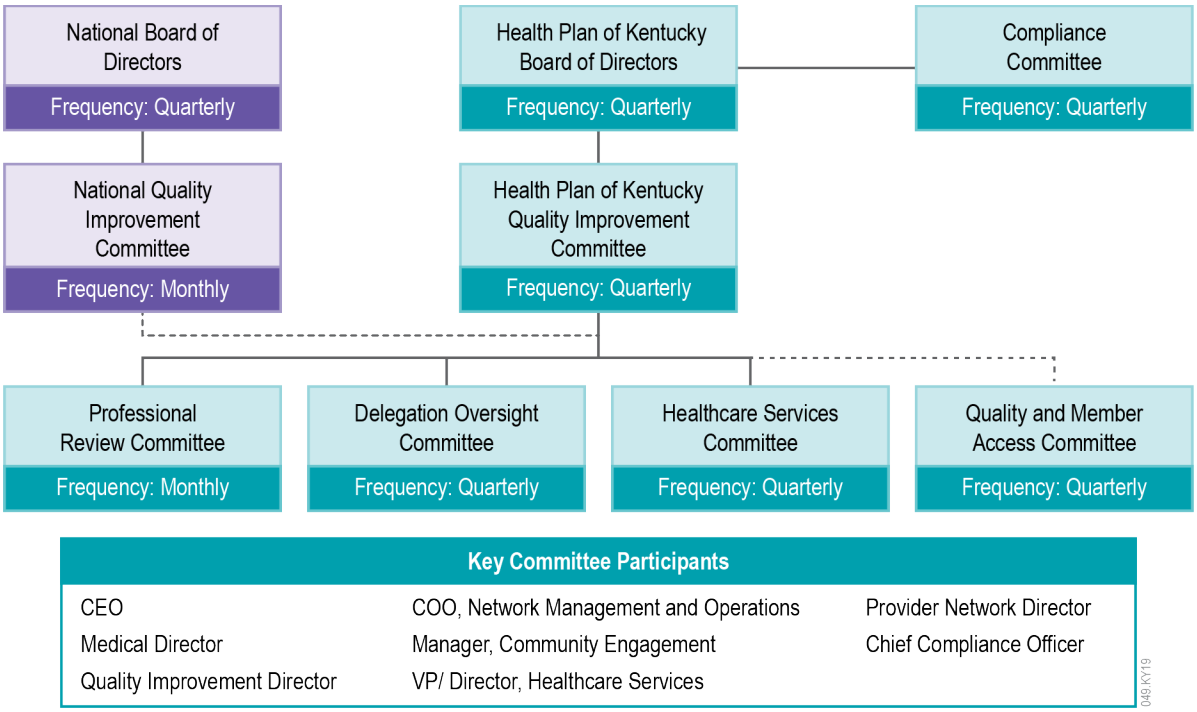


Exhibit C.9-2. Extensive Resources Support Molina's Quality Improvement Structure

Coordination with Subcontractors and Providers

Subcontractors

Molina may delegate credentialing, utilization management (UM), claim payment, and grievance and appeals to provider groups or Health Delivery Organizations that meet delegation requirements. For example, our Kentucky subcontractors include Avesis for dental services, March Vision Care for vision services, CVS Health for PBM, Lucina Analytics for high-risk OB identification, and Molina Healthcare, Inc. for administrative and support services. Prior to delegation, Molina conducts delegation pre-assessment audits to determine compliance with regulatory and accreditation requirements. Pre-assessment audits include review of established policies and procedures, interviews with staff, review of systems, and review of Quality Committee processes. Molina has established relationships with most of these subcontractors in affiliate health plans, so our pre-assessments will focus primarily on each subcontractor's readiness to comply with Kentucky Medicaid requirements and expectations.

We monitor compliance by reviewing monthly and quarterly performance reports and results from annual on-site assessments. This includes compliance with authorization turnaround times, appropriate rationale for services that are denied, and proper notification of Enrollees and providers about their appeal rights if service requests or payment is denied. Any potential areas of concern are addressed directly with the subcontractor to determine the presence of a reporting or performance issue. We may initiate a corrective action steps if we confirm ant performance issue.

Additionally, Molina designates an account manager for each subcontractor who works closely with delegation oversight staff and subcontractor staff. Account managers meet with subcontractors monthly to discuss topics like Enrollee grievances or benefit coverage clarifications. Quarterly Joint Operations Committee meeting include subcontractor staff and Molina network and delegation staff. These discussions include compliance with performance expectations, updates from subcontractors on quality initiatives on which we have partnered, network adequacy analysis, or other agenda items identified by subcontractors or Molina staff.

Our Kentucky Delegation Oversight Committee, reporting to the QIC, will monitor all delegation activities. Should we identify the need for corrective action, the Delegation Oversight Committee will implement and monitor the corrective action plan and keep the QIC informed. The relevant Molina manager will support delegation oversight process by coordinating and conducting annual on-site assessments, monitoring monthly reports, overseeing the corrective action process, and reporting to QIC.

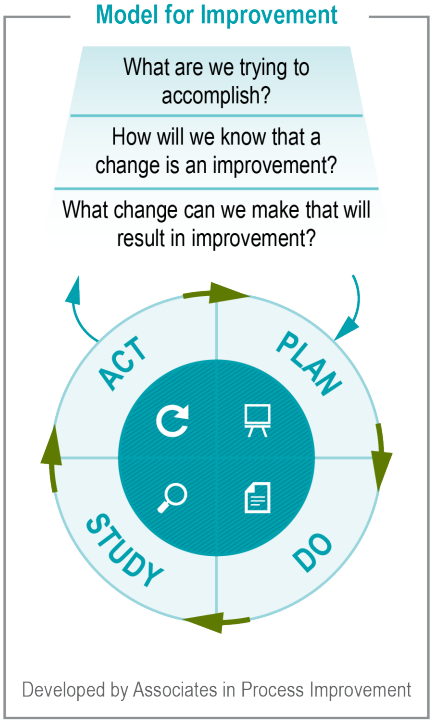
Molina will encourage providers that have the capability and meet our requirements to assume delegated functions to foster greater provider engagement and accountability.

Provider Support Structure

Our QI organizational structure incorporates the provider supports necessary to transform Kentucky Medicaid. Our local QI team will work closely with Kentucky-based provider services staff to share quality data. These Provider Engagement Teams will support QI and will work with Kentucky providers to interpret and act upon provider scorecards. In addition, our provider services team members will participate in related QI work groups to foster a holistic QI approach. Details on the quality data we share with providers and the other supports and tools we apply to improve quality are detailed in our Proposal Section C.9.a.v.

a.ii. STRATEGIC SOLUTIONS USED IN QUALITY MANAGEMENT, MEASUREMENT, AND IMPROVEMENT

Molina will deploy an array of strategic solutions in quality management, measurement, and improvement, each of which we describe in detail below. Building on our affiliates' experience, including in neighboring states like Ohio, Molina will deploy established strategic solutions to improve quality across the Commonwealth.



Strategic Solutions for Quality Management

Our overarching strategic solution for quality management is applying the Model for Improvement (adopted by the Institute for Healthcare Improvement) as the framework for our QAPI program. Consistent with the model, our QI team will leverage data to identify potential opportunities for performance improvement; prioritize topics and measures based on our Enrollee population (identified by the results of our community needs assessment and Enrollees' Health Risk Assessments), Department priorities, and provider and Enrollee feedback; and use continuous QAPI rapid cycle processes to drive toward gains.

Our QAPI Work Plan will establish our QAPI program foundation and address the Model for Improvement's three questions by outlining all key goals and measures (including Department-directed measures), assigning target performance metrics, and summarizing the interventions or solutions we will apply to advance each performance metric.

Following "Plan Do Study Act" (PDSA) cycles, our QI team plans each QI activity by defining the objective, predicting the potential outcome, conducting root cause analysis and barrier identification, identifying evidence-based solutions, and developing the project and data collection plan to guide the activity. We then implement solutions and interventions, document the findings—both quantitative and qualitative—to determine the results, and capture the data needed for analysis. QI specialists then study the data, compare the results to the initial objectives and study questions and summarize the findings of

the QI activity. Finally, Molina acts to identify the changes that may be made to the intervention and determine the next timeframe or cycle for improvement.

Our continuous QI cycle also includes three major steps, which we apply to the measures we collect and the outcomes we seek to achieve, as follows:

- Monitor quality metrics dashboards as an early warning system to identify and address potential gaps in data
- Gather input from Enrollees, providers, and other stakeholders to confirm that we consider their concerns
- Innovate, test, and replicate to improve our performance based on what works most effectively

We will evaluate our Kentucky QAPI program and strategies continuously throughout the year, analyzing relevant performance measures and strategizing with our QIC to review results to advance our performance. We will also share results and best practices with the Department and with the other Kentucky Medicaid MCOs when appropriate.

Our Kentucky QAPI program will align with NCQA standards and meet federal and state requirements, and we will adopt policies and procedures that have proven effective in improving quality with Medicaid populations. Our commitment to local quality data analytics teams and cross-functional work groups, when appropriate, will enable us to remain agile when identifying QI opportunities, testing solutions, measuring our progress, and refining our solutions as indicated by the data.

Strategic Solutions for Quality Measurement

As summarized above, annually our Kentucky QI team will prepare a QAPI Work Plan that will clearly identify each quality measure, its performance target, and the monitoring frequency. We will rely upon established systems and processes to continually analyze data across the health plan to measure and track our performance. As detailed in our responses below, our data analytics team will provide extensive data collection and measurement support, and we will rely on sophisticated software and reporting tools to gather and analyze QI data. (Details on our technology infrastructure and internal tools can be found in Proposal Section C.9.a.iv.) For example, our QI specialists will use HEDIS Dashboards to track month-over-month and year-over-year trending for each HEDIS measure, as illustrated in Exhibit C.9-3.

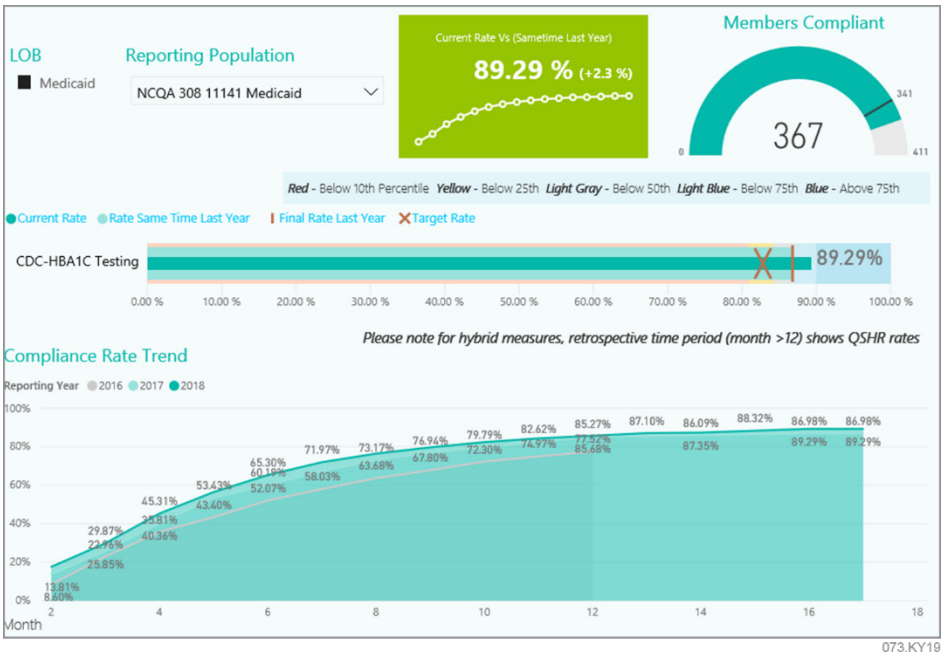


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Exhibit C.9-3. HEDIS Dashboards Support QAPI Trending and Tracking

To promote accurate quality data measurement, our national HEDIS team will support our Kentucky QI staff and follow established data verification protocols. Monthly, the HEDIS operations program manager, available to the Kentucky QI director and staff, extracts measures (including state-specific measures) from our HEDIS software, capturing and sorting data for all Molina affiliates. The project manager investigates any significant deviations from the expected rates to verify that all valid claims for the suspect measure were uploaded to the tool. If data transfer errors occur, the project manager corrects the issue. Through this process, we confirm that the data supporting quality measures are complete and valid. The data will then be available to our Kentucky QI specialists to view and analyze using dashboards developed by our local and national quality data analytics team. We describe and illustrate these tools in our response to Proposal Section 9.a.iv below.

Integral to our QAPI activities will be using data to understand opportunities across the Commonwealth or within specific regions (such as heat maps, provider quality scorecards, and Gaps in Care reports as we detail in Proposal Section 9.a.iv) but also to identify health disparities among specific Medical Assistance aid categories, racial or ethnic groups, or genders. Heat maps can also alert us to communities in which clusters of Enrollees identify with gaps in social determinants of health, such as communities where a heightened percentage of Enrollees indicate food insecurity in their Health Risk Assessment. ***With this data, we can take appropriate action by collaborating with food bank partners like Dare to Care Food Bank, God's Pantry Food Bank, and Feeding America, Kentucky's Heartland that outreach to every Kentucky county to concentrate their outreach efforts in identified areas.***

Strategic Solutions for Quality Improvement

Molina will implement an array of statewide and regional solutions that will be clearly outlined in our annual QAPI Work Plan. As we detail in our response to the following question, our strategic solutions will address the specific barriers to achieving quality performance targets. Our solutions are detailed throughout our proposal, but below we highlight some of our most significant programs to improve quality: Kentucky provider partnerships, Care Connections, Patient Safety Initiative, telehealth, and Enrollee and provider incentives.

In addition to key strategies highlighted below, Molina will continually seek new opportunities to advance system transformation by engaging and empowering Enrollees to take greater responsibility in their healthcare and increasing community engagement (employment, training, or volunteering). From the initial Welcome Call to ongoing outreach calls and educational materials, we will encourage Enrollees to obtain timely preventive screenings and well visits. Our use of community-based resources like Molina Community Health Workers, Care Connections nurse practitioners, and care managers embedded in key PCP offices will advance our efforts to enhance health literacy and engage Enrollees in self-management to improve their outcomes. (These initiatives are described in detail in Molina's Proposal Section C.12, Enrollee Services.) As part of our Enrollee-centered model, Enrollees in care management will receive education and coaching to improve their self-care and self-advocacy skills and support to achieve their goals for community engagement, such as referrals for job training. Molina's QI team will analyze data to identify new and emerging opportunities to engage Enrollees. For example, Molina Mobile (our mobile app described in detail in Proposal Section C.9.a.iv) incorporates reminders for health screenings and prevention services and easy access to Enrollee care plans and assessments, allowing Enrollees to keep up to date on their needed screenings and treatments. Enrollees can also view reminders for preventive services (for example, immunizations, cancer screenings, and flu shots) and access a "Symptom Checker." We describe innovative strategies to achieve this goal in the following section.

Kentucky Provider Partnerships

As part of our strategic approach, we will ***drive quality gains by partnering with key providers to capitalize on existing system transformation initiatives that are already underway in Kentucky***. This fosters efficiency and a systemic approach to quality improvement. For example, we are partnering with the Kentucky Primary Care Association (KPCA) to act as an Accountable Care Entity in our program. KPCA currently serves about 20% of Kentucky Medicaid Enrollees and includes approximately 350 federally qualified health centers (FQHCs), 84 rural health clinics (RHCs), 172 school-based sites, and more than 1,500 providers. As they enhance and expand their own quality improvement initiatives, Molina and KPCA will integrate our QI efforts to optimize efficient use of resources and foster a collaborative approach to QAPI activities.

Some KPCA providers participate in the Kentucky Consortium for Accountable Health Communities established by the University of Kentucky's Center for Health Services Research. Through this initiative, eligible Enrollees at those provider locations will be screened to identify social support needs with an aim to reduce the impact of social determinants of health. We are enthusiastic about working with KPCA to identify and encourage best practices resulting from this important initiative.

Care Connections

One integral strategy for QI is our Care Connections program. Working hand-in-hand with QI, providers, and community organizations, our Care Connections staff empowers Enrollees by linking them with the array of care and services they need to take charge of their health and obtain the services to improve their health outcomes. In addition, Care Connections nurse practitioners conduct annual comprehensive exams, comprehensive diabetes care, and postpartum visits through home visits, mobile clinics, or pop-up clinics in partnership with local community organizations. By emphasizing a community-based approach to cultivating relationships with Enrollees, we can better influence quality improvements, especially in rural communities that lack or have a limited number of traditional care providers. Care Connections services are illustrated in Exhibit C.9-4.

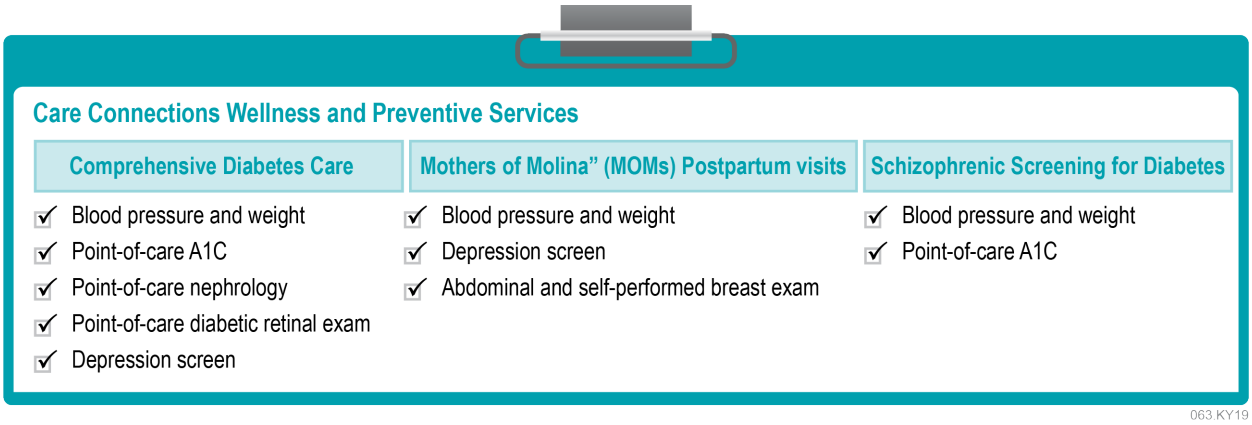

Exhibit C.9-4. Driving Quality Improvements through Community-based Services

Care Connections nurse practitioners boost quality outcomes by closing care gaps for Enrollees and extending the health plan's reach into each community. Fostering continuity and reinforcing the value of a medical home, they coordinate closely with Molina care managers and Enrollee' PCPs. ***Demonstrating the impact of Care Connections, our Utah affiliate used Care Connections to conduct in-home visits for HbA1c testing for members with diabetes who had care gaps, driving their HEDIS score beyond the 75th percentile. For HEDIS 2019, our Ohio affiliate experienced a 5% increase in Postpartum Visits through use of Care Connections to visit members and conduct in-home visits in 13 counties.***

82%

of our affiliate Medicaid health plans increased HEDIS score for Comprehensive Diabetes Care – Retinal Eye Exam between HEDIS 2017 and 2018

Pain Safety Initiative

Molina's Pain Safety Initiative has had significant success on which we will capitalize in Kentucky. Our national opioid strategy is designed to help Enrollees struggling with opioid addiction or overuse through treatment and to deploy sustainable mechanisms to help others avoid potential abuse. Our medical and pharmacy teams collaborate with each Molina health plan to tailor approaches to the unique needs of each plan's Enrollees and state regulatory environments. Using a multi-faceted approach, Molina employs a set of initiatives to enhance medical and pharmacy benefits, increase Enrollee and provider education, and improve network performance to combat the epidemic. The program, detailed in Molina's Proposal Section C.21, Pharmacy, includes an array of activities (such as a hard stop at the point of sale for a prescription request for a drug dosage higher than 90mg morphine equivalents).

85%

of our reporting affiliate Medicaid health plans improved their HEDIS scores for Use of Opioids High Dosage (UOD) between calendar years 2017 and 2018

In collaborative efforts with our behavioral health team, where regulations allowed, we modified drug utilization review requirements to promote access to care for Enrollees with substance use disorders, such as removing prior authorization for buprenorphine/naloxone and buprenorphine. ***In our affiliates' Medicaid populations between January 2016 and April 2019, Molina experienced a drop of 37% in opioid users and a decrease of 39% in opioid prescriptions per 1,000 members.***

Partnerships with Community Organizations

Molina will partner with and contribute to community organizations to deliver solutions for social determinants of health in Kentucky's high-need areas. ***To reinforce this commitment, Molina will establish a Molina Community Innovation Fund that will provide $625,000 per year for the first four years of the Contract term (up to $2.5 million cumulatively) to community organizations and***

healthcare initiatives that align with Enrollee needs in communities across the Commonwealth. Enrollees will also have access to a community resource guide through our Enrollee website. As we engage in quality improvement activities, Molina's QI team, working with the local Molina community engagement representatives, will continually explore opportunities to streamline collaboration with community-based organizations. Partnerships span the following areas and will continue to expand:

- **Food insecurity.** Through grants, we support three food banks that can reach every Kentucky county and serve Enrollees in all eight regions to address food insecurity—Dare to Care; Feeding America, Kentucky's Heartland; and God's Pantry Food Bank. For example, through Dare to Care's Provider Pantry program, providers will screen their patients for food insecurity, provide a box of nutritious food right off the shelf at their office, and connect the individual to Dare to Care for follow up food supplies. Feeding America, Kentucky's Heartland will develop nutritious food boxes that are tailored for Enrollees with diabetes who experience food insecurity.

In our Ohio affiliate, **22% of users indicated that they would have sought emergency services if they hadn't called, and 12% said they would not have obtained care at all,** demonstrating the value of the program in connecting individuals to appropriate care.

- **Self-Sufficiency.** We support Family Scholar House's (Louisville) Healthcare Pathways program that offers community outreach, workshops, and other activities for single mothers to assist in their pursuits for careers in healthcare-related fields. Another partner is the Louisville Urban League and its community health workers' engagement of families with an assessment of social determinants of health outreach campaign to identify and address barriers to family-sustaining employment, called ***"It Starts With Me!"***
- **Rural Access to Care.** In addition to Care Connections, telehealth, and KPCA providers in rural communities, Molina will identify opportunities to expand access through community partners. For example, working with the Audubon Area Community Services, we will use Audubon locations to expand health services outside their immediate footprint by supporting pop-ups clinics targeting back-to-school and other events, directly addressing the concern about access identified by our Enrollee focus group. We also support the United Way of Northeast Kentucky to enhance their 2-1-1 database to so that Enrollees in that region can more readily identify and access community organizations to overcome social determinants of health that impede their ability to obtain care.

We will continually seek additional opportunities to leverage community services across the Commonwealth to assist internal teams with achieving complementary goals. For example, our Ohio affiliate is establishing protocols for our internal teams to coordinate the referral of Enrollees to community-based organizations that specialize in addressing social determinants of health. This effort involves identifying community referral partners, establishing participation criteria, creating referral processes, and tracking to relevant health and social outcomes for participating Enrollees.

Telehealth

In another example, to increase access to care, reduce transportation barriers (two key themes from our Enrollee focus groups) and enhance Enrollee satisfaction, we will deploy Telehealth. Telehealth offers 24/7 access to a physician or advanced practice registered nurse for common urgent medical conditions via phone or mobile device. Enrollees may receive triage, diagnosis, and treatment for common conditions. Promoting holistic care and Population Health Management, Telehealth will refer Enrollees with mental health or chronic health conditions to Molina care managers for linkage back to their PCP and other supportive services if needed. To reinforce the importance of a medical home, Telehealth will share medical records with the PCP. ***Our Washington affiliate experienced a 21% increase in monthly utilization between year one and year two of the program, demonstrating member satisfaction.*** In our experience, 70% of Telehealth visits eliminated the need for a follow-up visit to an ED or urgent care center.

Enrollee and Provider Incentives

Incentives and value-based payment models align Enrollee and provider goals and behaviors with those of the Department. We will implement incentives that directly link to the Commonwealth's priorities. ***Incentives encourage Enrollees to take responsibility for their healthcare and obtain timely preventive care or screenings for chronic conditions and were identified as important by Enrollees in our focus groups.*** They have been effective for Molina health plans; our Ohio affiliate increased its HEDIS score for Postpartum Visits by 5% in 2018 after implementing a series of interventions, including incentives for prenatal and postpartum visits. Table C.9-1 summarizes Molina's Healthy Rewards Enrollee incentives.

Table C.9-1. Aligning Enrollee Incentives with Department Priorities

Healthy Rewards Topic	Incentive
Comprehensive Diabetes Care: Receive annual retinal eye exam and complete HbA1c screening	$50 gift card each ($100 annual maximum)
Breast Cancer Screening: Obtain an annual mammogram	$25 gift card
Cervical Cancer Screening: Complete an office visit that includes a Pap test	$25 gift card
Chlamydia Screening for Women: Complete an annual screening	$25 gift card
Follow-Up After Hospitalization: Complete a follow-up PCP visit within 7 days of an inpatient hospital or BH stay	$50 gift card
Adult Annual Well-visit: Complete annual adult preventive screening visit	$25 gift card
Annual Dental Visit: Complete annual preventive dental visit	$50 gift card
Prenatal Care: Complete a prenatal visit during their first trimester or within 42 days of enrollment	Car or Booster Seat
Postpartum Care: Complete a postpartum visit 7-84 days after birth	$25 gift card
Well Child Visits: Complete up to 6 timely well-child visits within the baby's first 15 months of life	$10 gift card per visit ($60 maximum)
Well Child Visits*:* Complete an annual well-child visit at ages 2, 3, 4, and 5	$25 gift card ($25 maximum per year)

Our provider incentives are linked to the following quality scores:

- Colorectal Cancer Screening (COL)
- Weight Assessment and Counseling for Nutrition and Physical Activity – BMI percentile documentation, Weight Assessment and Counseling for Nutrition and Physical Activity – counseling for nutrition, and Weight Assessment and Counseling for Nutrition and Physical Activity – counseling for physical activity (WCC)
- Comprehensive Diabetes Care – Retinal Eye Exam and Comprehensive Diabetes Care – HbA1c testing (CDC)
- Statin Therapy for Patients with Diabetes (SPD)
- Adolescent Well Care (AWC)
- Follow-Up After Hospitalization for Mental Illness (FUH) – 7-day follow-up
- Antidepressant Medication Management (AMM) – effective acute phase and effective continuation phase treatment

Provider incentives are effective at our affiliates. Our Illinois health plan affiliate experienced an 8% gain in their HEDIS 2019 Adult BMI Assessment score after implementing incentives. Our Ohio affiliate improved their associated HEDIS 2018 scores beyond the 75th percentile of NCQA's Quality Compass after implementing provider incentive for Follow-Up After Hospitalization for Mental Illness.

In addition, Molina is developing innovative quality-oriented Alternate Payment Models with key providers like KPCA. Detail on our value-based payment strategies for providers can be found in Proposal Section C.9.j.

a.iii. INNOVATIVE STRATEGIES AND ENHANCED SERVICES

Molina will deploy innovative strategies and services to enhance Enrollees' health and well-being and to improve health outcomes in Kentucky. Our solutions address the underlying causes of poor health outcomes or inefficiency to achieve sustainable improvements. Further, our regional emphasis and community-based staff will foster development of strategies that are tailored to the diverse needs of communities across the Commonwealth, and our innovations reinforce the impact of the social determinants of health. Below, we first describe our innovative strategies and later address enhanced services.

Table C.9-2 highlights key innovative strategies and solutions that are detailed throughout our proposal. Molina will closely collaborate with the Department to review all available data to identify priorities for innovation.

Table C.9-2. Driving Quality Gains through Adoption of Innovative Solutions

Innovative Strategies and Solutions	Performance Measures
QI Goal: Reduce opioid use	
• Deploy **substance use disorder (SUD) navigators** (dedicated staff who will be licensed counselors, peer support specialists, or Molina Community Health Workers) to continually engage Enrollees struggling with opioid use disorder (OUD) and encourage treatment adherence (See details in Proposal Section C.23, Behavioral Health) • Implement **Pain Safety Initiative** that will include modifications to prescribing protocols and has improved HEDIS scores at affiliate health plans (See details in Proposal Section C.21, Pharmacy) • Include a Kentucky-licensed **addictionologist** to support our medical director on developing and implementing solutions related to reducing opioid use	**HEDIS:** Use of Opioids at High Dosage (UOD) Use of Opioids from Multiple Providers (UOP)
QI Goal: Improve health outcomes	
• Leverage **Care Connections** nurse practitioners in the community who will work closely with community-based organizations to conduct community-based screenings in communities with a high rate of care gaps and conduct in-home visits, including postpartum visits • Deploy **Provider Engagement Teams** to collaborate with providers to interpret and act on quality scorecards to improve results • Mobilize **Molina Community Health Workers** to develop relationships with Enrollees in their community and provide hands-on support to identify and address barriers to care, including social determinants of health and to support location and engagement of hard-to-reach Enrollees (See details in Proposal Section C.24, Population Health Management) • Develop **partnerships with providers**, such as KPCA, to support integration of physical and behavioral health within FQHCs, RHCs, and other practice sites (See details in Proposal Section C.18, Provider Network)	**HEDIS Effectiveness of Care Measures (including, but not limited to):** Cancer Screenings Comprehensive Diabetes Control Adolescent Well Care Well-Child Visits Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents Follow-Up After Hospitalization for Mental Illness Adult BMI Assessment Child Immunization Status

Innovative Strategies and Solutions	Performance Measures
• Establish appropriate **telemedicine** availability in communities where heat maps indicate low HEDIS scores (See details in Proposal Section C.18, Provider Network) • Collaborate with **Departments for Public Health** and local health departments to coordinate referral of Enrollees to programs such as the Diabetes Self-Management Programs and Diabetes Prevention Program (See details in Proposal Section C.9. h) • Initiate **outreach by pharmacy team** to PCPs of Enrollees with diabetes who are not taking their medications as prescribed to educate them and offer assistance with other referrals or supports, such as referral to a dietician for nutrition counseling (See details in Proposal Section C.9.f) • Deploy our **Resource Mothers** program that pairs pregnant Enrollees with a lay case worker who is trained to be a role model, provide counsel, and offer transportation for Enrollees to prenatal, postpartum, and well-child appointments (complementing our High Risk OB Program). (See details in Proposal Section C.12, Enrollee Services) • Identify pregnant Enrollees as rapidly as possible using Lucina Analytics **maternity-specific algorithms** to find more than 3,000 early pregnancy identifiers to find mothers as early as possible and stratify by risk to prioritize outreach	Prenatal and Postpartum Care **HEDIS Access/Availability of Care Measures:** Adult Access to Preventive/Ambulatory Health Services Children and Adolescent's Access to Primary Care Providers **Other Measures:** Low Birth Weight Rate Infant Mortality Rate
QI Goal: Expand access to care in rural communities	
• Deploy **Telehealth programs**, including telepsychiatry, and eConsults (Detail in Proposal Section C.18, Provider Network) • Identify areas with clusters of HEDIS care gaps (such as Comprehensive Diabetes Care or Postpartum Visits) and deploy **Care Connections** staff to provide community-based screenings • Partner with dental and vision subcontractors and other community programs (such as the UK North Fork Valley Community Dental Outreach Program) to conduct **mobile screenings** in rural communities • Enhance reimbursement to **independent pharmacies** in counties that have fewer than five independent pharmacies in operation, promoting access to medication and encouraging continued access to other services that independent pharmacies provide in underserved or rural communities, such as medication counseling, immunizations, medication management, and blood pressure monitoring • Capitalize on KPCA's 172 **school-based health providers** across Kentucky that connect to other KPCA providers through the HIE (See details in Proposal Section C.8, Provider Network)	**HEDIS Effectiveness of Care Measures** All above **HEDIS Access/Availability of Care Measures** All above, plus: Annual Dental Visits Controlling High Blood Pressure
QI Goal: Reduce impact of social determinants of health	
• Invest in four **housing specialists** for our Population Health Management team to train care managers about affordable housing options, the process to screen Enrollees who may benefit from housing assistance and engage the support of a housing specialist to locate affordable housing options that meet their needs and preferences (such as Enrollees who experience chronic homelessness) (See details in Proposal Section C.24, Population Health Management) • Incorporate **screening for potential social determinants of health** during the health assessment process, incorporation of solutions in care plans, and tracking as part of our Population Health Management program (See details in Proposal Section C.24, Population Health Management)	**HEDIS:** All measures Reduce avoidable inpatient admissions and ED visits and improve management of chronic conditions **Other measures:** Changes in social determinants of health measures such as housing insecurity, food insecurity, safety, education, and socialization captured during assessments

Innovative Strategies and Solutions	Performance Measures
• Partner with KPCA, some of whose providers participate in the **Kentucky Consortium for Accountable Health Communities**, and screen eligible Enrollees to identify social support needs with an aim to reduce the impact of social determinants of health • Leverage community-based **Care Connections** staff to screen for social determinants of health and coordinate with community-based organizations and our Care Management team to address them • Recognize the important role caregivers have in promoting Enrollee health through inclusion of our **caregiver support program** in which we will use the American Medical Association's evidence-based screening tool to identify caregivers at risk of burnout and incorporate referral to support groups and other available resources in the Enrollee's care plan (See details in Proposal Section 24, Population Health Management) • Partner with **community-based organizations**, such Feeding America, Kentucky's Heartland and the Farm to Table program, in which we will partner with local farms to distribute fresh fruit and vegetables to Enrollees, reducing food insecurity and promoting healthy nutrition	
QI Goal: Engage and empower Enrollees toward self-sufficiency	
• Welcome Enrollees to our **Molina One-Stop Help Centers** in our six offices across Kentucky where they can get assistance with finding food, housing, utility or filling out forms to receive SNAP assistance; participate in nutrition, cooking and health classes; and obtain job and education support such as signing up for GED classes and testing, using a computer to help find work through Kentucky job link websites, and getting assistance with resume writing or job applications (See details in Proposal Section 12, Enrollee Services) • Connect Enrollees to **suite of online tools** that include interactive risk screenings and self-management tools to empower Enrollees with chronic conditions, such as diabetes, to improve self-care • Deliver **Enrollee education tools**, such as Molina Mobile, to support education and engagement in care planning and self-care (See details in Proposal Section C.12, Enrollee Services) • Invest in and refer Enrollees to existing **community programs** like Family Scholar House's Healthcare Pathways program that conducts community outreach, workshops, and other activities for single mothers to assist in their pursuits for careers in healthcare related fields and the Louisville Urban League's "*It Starts With Me*!" program in which Molina Community Health Workers will engage families to identify and address barriers to sustaining employment	Achievement of sustainable employment for Enrollees who wish to include it in their care planning process
QI Goal: Improve provider satisfaction with Kentucky Medicaid MCOs	
• Deploy a **community-based Provider Services team** to work directly with providers to educate, engage, and rapidly respond to issues or concerns, *a chief desire of Kentucky Medicaid providers in our focus groups* (See details in Proposal Section 17, Provider Services) • Implement **Provider Engagement Teams** to provide hands-on support to providers in interpreting and acting on quality data provided by Molina, *a need expressed by Kentucky Medicaid providers during our focus groups* • Adopt monthly **"It Matters to Molina Provider Forums,"** conducted via WebEx, in which we invite Kentucky providers and their staff to talk with Provider Services staff about their questions, concerns, or recommendations to improve service (See details in Proposal Section C.17, Provider Services)	Provider satisfaction survey results

Innovative Strategies and Solutions	Performance Measures
• Encourage provider engagement and accountability through contracts that include **delegated credentialing**, such as our partnership with KPCA, as credentialing remains a hot button issue for Kentucky's Medicaid providers (See details in Proposal Section C.18, Provider Network	

Molina will continue to work closely with the Commonwealth, Enrollees (through regional QMACs), our providers, and community stakeholders to identify emerging QI priorities, establish associated quality benchmarks, and implement data-driven solutions and innovations. In addition, as our Medicaid affiliates identify high-performing innovations that may be adopted in Kentucky, our local team will evaluate their feasibility and identify how they can best be adapted to service our Kentucky stakeholders.

Innovative Value-added Services to Enhance Enrollee Health and Well-being

Molina's value-added services directly link with improving Enrollee outcomes. In addition to the Healthy Rewards program described in Table C.9-2, we will support the new administrations goals by encouraging our Enrollees to take the GED test and reward them with a $50 gift card once they pass the test. They also include up to eight hours of respite care per year for caregivers for Enrollees with Special Health Care Needs living in the community with a regular caregiver. Offering respite enables caregivers to recharge and rejuvenate, fostering continued community living.

Examples of Successes with Similar Medicaid Populations

Kentucky Medicaid will benefit from programs that have demonstrated success with similar populations in other states. Throughout this response we highlight key successes, and just a few are listed below.

To increase its **HEDIS score for Pharmacotherapy Management of COPD Exacerbation (PCE)**, our Wisconsin affiliate undertook extensive care manager **training** about identifying and addressing **preventive services**, including appointment scheduling assistance. The health plan's **score increased 12 percentage points between HEDIS 2017 and HEDIS 2018, achieving the 90th percentile.**

- Use of Care Connections staff to conduct in-home postpartum visits in our California affiliate resulted in a ***15% increase in HEDIS scores*** between 2016 and 2018 and a 37% increase between 2016 and 2017 for African-American members whose scores typically lag below average. The initiative earned our affiliate the *1st Annual Health Equity Award* that recognizes plans that improve outcomes for beneficiaries with social risk factors and shines a spotlight on interventions that are successful at reducing disparities.
- Between HEDIS 2018 and HEDIS 2019, our Ohio affiliate experienced a ***more than 23% increase for Weight Assessment and Counseling: Counseling for Nutrition and a 33% increase for Weight Assessment and Counseling: Counseling for Physical Activity*** after Provider Engagement Teams completed visits to PCP offices to review the HEDIS Provider scorecard and WCC clinical guidelines, best practices, and tips to improve compliance.
- Molina's use of technology to increase access to care for Enrollees has delivered results in our affiliates. In Puerto Rico, our affiliate health plan's ***telehealth provider reports that 92% of issues are resolved after the first visit and 95% of members are satisfied with the telehealth services*** delivered. Our Ohio affiliate reports ***claims savings of more than $470 per telehealth episode***.

The Impact of Care Connections

Emily Wong, NP (WA) just visited a Enrollee whom she had seen one year ago. Last year the Enrollee had a critically elevated blood pressure, 200s over 100s. **Emily provided education around hypertension and medication compliance and helped to care coordinate with the Enrollee's PCP.**

When she returned, the Enrollee's blood pressure was well controlled! The Enrollee was very grateful to Emily for caring and providing education and care coordination to help the Enrollee reach control of his blood pressure and for preventing a heart attack or stroke.

Dr. Juan Pena, Senior National Medical Director

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a.iv. INTERNAL TOOLS AND TECHNOLOGY INFRASTRUCTURE

As a data-driven organization, Molina relies on sophisticated internal tools and a technology infrastructure to support improvements in health outcomes. In this section, we describe our quality technology infrastructure (including the breadth of data) that we leverage to improve quality performance, the technology tools that support our efforts, and the tools that track and report quality and performance metrics of network providers at the regional and statewide level.

Relying on a Solid Technology Infrastructure

Molina's integrated, cross-functional health information system enables our QI team to collect, integrate, analyze, and report data necessary to implement and evaluate our QAPI program activities. Our technology infrastructure and the multiple available data sources allow us to monitor important aspects of healthcare and service that focus on:

- Access and availability
- Continuity and coordination of care
- Population Health Management
- Potential over- and under-utilization
- Patient safety
- Pharmacy management
- Preventive care
- Potential quality of care concerns

Our technology platform integrates data across health plan systems, including QNXT (our core platform), GeoAccess, and Clinical Care Advance. In addition, a key software supporting our QAPI program is Inovalon's Quality Spectrum Insight (QSI) platform, an NCQA-certified HEDIS software. Additional subsystems enable Molina to:

- Incorporate data gleaned from medical record reviews
- Develop HEDIS alerts that notify staff (such as Call Center customer service representatives and care managers) about an Enrollee's HEDIS care gaps through integration with our core and customer relationship management systems
- Manage a HEDIS operation dashboard used to validate data and conduct operational quality checks
- Apply the data to create provider quality scorecards, care gap reports, and an Executive Dashboard

Capitalizing on Our Depth of Data

We use our Quality Data Repository to manage, track, and maintain data used for QI. Our quality reporting system leverages data across the health plan to design, implement, and evaluate program effectiveness. Exhibit C.9-5 summarizes our quality data sources.

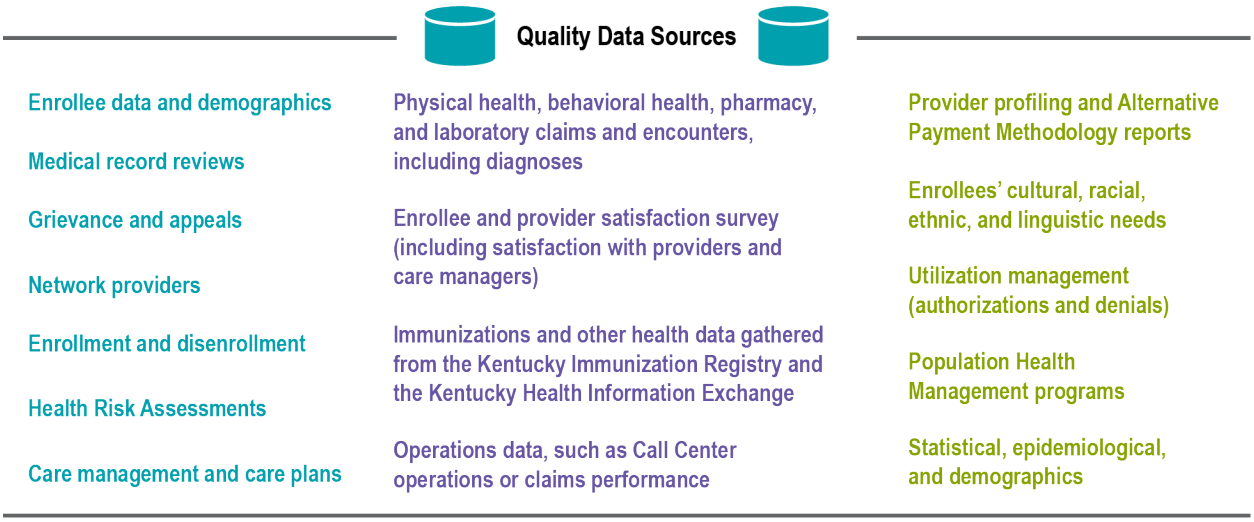

Exhibit C.9-5. Leveraging Data across the Health Plan for Quality Improvement

In addition, we will be expanding the scope of available data to include social determinants of health. We will educate providers about use of ICD-10-CM codes related to social determinants, such as food insecurity or housing instability, and capture that data in our claims system (in addition to screening data collected during Health Risk Assessment processes). With this data, we can conduct a more granular analysis of the impact of social determinants in our quality reporting and improvement processes.

In addition, through deployment of a new predictive modeling solution, Molina will also be gathering additional data on social determinants of health to inform our QI activities, as shown in Table C.9-3. The tool's proprietary and social determinant indices are generated when run against large public databases, providing Molina with valuable data to improve care and services for Enrollees.

Table C.9-3. Using Social Determinants of Health to Assess Enrollee Risk Levels

Predictive Modeling Tool's Social Determinants of Health Features	
Indices	**Social Determinants of Health**
• Propensity to engage • Health ownership • Social isolation • Homelessness	• Ethnicity • Language • Socioeconomic status • Race • Education

Internal Technology Tools Enable Data-driven Quality Initiatives

With this solid foundation and depth of data, our Kentucky QI team will have access to an array of tools to analyze, track, and improve quality performance. Complementing QI supports, Molina will maintain tools to engage others (such as health plan leadership, other Molina departments, and providers) to support QI, promoting a holistic and comprehensive QAPI model. Below we describe the following: tools to support our QI team, health plan leadership monitoring tools, Enrollee tools, and tools to monitor the quality of services from network providers.

Tools to Support QI Team

Using Microsoft business intelligence (BI) tools, our quality analytics team creates monthly reports to monitor each performance metric in the QAPI Work Plan. The team synthesizes relevant data and work with the QI specialists and work groups, as appropriate, to incorporate meaningful and actionable data. QI specialists review the monthly reports to guide program evaluation and development. Reports also stratify

measures, where appropriate, by demographic and geographic characteristics to identify disparities and target improvement activities to specific populations, providing us with actionable information on regional quality gaps.

For example, we will view performance trends using our HEDIS Dashboard, illustrated in Exhibit C.9-6. With this data, our QI team can quickly identify emerging trends and monitor rapid cycle projects to see the results. The dashboards will provide a valuable resource that enables QI specialists to evaluate our performance on a regional, statewide, or national basis, so that our quality interventions can be more granularly defined and measured by region.

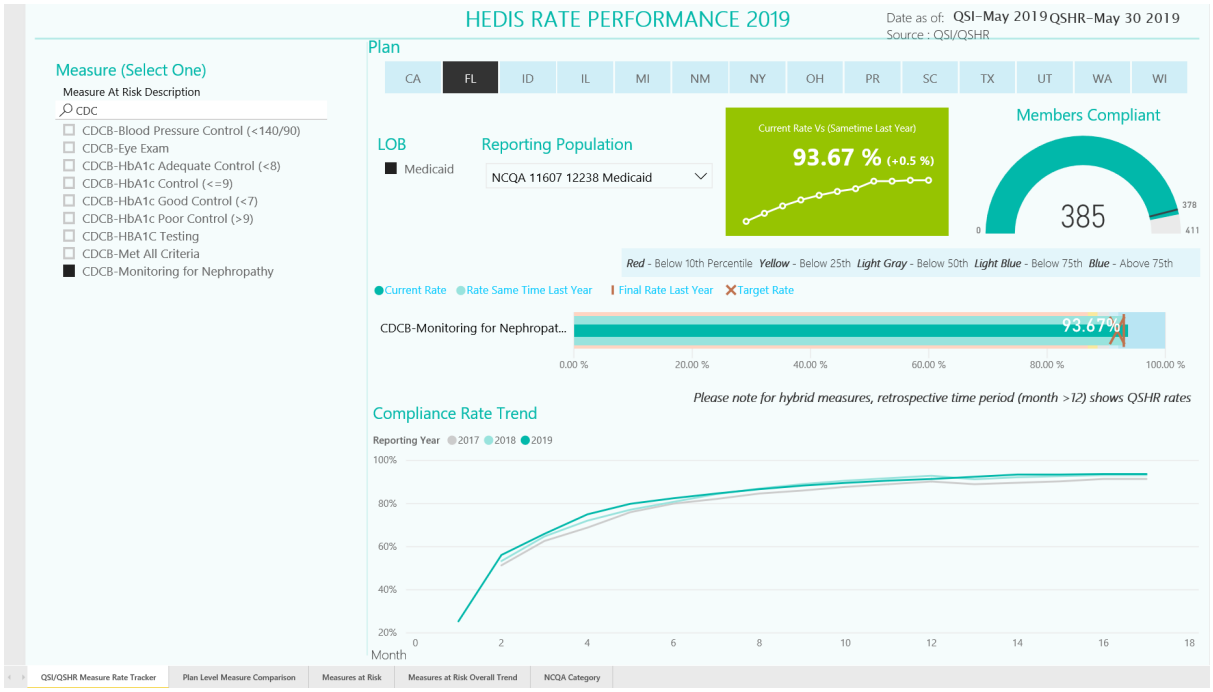

Exhibit C.9-6. HEDIS Dashboards Support Performance Monitoring

Dashboards provide valuable data around HEDIS service completion rates as well as provide information about Enrollees who have not yet obtained HEDIS services, so QI specialists will have an at-a-glance look at Enrollees by age, race, and ZIP code. (Exhibit C.9-7) With this data, QI specialists can evaluate the interventions that are likely to have the greatest impact.

To further guide identification of regional or localized disparities, heat maps pinpoint gaps in care by ZIP code. By looking at quality performance, such as HEDIS measures, by region or geographic area, QI specialists can work with their community-based provider services and community engagement representative partners to develop solutions that are tailored to the local area. Using rapid cycle processes, QI specialists will monitor how these interventions influence the performance metric and adjust the plan accordingly.

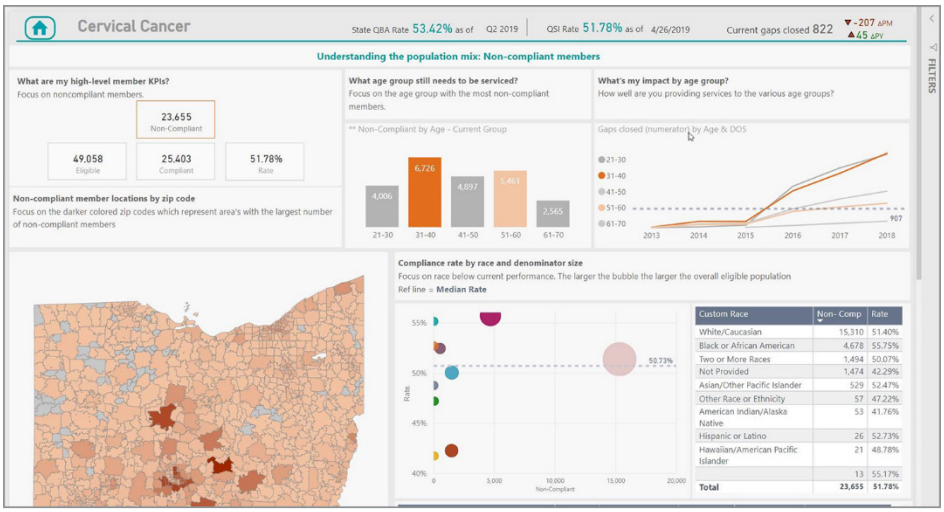

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Exhibit C.9-7. Tracking Tools Support Pinpoint Analysis of Quality Gaps

For example, should the heat map identify gaps in Annual Dental Visits in a community with few available dentists, the team may work with our dental subcontractor, Avesis, and our Care Connections staff to schedule pop-up clinics at FQHCs and RHCs in affected areas or collaborate with UK North Fork Valley Community Dental Outreach Program to coordinate mobile dental services for communities in Eastern Kentucky. In another example, the heat pap can be used to identify food deserts, communities in which clusters of Enrollees report food insecurity. We can then identify potential community partners with which we can collaborate to identify potential solutions, such as a promotion of community food banks.

Heat maps may also identify care and service gaps in a community for which our Care Connections nurse practitioners are best positioned to assist. They will initiate home visits and work with local community organizations to conduct pop-up clinics at which Enrollees can obtain annual comprehensive service exams, diabetic retinopathy screenings, or other services. This approach will be especially impactful in Kentucky communities lacking adequate access to traditional care or in refugee/immigrant communities that are often mistrustful of traditional care providers, such as the large community of immigrants from Somalia in Louisville.

Molina will also produce Gaps in Care reports and share them with stakeholders who can act on the data, such as PCPs and Enrollee Services and Care Management staff. Powered by Inovalon's QSI HEDIS platform, the report highlights missing preventive services and chronic care screenings and services. Armed with this data, PCPs and our staff who interacts with Enrollees are fully prepared to coordinate missing services, boosting access to care and timely services.

Health Plan Leadership Monitoring Tools

More strategically, our Kentucky leadership will monitor and track our QAPI performance through our Quality Operations Dashboard (Exhibit C.9-8) that provides an up-to-date snapshot on current health plan QAPI projects. This dynamic reporting tool provides drill-down statistics across a multitude of population health categories for our 14 affiliated Medicaid health plans across the nation, including the display of the progress. The Quality Operations Dashboard provides valuable data related to enrollment, Enrollee demographics, utilization, top diagnoses, HEDIS scores, and more.

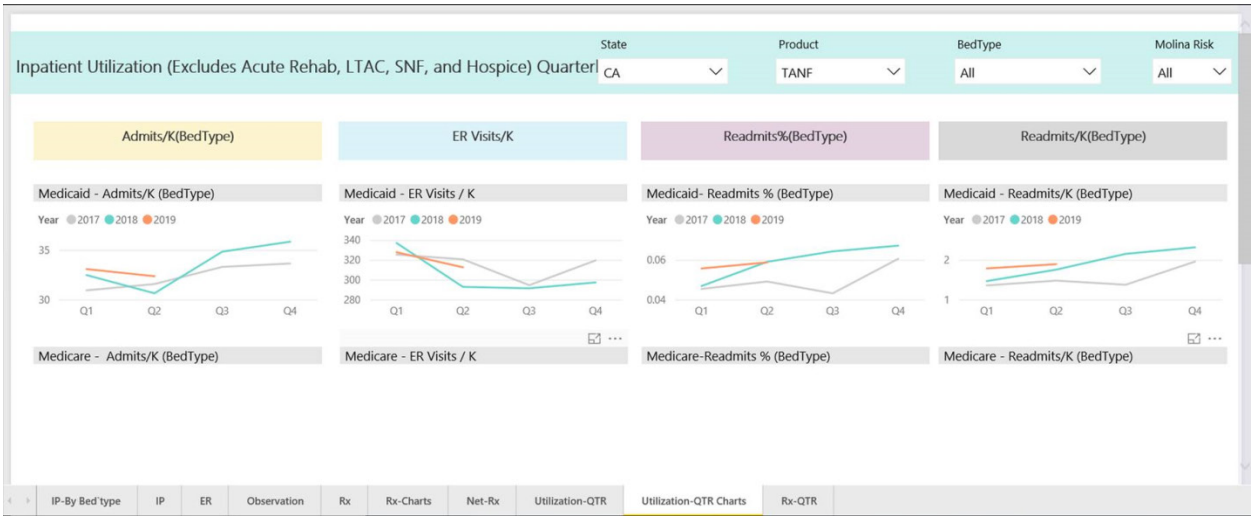

Exhibit C.9-8. Delivering Actionable Data to Health Plan Leadership

In addition, Molina will deploy specialized dashboards to monitor various programs. For example, our ***Substance Use Disorder (SUD) Dashboard*** summarizes key performance metrics for our SUD Model of Care with Opioid Use Disorder Focus, including our performance relative to Enrollees with opioid use disorder. In addition to process measures (such as number of referrals and percent of Enrollees working with navigators), the tool will provide valuable insight into outcomes measures, including reduction in 30/60/90 day readmission rates for identified Enrollees with high acuity utilization, costs for identified Enrollees with high acuity utilization, costs for identified Enrollees with low to intermediate utilization, and total medical costs of identified Enrollees. By continually monitoring our performance, Molina will remain nimble in analyzing and refining our model to drive the greatest quality improvements. A ***Potential Quality of Care Dashboard*** enables ongoing tracking of potential quality to support identification and remediation of any emerging trend.

Enrollee Tools that Contribute to Improving Quality

Molina will also offer tools that promote gains in quality and performance measures by engaging Enrollees. Our Molina Mobile app incorporates features like Care Cards that deliver a comprehensive to-do list of activities and reminders and an online risk assessment. It includes reminders for scheduling appointments (such as prenatal or postpartum visits), completing risk assessments, or taking medications. Complementing the reminder, the app provides instructions and educational materials to assist Enrollees to take action. New in 2019, Enrollees can view reminders for preventive services (for example, immunizations, cancer screenings, and flu shots) and access to a "Symptom Checker." ***During our Enrollee focus groups, participants indicated that they would highly value a tool like Molina Mobile.***

Molina Mobile incorporates a full array of features and functionality, as illustrated in Exhibit C.9-9.

Exhibit C.9-9. Technology Tools to Help Enrollees

Tools to Monitor the Quality of Services from Network Providers

As detailed in our response to the following question (Proposal Section C.9.a.v), Molina will monitor the quality of services provided by our Kentucky network providers using quality scorecards that we share with them. QI specialists will use these scorecards to identify high-performing providers (that may offer insight into best practices) as well as providers with improvement opportunities. By evaluating gaps in care by provider or office, QI specialists will work with their regional teams to partner with providers to improve scores or coach and educate them about ways to improve their scores such as proper coding of claims so that we capture all services provided.

As appropriate, QI specialists will recommend that the Provider Engagement Team work with a provider to improve quality scores. Delivering actionable and meaningful information to providers and supporting them with onsite visits by Provider Engagement Team staff to coach them through changes will boost quality scores. All provider scorecards will be accessible through our provider portal for convenient access by providers and their staff.

For larger and high-volume providers, Molina will implement Joint Operating Committee meetings in which we discuss operational and clinical topics (such as ED utilization or hospital readmission rates) to enhance provider coordination and collaboration.

Complementing scorecards, our QI team will conduct Provider Access and Availability surveys to confirm that Enrollees can schedule appointments on a timely basis. We will monitor grievance and appeals data and CAHPS survey responses related to Enrollee satisfaction with providers.

Our Illinois affiliate that implemented a value-based payment program for PCPs tied to quality performance measures experienced a more than **7 percentage point jump in the Adult BMI Assessment measure** between HEDIS 2018 and HEDIS 2019, **improving by 8%**

QI specialists will also monitor our ***Potential Quality of Care Dashboard*** to identify any emerging trends related to the quality of services from network providers. If we identify a potential issue or emerging quality of care trend, QI specialists initiate a more detailed review, following established protocols, to assess the level of risk and engage the medical director before the risk escalates.

To support value-based payments (VBP) to providers, Molina will implement the ***3M Transformation suite***. The 3M tools support detailed and expert analysis of risk-adjusted claims data, starting with analysis of Molina's current VBP arrangements, to set a meaningful baseline and comparison among populations. Our response to Proposal Section C.9.k describes the tool and its application in detail.

Committed to Flexibility. Molina will remain flexible and tailor our approach with key partners. As part of our Accountable Care Entity partnership with KPCA, we will collaborate with them to integrate our quality improvement activities. As they develop and enhance their technology infrastructure to capture and deliver quality data to their participating providers, Molina will collaborate to integrate efforts and not replace or duplicate KPCA's capabilities. This integration demonstrates true partnership and a commitment to meeting our provider partners where they are to achieve our quality goals.

Collaboration to Streamline Provider Quality Data Reporting. To illustrate Molina's commitment to delivering actionable quality and utilization data while streamlining data delivery to ease providers' program administration, we look to our Ohio affiliate. In 2017, both CMS and Ohio Medicaid launched Patient-Centered Medical Homes (PCMH) initiatives, which require differing quality and utilization reporting but share about 50% of provider practices. Our affiliate's Medicaid PCMH providers indicated that they liked the data aggregating tool developed by the Health Information Exchange (HIE) that was chosen by CMS to collect MCO data for the federal program. After engaging Ohio's other Medicaid MCOs, our affiliate negotiated with the HIE to expand the scope of its data reporting capabilities to include data elements required for Ohio Medicaid so that PCMH providers participating in both CMS and Ohio Medicaid had a single tool for quality and utilization data for both programs. Beginning in April 2019, Ohio Medicaid and CMS PCMHs access a single dynamic tool for critical information to support practice transformation in both the state and federal programs. Additionally, our affiliate, other Medicaid MCOs, and the HIE are now teaming to expand the tool's functionality.

a.v. METHODS TO ENSURE A DATA-DRIVEN, OUTCOMES-BASED PROCESS

Molina's Kentucky QAPI program will reflect quality improvement best practices, including the PDSA methodology, and below we describe how that promotes a data-driven, outcomes-based continuous quality improvement process. We also detail the data that we share with providers to support their understanding of progress in improving outcomes.

Establishing a Data-driven Approach with Our Model for Improvement

The Model for Improvement establishes evidence-based practices throughout our processes. At every step in our QAPI process, we emphasize the use of data to drive focus areas, priorities, and measurement. Our QAPI processes are detailed above in Proposal Section C.9.a.b.

Using the vast array of data in the Quality Data Repository, dashboards, and the technology tools described above, our QI specialists monitor our ongoing performance, identify trends, and identify and address any potential data gaps. We also gather feedback from cross-functional QI work groups, providers, or Enrollees (for example through the regional QMACs) and monitor progress. Throughout the process, we innovate, test, and replicate in order to improve our performance based on what had demonstrated success. We continuously monitor our performance against the targets established in our QAPI Work Plan.

Our California affiliate's **Cervical Cancer Screening rate** was 22% lower among Hispanic/Latino members than the overall population. The QI team identified differences in cultural norms between providers and patients as a barrier. After initiating **provider training on cultural competency and related services**, the health plan experienced a **13% jump in the rate in the following year.**

Developing and Monitoring our QAPI Work Plan

In preparing our QAPI Work Plan, Molina's QI team will evaluate all available data to identify and prioritize initiatives. This includes HEDIS and CAHPS results, non-clinical performance metrics, provider satisfaction survey results, data and results from the annual evaluation by Island Peer Review Organization (the Department's External Quality Review Organization [EQRO]), and any other data or information provided by the Department.

In accordance with the monitoring frequency outlined in the QAPI Work Plan (monthly or quarterly), we will compare our quality performance against the established target (for example, NCQA's 75th percentile

for HEDIS measures). In addition, using the data gathered through our Culturally and Linguistically Appropriate Services and Population Health Management programs, we will compare quality measures, including HEDIS and CAHPS, across each measure by Medicaid Region, Medicaid eligibility category, race, ethnicity, gender, and age to identify any potential disparities. We will present key outcomes and meaningful trends to Molina's national and Kentucky QICs who will provide guidance on identification and prioritization of improvement opportunities. Then our QI specialists, leveraging cross-functional work teams when indicated, will conduct a more in-depth barrier analysis as part of the PDSA rapid cycle process, including analysis and strategizing on reducing disparities.

By **delivering scorecards**, establishing **payment incentives for providers**, and **using the community shelter board** to locate members experiencing homelessness, our Ohio affiliate boosted their **HEDIS 2018 Follow-up after Hospitalization for Mental Illness score beyond the 75th percentile.**

Our quality analytics team will play a vital role in the QI process, gathering and sharing meaningful data to inform quality improvement solutions. The team will also maintain a system to track the outcomes of each intervention at the Enrollee level to verify that initiatives can be evaluated for ongoing feedback to QI specialists. For instance, our quality analytics team will provide metric data to the quality interventions team, such as the monthly HEDIS reports used to track progress against the Department's targets or accreditation estimates. The reports are based upon the monthly HEDIS rates and contain summary and detailed information for the various measures.

To illustrate how we use data to ensure a data-driven, outcomes-based QAPI, we look to our Ohio affiliate. The health plan's HEDIS 2017 score for Postpartum Visit between 21 and 56 Days after Delivery fell below its target. After evaluating potential barriers, our Ohio affiliate implemented a series of solutions to boost the score, including:

- Implemented the gift card incentives for members who obtained timely prenatal and postpartum visits
- Initiated in-home postpartum visits to members in targeted communities
- Established the Diaper Visiting Program in which Molina Community Health Workers help new moms schedule and keep their postpartum visit and connect them to additional services such as transportation that may impede their ability to attend the visit. Molina Community Health Workers also offer to attend the visit with the member. Upon completion of the postpartum visit, the Molina Community Health Worker delivers a pack of diapers, educational information, and her incentive gift card.

Our Ohio affiliate improved its HEDIS score for Postpartum Visits by 5% in 2018. Based on the strong results from these initiatives, the health plan is expanding use of in-home postpartum visits to improve scores statewide. In Kentucky, Molina will adopt similar interventions, including the gift card incentives.

Improving Quality by Sharing Data with Providers

Supporting providers by sharing meaningful quality data and offering coaching on how to act on that data helps providers understand their progress in meeting quality targets. To that end, we deliver provider quality scorecards and also make them available online through our provider portal.

Orienting providers toward the Department's goals will be vital to achieving sustainable quality gains in Kentucky. ***Our provider focus group participants suggested that they would welcome greater engagement with Kentucky Medicaid MCOs, and Molina is fully prepared to deliver meaningful data to providers through quality scorecards.*** Further, we will provide on-the-ground support through our Provider Engagement Teams that include provider services representatives who will extend the reach of our QI team into the community by helping providers understand their quality performance and identify ways to improve it.

Provider Quality Scorecards

To make the data most meaningful, we deliver measurements that are comparable among providers, and include information on the following: quality metrics (including standard HEDIS metrics applicable to the provider), clinical outcomes and utilization metrics (such as admissions/1,000 and readmission data) and financial performance (total cost of care or cost per episode of care). Molina produces discrete scorecards for PCPs, high-volume specialists, and hospitals so that each stakeholder gets the information that will be most impactful for them.

Molina's profiling system also produces outlier reports for each category of providers. Outliers are identified by reviewing over- or under-utilization of healthcare services, poor performance on quality metrics, or high or low financial performance. These reports are reviewed by a multi-disciplinary team that includes staff from QI, Provider Network, and Utilization Management to determine provider-specific education and interventions. Interventions can range from educational visits, personal meetings, or more frequent data reporting. While our focus is on education and improved performance, providers may be removed from our network panel if they do not show improvement in performance over a reasonable time period.

As noted above, for larger and high-volume providers in each region, Molina will implement Joint Operating Committee meetings in which we discuss operation al and clinical topics (such as ED utilization or hospital readmission rates) to enhance provider coordination and collaboration.

Primary Care Providers. Molina produces quality scorecards for PCP groups as well as individual PCPs with a statistically significant Enrollee panel size during each month of the evaluation period to verify that the data is statistically significant. Table C.9-4 summarizes key elements of PCP scorecards. In addition to data on the PCP's panel size and the number of Enrollees with a visit in the past 12 months, the scorecard includes three separate sections on quality that enable providers to drill down to identify Enrollees who are missing quality-related services or additional detail on potentially preventable events.

To verify that they are meaningful and well-received, Molina engages **providers to participate in the design and review of our quality scorecards.**

Table C.9-4. Improving Quality through PCP Scorecards

Quality Metrics	Data Provided
HEDIS	• Measures that indicate adherence to preventive health guidelines as well as management of chronic diseases • Includes individual performance relative to the health plan and NCQA national percentiles
Clinical outcomes and utilization management metrics	Utilization statistics to identify trends in over- or under-utilization of services
Inpatient services	• Admissions per 1,000 Enrollees • Readmissions within 30 days • Average length of stay
Emergency department.	ED visits per 1,000 Enrollees to identify potential unmet physical or behavioral health needs, lack of after-hours access, appointment availability, and wait time standards
Pharmacy	Prescriptions per 1,000

Quality Metrics	Data Provided
Imaging	Imaging procedures per 1,000 Enrollees
Financial Performance.	• Total cost per Enrollee per month basis • Cost by categories such as inpatient, outpatient, professional, pharmacy, imaging, and ancillary costs

Exhibit C.9-10 illustrates our PCP quality scorecard.

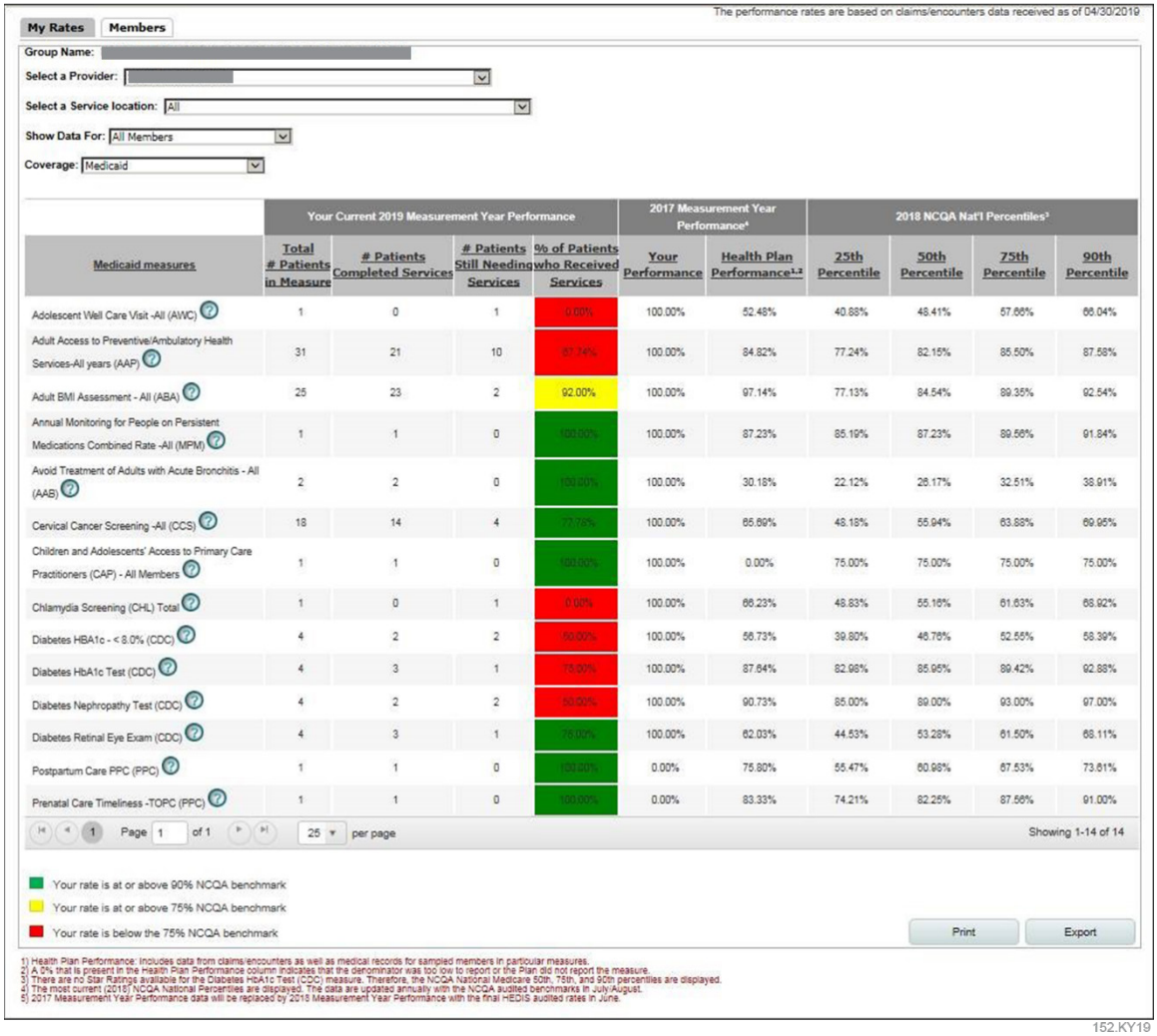

Exhibit C.9-10. Delivering Meaningful Quality Data to PCPs

Acute Care and High-volume Specialists. Molina will produce quality scorecards for high-volume specialists in obstetrics and gynecology, pulmonology, behavioral health, orthopedics, and allergy and immunology in the Commonwealth. For these specialties, quality scorecards review episodes of care (defined as the set of services provided to treat a clinical condition or procedure) and cost and quality outcomes. These specialties were selected based on the prevalence of relevant chronic diseases treated by these provider types and the importance of managing chronic diseases in improving health outcomes for Kentucky Medicaid. As our affiliates do in other states, we will produce scorecards for all provider groups who have seen a statistically significant number of Enrollees within these specialties.

Hospitals. Hospital quality profiles include summary demographic data around total Enrollees served, quality metrics, clinical outcomes, utilization management and financial performance. We share them at regular meetings in which we discuss outcomes and identify opportunities for improvement. Hospital quality scorecards include quality metrics that center on reducing potentially preventable events for the ED, admissions and readmissions, clinical outcomes and utilization management metrics (such as average length of stay and 30-day readmission rates), and cost per admission.

Quarterly Delivery of Quality Scorecards

Molina will produce scorecards quarterly. Providers may access their individual profiles through our online provider portal or they may receive them by email or hand-delivery by their Provider Services representative.

Coaching Providers to Drive Sustainable Quality Gains

Delivering data enables providers to see their own performance, including their performance relevant to local, regional, and national benchmarks. Molina will offer greater value to high-volume providers in each Kentucky Medicaid region through onsite visits by our Provider Engagement Team. Reviewing provider scorecards and sharing best practices from top-performing practices will enable Molina to increase provider quality scores. With experts from QI and Provider Services, the Provider Engagement Team will help providers identify ways to boost their quality scores by identifying providers' performance trends, providing Gaps in Care lists to inform provider office outreach to Enrollees, educating providers about service coding so that they provide accurate and complete data about services performed, and coordinating Enrollee outreach as appropriate. ***In Ohio, aggregate HEDIS scores for providers that worked with Provider Engagement Teams exceeded aggregate scores for those who did not for most priority measures, such as Controlling High Blood Pressure (14% higher score), Adult BMI Assessment (6% higher), and Cervical Cancer Screening (7% higher).***

When delivering the scorecard, Molina will review opportunities to improve provider scores. For example, to boost children's wellness scores, we recommend best practices such as completing missing wellness or preventive services during a sick visit or sports physical and improving women's cancer screening rates by capitalizing on provider incentives that are in place.

Molina welcomes the opportunity to share our quality improvement process expertise with providers.

For example, in our Ohio affiliate a high-volume, multi-site FQHC had received quality scorecards and guidance from the Provider Engagement Team about improving scores but continued to lag behind the quality benchmark for its HEDIS score for Follow-Up after Hospitalization for Mental Illness. The FQHC could not identify the reason for poor performance, so our Provider Services staff and a QI specialist went onsite to collaborate on process improvements. They:

- Shared the Model for Improvement methodology with the staff
- Followed the methodology with the provider staff to identify the most significant barrier
- Together developed a PDSA to rapidly test a key solution

Our QI expertise helped the FQHC understand evidence-based quality improvement protocols, and they continue to use those processes to identify barriers and test solutions to improve their HEDIS scores. **We will bring this hands-on approach to supporting providers to drive quality gains in Kentucky.**

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Providing Ongoing Updates

Molina also distributes monthly or ad hoc quality updates to providers. These focus on targeted topics such as updates on coding or HEDIS.

Our QI team updates providers about quality through our quarterly *Quality Bulletin*, which reminds providers about best practices and alerts them to new opportunities. For example, our Ohio affiliate's first quarter 2019 bulletin alerted providers about reimbursement for use of portable handheld retinal scanning

cameras, which enable PCPs to obtain retinal images for members with diabetes in the office without dilation and upload for evaluation using telehealth by a board-certified retina specialist. (The specialist will deliver a complete diagnostic report to the PCP.)

The *Quality Bulletin* also educates providers about the availability of home-based blood pressure monitoring tools, enabling PCPs to be alerted to any rising risk for their Enrollees. Alerting providers about emerging technology tools like these in the *Quality Bulletin* promotes an increase in timely care and services and avoids inappropriate use of the emergency department or a decline in health status.

b. NCQA ACCREDITATION

Molina has extensive experience with accreditation that we will apply in Kentucky. Ten Molina Medicaid plans have achieved NCQA Health Plan Accreditation, and our newest plans will undergo the process soon. For Kentucky, we will obtain NCQA Health Plan accreditation within two years of the MCO Contract Effective Date. ***Eleven Molina Medicaid plans have also achieved Multicultural Health Care Distinction from NCQA, demonstrating our commitment to providing culturally and linguistically appropriate services for our Enrollees.*** Four of our Medicaid plans have also obtained NCQA's new Long-Term Services and Supports (LTSS) Distinction. Exhibit C.9-11 illustrates the depth and breadth of Molina's accreditation status nationwide.

MHI's **11 health plans with Multicultural Health Care Distinction** represent one of the largest percentage of all Medicaid health plans in the country awarded this distinction.

Demonstrating our organizational commitment to meeting the highest quality standards, six of Molina Healthcare, Inc.'s Marketplace health plans have received NCQA accreditation, and the remaining two will be accredited by mid-2020. In addition to NCQA, our parent company's Nurse Advice Line has been URAC accredited since 2008.

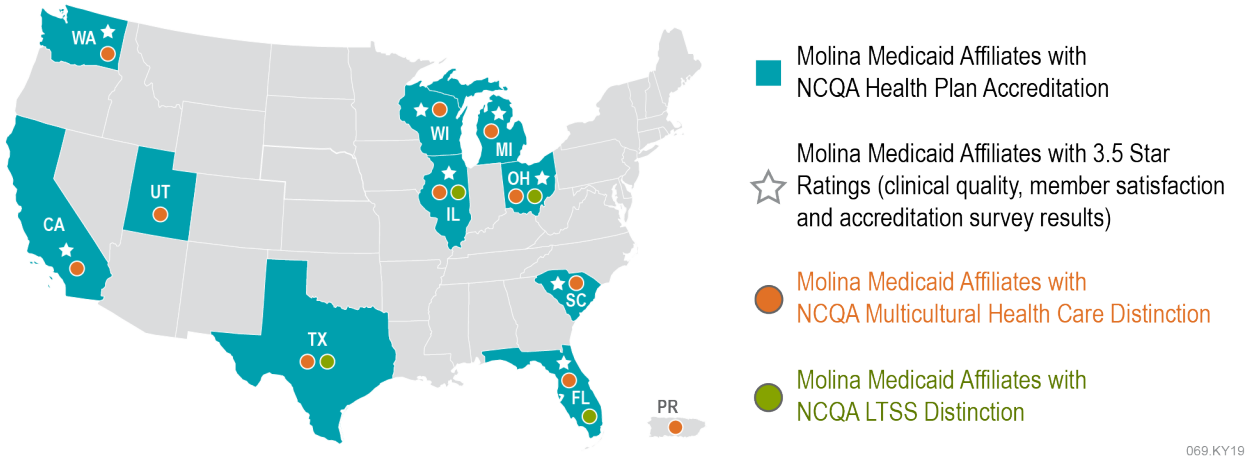


Exhibit C.9-11. Demonstrated Success Achieving NCQA Accreditation

Complementing Kentucky health plan accreditation, we will pursue attainment of Multicultural Health Care Distinction in Kentucky at the earliest opportunity.

PROPOSED TIMELINE

Our national Quality Program Management and Oversight team supports affiliate health plans across the country in obtaining accreditation and Multicultural Health Care Distinction. Their guidance and support will promote Molina's timely attainment of NCQA accreditation in Kentucky as required by the Department. Exhibit C.9-12 illustrates our proposed timeline.

Our parent company's national NCQA experts will support our Kentucky team and guide them through the process by sharing best practices and offering technical expertise and support. Following established accreditation protocols that have been refined across all Molina affiliates, the national team assists with preparation of accreditation documentation, data analysis, completion of required reports, bookmarking, and document submission. They also share best practices across our affiliate health plans. Their supports will foster a streamlined and expedited accreditation process informed by lessons learned over many years.

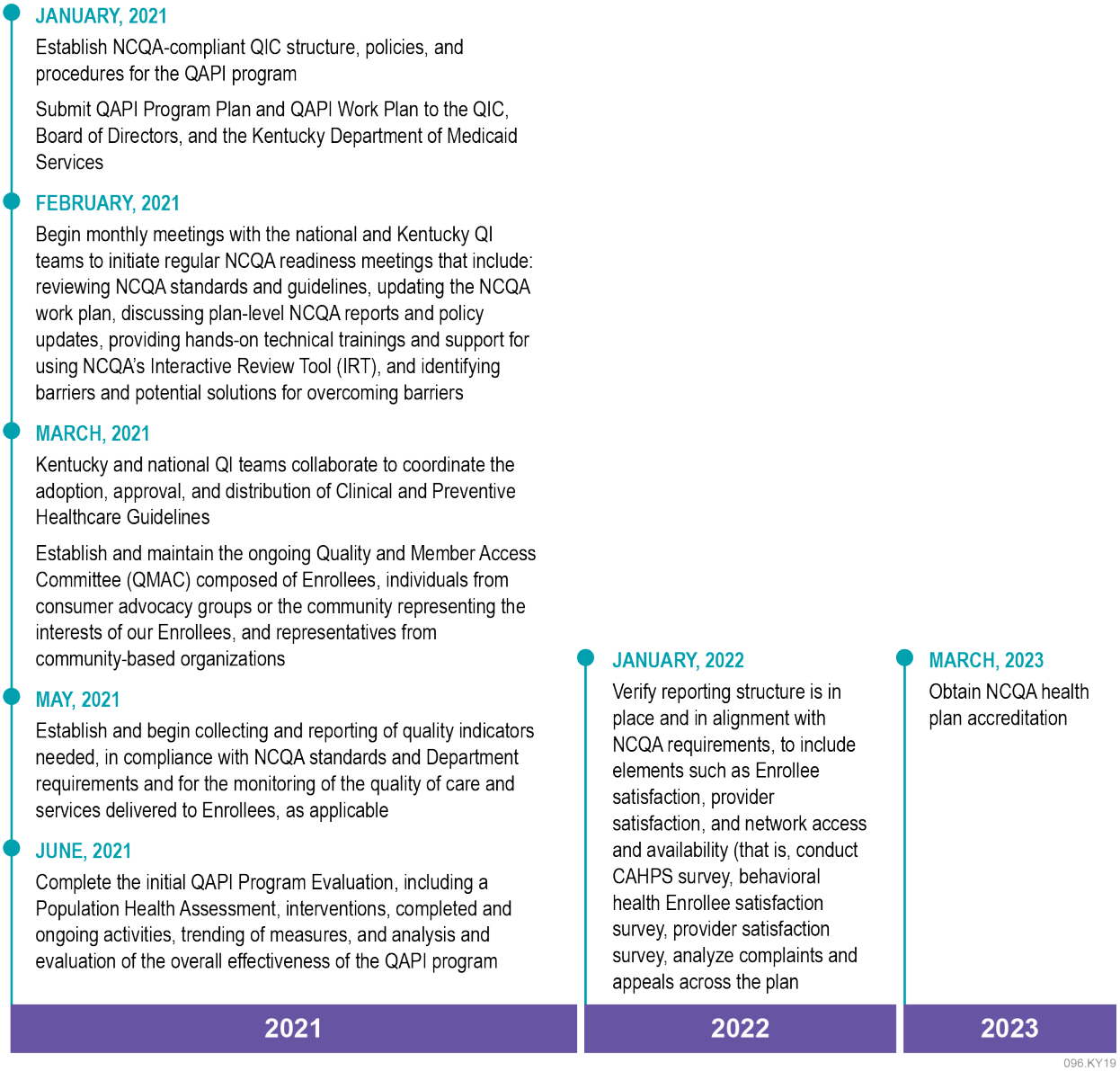


Exhibit C.9-12. Achieving Timely NCQA Accreditation

c. USE OF THE QUALITY IMPROVEMENT COMMITTEE

To achieve sustained quality improvements across Kentucky, Molina will rely on the active engagement of our Kentucky Quality Improvement Committee (QIC), which will bring together a collaborative and multidisciplinary team to plan and evaluate our quality improvement efforts. The QIC plays a prominent and dynamic role in offering recommendations and feedback to optimize our QI process.

We will encourage an **active and dynamic role for the QIC and its subcommittees.**

Our health plan's board of directors, led by our CEO, will have ultimate authority and responsibility for the quality of care and service we deliver. The board will delegate authority to the QIC.

Molina's Kentucky QIC will be responsible for oversight of our QAPI program and will meet all Department requirements. Chaired by our medical director, our QIC will reflect a diverse array of expertise, including our CEO and the leaders from the QI, Health Care Services, Behavioral Health, Network, Provider Services, Compliance, and Community Engagement teams. Network physical and behavioral health practitioners will also participate, promoting a community-based approach to our QAPI program.

Meeting quarterly, our Kentucky QIC will be responsible for designing, approving, implementing, monitoring and modifying the activities within our QAPI program. The QIC will recommend policy decisions, analyze and evaluate the progress and results of all QAPI activities, institute necessary action, and ensure follow-up. Subcommittees will continuously monitor data, identify areas for improvement, track interventions and performance, and report to the QIC. Through committee activity, participating providers may review and provide feedback on proposed clinical practice guidelines, performance measure results, clinical protocols, review performance improvement project results, QAPI study designs and interventions and plans to improve levels of care and service. We will also encourage providers to provide recommendations or suggestions about new QI initiatives based on their experience in their own practice or community.

Because the QIC reflects a diverse array of expertise and experience (both within and outside of the health plan), we will engage them to discuss quality measures that may not be hitting their target (such as preventive services, provider access, or Enrollee satisfaction) and encourage brainstorming to gather input from multiple perspectives. The QIC will also receive reports from all subcommittees, offering a collaborative forum to explore solutions that affect Enrollees and providers. For example, the QI and Community Engagement Teams will present any concerns raised in any of our regional QMACs so we can collaboratively strategize on solutions.

Offering further support, our national QIC meets monthly and evaluates quality performance across all Molina affiliates to identify best practices, share quality findings, and explore innovative options for improving quality and health outcomes for Molina affiliates.

To illustrate the important role of the QIC in influencing QAPI efforts, last year the QIC in our Ohio affiliate was brainstorming ideas for improving the health plan's HEDIS rate for Postpartum Visits. During the discussion, a network provider on the QIC expressed concern about the lack of available resources within his county for referral of members who screened positive for postpartum depression. The QIC then explored opportunities to educate providers about available resources in that county. After the meeting, the Molina team located resources. As a follow-up, the QIC reviewed the resources and initiated training of providers in that county through the Provider Engagement Team.

d. USE OF THE QUALITY AND MEMBER ACCESS COMMITTEE

Achieving sustainable quality gains requires a collaborative approach that respects and welcomes recommendations from our Enrollees and other stakeholders in the communities we serve. Molina has a long history establishing committees like the Quality and Member Access Committee (QMAC) that we will leverage to improve the Kentucky Medicaid managed care program. We welcome Enrollee contributions toward our quality and access standards, grievance and appeal process, Enrollee handbooks, Enrollee educational material, Molina and Department policies, and community outreach activities. We will also seek their input on our care management, Population Health Management, and Enrollee incentive programs.

To encourage a diversity of Enrollee and stakeholder perspectives, **Molina will establish regional QMACs across Kentucky.**

To address the diverse perspectives across Kentucky, Molina will establish regional QMACs. As the healthcare landscape, available resources, demographics, and social determinants of health vary dramatically among Kentucky regions, regional QMACs will enable us to capture stakeholder feedback and recommendations that reflect the nuances of each region. Our regional QMACs will align with our local Molina One-Stop Help Centers in Louisville, Covington, Lexington, Hazard, Bowling Green, and Owensboro.

Our Community Engagement team will lead the establishment and oversight of Molina's QMACs. Our local community engagement manager will develop the meeting agenda and chair the quarterly QMAC meetings. The QI specialist for that region will participate to hear first-hand about the issues that are of the greatest importance to Enrollees. Representatives from our health plan leadership team will attend each QMAC to foster a strong understanding of Enrollee needs and priorities at the highest level within our organization. Depending on the agenda topic, our medical director or leaders from our QI, Health Care Services, Network, or Health Education team will also attend. They will convene the QMAC quarterly and document recommendations and feedback that will be distributed to all health plan leaders.

d.i. PROPOSED STAKEHOLDER REPRESENTATION

Regional QMACs will foster stakeholder representation that mirrors the composition of our Enrollee groups as required by the Department. They will also encourage a diversity of Enrollee voices to guide our program.

Our goal is to have at least 15 Enrollees at each meeting. We will invite Enrollees and their families and caregivers to be part of the QMACs. In addition, at least one member of the following Molina internal departments will be expected to attend: Community Engagement, Quality Improvement, Enrollee Services, Healthcare Services, and Provider Services.

Using dashboards developed by our local quality analytics team, ***our QI team will monitor the composition of our QMACs to verify that they are consistent with the composition of our Enrollee population,*** including aid category, gender, geographic distribution, and racial and ethnic minority groups. We will also verify representation by Enrollees with Special Health Care Needs and related advocacy organizations.

On an ongoing basis, our Community Engagement team will identify Enrollees with whom they regularly interact and recruit them to join the QMAC. They will also collaborate with staff who interact with Enrollees (such as Molina Community Health Workers, peer support specialists, care managers, and Enrollee Services staff) to identify Enrollees who may be interested in participating on the QMAC.

Our Community Engagement team will also invite and welcome participation from key community-based organizations or advocacy groups with experience serving Medicaid Enrollees to promote a broad perspective for the QMAC. We will invite participation from organizations that reflect the diverse array of issues facing our Enrollees, such as:

- **Kentucky Youth Advocates**, which represents issues related to children across Kentucky
- **Kentucky Voices for Health**, a coalition working together to improve the health across the Commonwealth
- **Foundation for Healthy Kentucky**, which focuses on a range of issues, including improving access to care, reducing health risks and disparities, and promoting health equity
- **Center for Women and Families**, which provides trauma-informed advocacy and support for individuals and communities affected by partner violence and sexual assault.
- **Kentucky Foster and Adoptive Care Association**, which advocates and supports children in out-of-home care and the families that serve them
- **The ARC of Kentucky**, which provides advocacy, education, resources and training for people with intellectual and developmental disabilities.
- **Children's Alliance**, which advocates on behalf of at-risk children, including those in Foster Care

In addition to successfully engaging stakeholders and Enrollees in advisory committees, Molina affiliates have *acted* on their recommendations to improve quality for their Enrollees. In Ohio, Enrollee feedback resulted in updates to Enrollee marketing materials to strengthen messaging, including promoting the health plan's value-added services. At the advisory group's suggestion, the health plan also added a fitness benefit (promoting healthy behaviors and outcomes). They also recommended updates to our Molina Mobile app to include a link to Telehealth.

In Illinois, based on feedback from the committee our affiliate modified their Enrollee incentive program to include more attractive gift cards and recruited providers that were popular in their community.

The Community Engagement team will also collaborate with community-based organizations to host our QMAC meetings in convenient and easily accessible locations. This approach enables these organizations to build awareness among Enrollees about available programs and services which often assist Enrollees with social determinants of health.

d.ii. INNOVATIVE ENROLLEE PARTICIPATION STRATEGIES

Building on successful and innovative strategies deployed by our affiliates, we will encourage Enrollee participation in our regional QMACs with gift card incentives and provide meals and beverages for those in attendance. We will also accommodate Enrollees who need child or adult care or transportation assistance to attend QMAC meetings. We will use IVR to send meeting reminder announcements to Enrollees in the area, and we will partner with CBOs to promote meetings.

Molina will also take a flexible approach to maximize Enrollee participation. As participation barriers may vary among regions or Enrollee cohorts (such as Enrollees with Special Health Care Needs), we will examine creative ways to overcome obstacles for Enrollees who are interested in joining our QMACs.

Listening to what is most interesting and impactful for QMAC participants is the most effective way to encourage participation. We will survey participants about the topics that are of the most interest to them. We will then establish an agenda and schedule speakers that will be most meaningful for participants, encouraging active involvement. For example, members in a comparable committee in our California affiliate expressed interest in learning more about the health plan's efforts to address heart disease and resources within the community. After one of the presentations, a member took the step of signing up for the health plan's health education classes. Since then, he has lost a significant amount of weight as a result and no longer requires an oxygen tank. We will also share state and county updates with our Kentucky Enrollees, information which is

meaningful to them personally. This includes updates on available programs and community resources for which Enrollees or their families may be eligible.

In another example, our Ohio affiliate Member Advisory Committee members have had questions regarding the care management process. Members of Molina's care management team regularly attend meetings to discuss various staff roles such as housing specialists, behavioral health peer specialists, Molina Community Health Workers, and care managers. Additional topics include qualifications for care management, how to request support and how to get the most out of the care management process.

We will also continuously seek opportunities to make Enrollees feel welcome to encourage the most active participation. For instance, our California affiliate learned that members sometimes felt uncomfortable joining the group. They placed a greeter at the door to welcome every participant and facilitate introductions to others, fostering a warm and open environment in which members felt comfortable expressing their views and opinions. We will apply the same tactics in our Kentucky regional QMACs.

Our Community Engagement team members will attend QMAC meetings and facilitate participation for Enrollees who may require assistance during the meeting, such as Enrollees with disabilities.

d.iii. EXAMPLES OF SUCCESSFUL STRATEGIES

Our Community Engagement team will work closely with community organizations and our internal team to identify innovative ways to encourage Enrollee participation in the QMAC. In Ohio, our affiliate intensified its member recruitment efforts by reaching out to care managers and Molina Community Health Workers to recruit members in care management and members who recently met with Molina staff in person. They also added appealing meals and beverages to their meetings and coordinated or reimbursed for transportation. ***Because of these recruitment strategies, participation in our Ohio affiliate's Member Advisory Committee in 2019 is 64% higher than in 2018.*** We will adopt our affiliates' successful strategies to gain the greatest value from our Kentucky QMACs.

e. DESCRIPTION OF QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

Molina will improve health outcomes and foster efficiency in Kentucky by implementing a comprehensive and data-driven QAPI program, with a focus on areas of important to the Commonwealth. We will structure our QAPI program to align with NCQA standards and apply the Model for Improvement as the framework. We will work closely with the Department to verify that our QAPI program remains consistent with its priorities. In addition to verifying that our QAPI program will meet all Department requirements, our QI team will seek to integrate our efforts with those of related State and local agencies. Our Kentucky team will also receive support from our national QI compliance and HEDIS operations teams, who will provide regional oversight and direction, as described in detail in Proposal Section C.9.a.i.

To capitalize on existing programs and supports, our QI team will rely on local partnerships with organizations and agencies already established in the Commonwealth, for example Boys and Girls Clubs and the Louisville Urban League. This promotes efficient use of existing resources and strengthens the overall system of care. These partnerships will fortify our ability to engage Enrollees as community organizations often have established relationships with individuals with the greatest needs, enabling us to build on an already trusted resource.

To address health disparities, we will build on the work of the University of Kentucky Center for Health Equity Transformation (CHET) and leverage the findings of the *Louisville Metro 2017 Health Equity Report*, published by the Louisville Center for Health Equity.

For example, as detailed in Proposal Section C.9.h, we will work closely with the Department for Public Health to advance its priorities, such as implementing school

education initiatives that emphasize education about nutrition, physical activity, and tobacco and drug use prevention to align with the prevention goals and strategies in the *Kentucky State Health Improvement Plan 2017-2022*.

The QAPI program will complement the Triple Aim goals of the Institute for Healthcare Improvement to improve the health of our Kentucky Medicaid Enrollees, enhance their experience of care, and reduce the cost of healthcare. Most importantly, it will orient the entire health plan to support Enrollees to achieve person-centered goals.

Further strengthening integration, our regionally designated QI specialists will join forces with their community-based Provider Services and Community Engagement representatives to ensure that our QAPI initiatives are infused with an understanding of local and regional resources and needs.

Within this response, we describe:

- Molina's QAPI program for Kentucky which will be reflected in the Kentucky QAPI Program Plan
- Alignment with QAPI program requirements outlined in Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 19.3. Quality Assurance and Performance Improvement (QAPI) Program

Molina's QAPI program will incorporate, monitor and measure performance for:

- Quality measures, including HEDIS, CAHPS and Kentucky-specific measures
- Provider contracting and monitoring (such as credentialing, access and availability, and quality performance) for medical, behavioral health, and other specialties
- Enrollee and provider experience
- Continuity and coordination of care
- Culturally and Linguistically Appropriate Service standards
- Population Health Management
- Utilization Management
- Patient Safety

QAPI PROGRAM PLAN

Outlining the scale and scope of our QAPI program, the QAPI Program Plan will reflect all Department-required elements. Table C.9-5 highlights the key elements of our QAPI Program Plan, combining our QAPI Program Description and QAPI Work Plan.

Table C.9-5. A Comprehensive and Holistic QAPI Program Plan

QAPI Elements	Description
Program Philosophy	• Outlines the key values, assumptions, and operating principles for our QAPI, such as – Adherence to NCQA standards and Department requirements – Applicability across all health plan functions and operations – Commitment to a team-based approach to improvements – Importance of data collection and analysis to solve problems and improve processes, – Role of each health plan employee in the process
QAPI Program Goals	• Defines key goals for the QAPI program that focus on structure, process, and outcomes. These Program goals are consistent with the Donabedian Model, one of the most well-known concepts in quality improvement (Avedis Donabedian, "The quality of care: How can it be assessed, JAMA, 260 (12): 1988). • Examples include, but are not limited to: – Defines and demonstrates Molina's commitment to quality through activities that achieve improvements in quality of care and health outcomes, address health disparities, Enrollee safety and quality of service – Improves the quality, safety, appropriateness, availability, accessibility, coordination and continuity of healthcare and services delivered to Enrollees

QAPI Elements	Description
	– Plans and maintains programs that aim to improve the health and health outcomes of Enrollees – Reviews, analyzes, and understands Enrollee demographic and epidemiological data to identify and address needs – Helps make sure that healthcare and services and interventions address the varied cultural, racial and ethnic, linguistic and additional unique needs of Enrollees
QAPI Program Objectives	• Identifies QAPI program objectives focused on the use of staff, completion of activities, and needed resources to reach QAPI program goals
Scope of QAPI Program Activities	• Sets forth the vast scope of our QAPI program, including all aspects of Enrollees care and services (medical and behavioral health and social supports) to monitor that Enrollees get timely, appropriate, effective, efficient, and safe care in the right setting at the right place • Encompasses multiple and wide-ranging topics within the scope of quality improvement and focus on activities that consider Enrollees' entire healthcare experience. • With our fully integrated model of care, directly incorporates behavioral health measures, including those reflecting integration and coordination of physical and behavioral health to improve health outcomes. • Outlines all of the data sources used to inform QAPI activities, summarized in Proposal Section C.9.a.iv
Quality Improvement Strategy	• Details strategies and innovative programs deployed to improve Enrollees' health status and support achievement of the Department's goals that are outlined in the annual QAPI Work Plan including but not limited to: – Description of the relevance of the quality improvement strategy to Enrollees, performance measures, and benchmarks/goals and thresholds – Specific activities in place to reduce healthcare disparities, improve health outcomes, improve Enrollee safety and reduce medical errors, and prevent hospital readmissions – Program goals, timeline and information about barriers and mitigation planning • Outlines key QAPI activities, such as identifying and prioritizing QAPI activities and use of the Model for Improvement • Highlights routine assessment of the needs of our Enrollees by age, race and ethnicity, language, disease categories, and risk status to link our efforts to Enrollee needs and implement programs to reduce health disparities
Organizational Structure Supporting Quality Improvement: Accountability	• Detailed in Proposal Section C.9.a.i • Includes detailed staffing and resources designated for the QAPI program and emphasizes local accountability and decision-making to underscore our commitment to QAPI program that reflects Kentucky's healthcare environment
Culturally and Linguistically Appropriate Services (CLAS) Program	• Outlines the tools and training to verify that Enrollees receive quality care that is culturally and linguistically sensitive and that our programs are culturally appropriate for our Enrollees • Describes our Cultural Competency Plan to promote delivery of culturally competent services and the provision of language access and disability-related access to all enrollees, including Enrollees with limited English Proficiency (LEP), based on guidelines outlined in the National Standards for Culturally and Linguistically Appropriate Services in Health Care (published by the U.S. Department of Health and Human Services, Office of Minority Health), and highlights the details activities that are included in the annual QAPI Work Plan • Outlines our methodology to collect, analyze, and act on relevant data, including race, ethnicity, and language preferences of our Kentucky Enrollees and use of translation services to promote optimal communication with Enrollees

QAPI Elements	Description
Clinical and Preventive Evidence-Based Guidelines	• Describes our adoption and dissemination of evidence- practice guidelines for provision of preventive, acute or chronic management and behavioral healthcare services • Detailed in Proposal Section C.9.i.ii
Delegation Activities	• Includes protocols to monitor the quality performance of our subcontractors, March Vision Care, Avesis, Lucina Analytics, Molina Healthcare, Inc., and CVS Health. • Detailed in Proposal Section C.9.a.i
Quality Improvement Program Evaluation	• Summarizes our approach to a formal annual QAPI program evaluation, augmenting our ongoing monitoring of quality performance measures • Detailed in Proposal Section C.9.i
Governing Body Review and Approval	• Describes the role of our Board of Directors in reviewing and approving all QAPI program activities • Detailed in Proposal Section C.9.a.1

ALIGNMENT WITH QAPI PROGRAM REQUIREMENTS

Below, we describe how our QAPI program meets all Draft Contract requirements, as outlined in Draft Contract Section 19.3, including the following:

- Approach to meeting all requirements set forth in the Department's Quality Strategy
- Use of a QIC to provide oversight of QAPI functions
- Methods for seeking input from stakeholders
- Methods for addressing the Department's mandated performance measures
- Integration of behavioral health indicators into the QAPI program
- Methods to monitor improvements in physical health outcomes resulting from integration of behavioral health
- Use of a health information system
- Methods to evaluate QAPI program activities

Approach to meeting all requirements set forth in the Department's Quality Strategy (Contract Requirement 19.3.A)

Molina will develop and implement our QAPI program to support the Department's objectives and requirements. We will maintain close relationships with Department staff to identify new or emerging trends or priorities so that we can adjust our QAPI appropriately.

Conducting and assessing Performance Improvement Projects (PIPs). As detailed in our Proposal Section C.9.g, Molina will collaborate with the Department, its EQRO, and other MCOs as appropriate to develop and implement PIPs (both clinical and non-clinical) that drive increases in quality performance metrics in selected focus areas. Our parent company brings 20 years of experience to Kentucky delivering successful PIPs for Medicaid populations in 14 states.

Collecting and submitting performance data to the Department. Supporting our data-driven QAPI program, we will work with the Department to identify, track, and deliver data across a spectrum of quality measures, including measures specifically developed or implemented for Kentucky. We will deliver such data to the Department at the frequency required, for example annually for HEDIS. In addition, we will collaborate with the Department throughout the year on QAPI activities and share data as necessary to launch a data-informed discussion about potential initiatives for consideration by the Department.

Fostering transparency and accountability, through an online dashboard (detailed in Proposal Section C.6, Management Information System), Department staff will be able to view key performance metrics related

to enrollment, network adequacy, utilization, encounters, grievances and appeals, and call center activities. For example, staff will be able to view claims payment trends as well as our call handling metrics (such as calls answered within 30 seconds).

Detecting under-utilization and over-utilization. Molina's QI staff, with the support of cross-functional work teams that include representation from the medical director, health care services, and provider services when appropriate, will evaluate potential over-and under-utilization in collaboration with our network providers. Analytical activities include the following:

- Tracking potential quality of care issues, including adverse events, critical incidents, and sentinel events
- Reviewing Enrollee grievances and appeals
- Evaluating utilization management and care management reports
- Reviewing medical, pharmacy, and utilization data
- Monitoring of performance measures and other quality metrics relative to targets, including preventive health measures and adherence to clinical practice guidelines (for example, flagging measures that fall below the 10th percentile as a potential indicator of under-utilization)
- Overseeing Enrollee satisfaction and utilization by delegated groups

To address potential under-utilization, our South Carolina affiliate established a specialized program to reach and engage newly enrolled pregnant women. The health plan paired each new pregnant member under the age of 20, a cohort with historically low Timely Prenatal Care HEDIS rates, with a Molina Community Health Worker. Molina Community Health Workers cultivated warm and trusting relationships with members through in-person visits, helped them connect with an OB/GYN and attend prenatal visits, identified any potential social determinants that might impede success (transportation, housing, nutrition), educated them about self-care and the importance of attending office visits, and helped select a pediatrician for the new baby. Molina Community Health Workers visited members every month during pregnancy and visited in the hospital when they delivered. They also visited members at home monthly for three months to verify each mom's recovery and a healthy start for the baby, verifying a postpartum visit and baby's well child visits.

Elevated readmission rates can also be a sign of over-utilization. Our Ohio affiliate sought to reduce readmission rates through implementation of a Transition of Care program (based on the evidence-based Coleman model) that includes on-site transition support for their members admitted to Ohio State University hospital. In 2018, the 30-day readmission rate at the hospital dropped by more than 30%, and 90-day readmission rate fell by 14%. ***We will implement this successful initiative in Kentucky with key providers.***

In addition, our Gaps in Care adherence program targets 11 conditions where pharmacy data suggests that Enrollees may be under-utilizing care based on national guidelines. If we identify a gap in therapy or non-adherence, we alert the provider about the issue and recommend an appropriate next step. We identify Enrollees with medication gaps using the following criteria: an Enrollee who initially fills a prescription for a targeted drug but does not obtain a refill *or* an Enrollee with a history of refills for a targeted drug or condition who has stopped obtaining refills beyond five refills. The program focuses on key conditions and targeted medications for each condition, including:

- Respiratory Disorders
- Heart Failure
- Diabetes
- Ischemic Heart Disease
- Osteoporosis
- Rheumatoid Arthritis

Through QAPI monitoring, Molina will identify any emerging under- or over-utilization trends that may suggest the need for similar programs in Kentucky.

Assessing quality and appropriateness of care for Enrollees with Special Health Care Needs. Molina's QI team will monitor performance metrics that indicate the quality of care and services for Enrollees with Special Health Care Needs. Using evidence-based tools to identify Enrollees for participation in care management or other supportive programs and tracking healthcare and other outcomes (such as EPSDT compliance rates and satisfaction with care management programs), we will prioritize monitoring of our impact on the health outcomes of Enrollees with the highest level of needs. We consider the social determinants of health to determine Enrollees' risk level (through Health Risk Assessments and our predictive modeling solution) and also track delivery and coordination of social supports that drive improved outcomes, such as changes in status for food or housing insecurity. As we analyze our QAPI data, our Kentucky QI team will identify opportunities for new partnerships or programs to improve outcomes for Enrollees with Special Health Care Needs.

82%

of our affiliate Medicaid health plans increased HEDIS score for Comprehensive Diabetes Care – Retinal Eye Exam between HEDIS 2017 and 2018

For example, we have established relationships with God's Way and Feed America, Kentucky's Heartland to support availability of dietary-appropriate meal boxes (for Enrollees with diabetes, for example). These partnerships are described in more detail in Proposal Section C.9.g.

In Utah, our affiliate deployed **in-home assessments and services for Medicaid members with diabetes** to enhance Comprehensive Diabetes Care measures and value-based payment and education for providers, **driving their HEDIS 2018 score for A1c Testing beyond the 75th percentile.**

To illustrate our ability and commitment to identifying tailored solutions for Enrollees with Special Health Care Needs, we look to our South Carolina affiliate. The health plan established a specialized Population Health Management program to address the highly specialized needs of their members with sickle cell disease. A dedicated care manager supports members with elevated risk levels, and the health plan established partnerships with key providers (such as hematology and oncology) and facilities. The Care Management and Utilization Management teams work closely to facilitate care and services, including coordination of home-based pain management and infusion and integration with community support groups. The initiative has driven reductions in ED visits and improved adherence to prescribed medications for participating members and demonstrated a cost savings to the state.

Use of a QIC to Provide Oversight of QAPI Functions (Contract Requirement 19.3.B)

Our health plan's board of directors, led by our CEO, will have ultimate authority and responsibility for the quality of care and service we deliver. The board will delegate authority to the QIC, and Molina will encourage an active role for our Kentucky QIC. Our approach to using the QIC to improve quality is detailed in Proposal Section C.9.c.

Methods for Seeking Input from Stakeholders (Contract Requirement 19.3.C)

Through representation on QI committees, formal meetings, or informal discussions, Molina recognizes that we will achieve significant and sustainable quality gains by engaging with stakeholders across the Kentucky healthcare system to collaboratively identify barriers and solutions and to define measurable success. For example, we will establish regional QMACs and include representatives from community organizations to foster the gathering of perspectives that broadly reflect each service region. (Our approach to regional QMACs to gather feedback from Enrollees and community organizations is detailed in Proposal Section C.9.c.) In addition to representation on the QIC, we will invite provider participation in QAPI activities through the Healthcare Services and Professional Review subcommittees, as applicable.

Molina will actively encourage QAPI participation by practitioners, providers, Enrollees, federal and State agencies to carry out our QAPI program. This includes, but is not limited, to:

- Inclusion of contracted medical and behavioral health practitioners and providers in the planning and execution of clinical programs and activities (such as PIPs and QI activities)
- Review, approval, and dissemination of preventive health and clinical practice guidelines and measurement of adherence with current recommendations

In our South Carolina affiliate, implementation of **in-home postpartum visits** drove their **preliminary HEDIS 2019 score beyond the 75th percentile, a gain of almost five percentage points.**

- Development and adoption of Medical Coverage Guidance documents that address medical, surgical, diagnostic, new technology, or other services
- Identification of legislative and benefit changes that enhance health promotion
- Collaboration with the Department and its EQRO in the development of studies and other care management programs, interventions and the methodology to evaluate activities
- Performance of targeted and specific training about Medicaid to carry out activities
- Review of practitioner and Enrollee satisfaction surveys and proposed activities for improvement, on an ongoing basis and at least once a year.

Molina manages the provider network through management of healthcare practitioner and provider credentialing and recredentialing processes.

With Molina One-Stop Help Centers located in Louisville, Lexington, Covington, Hazard, Bowling Green, and Owensboro, we will welcome Enrollees, providers, and other stakeholders to visit our offices and interact personally with our team, offering an excellent opportunity to continually gather feedback. A visible presence throughout the Commonwealth by our Provider Services and Community Engagement teams will support the development of strong relationships through which we will gather ongoing feedback about QAPI activities.

Examples of Stakeholder Engagement in QAPI Activities

We will build on the success of our affiliates serving Medicaid populations to actively work with stakeholders, including State agencies, community initiatives, providers, and other MCOs and incorporate similar initiatives into our Kentucky QAPI to drive system-wide quality gains. A few examples that will guide our QAPI efforts in Kentucky are below.

Actively participating in community transformation initiatives. In South Carolina, our affiliate recently joined the Healthy Tri-County initiative, powered by Trident United Way, in partnership with key health system partners, with the goal to improve the health and well-being of every person and community within the Tri-County region. The initiative's health improvement plan incorporates recommendations and action steps to address five prioritized health topics: access to care; behavioral health; immunizations; cancer screenings; diabetes; obesity, nutrition, and physical activity; and maternal, infant, and child health. Through active participation on Healthy Tri-County, our affiliate will integrate their QAPI activities to capitalize on and amplify those of the Healthy Tri-County Initiative, promoting improved results for the health plan as well as the region.

Working with other MCOs to improve Kentucky Medicaid Program efficiency while improving outcomes. We will seek opportunities to collaborate, guided by successes at our affiliates like Puerto Rico. The Puerto Rico QI team identified an uptick in Potential Quality of Care issues (cases that may indicate a safety risk) with new members transitioning from other MCOs, a particularly vulnerable period for member's continuity of care. They engaged the other MCOs to establish standardized data and

information sharing protocols and processes during transitions, including service authorizations, special coverage registries, and care management activities and care plans. In addition, they established informal relationships with peers at other MCOs to expedite resolution of any future transition issues. ***The health plan experienced a drop of 22% in monthly Potential Quality of Care issues after initiation of the activity.***

Boosting provider satisfaction by streamlining credentialing and provider data management. Providers in the Illinois Medicaid program had long expressed frustration with varying credentialing protocols among the nine MCOs. In 2018, our affiliate took a leadership role within the Illinois Association of Medicaid Health Plans to create a Universal Roster, which standardized data gathering across health plans. Engaging providers to share their feedback about what worked and did not work, the affiliate worked closely with the other MCOs to create a single form that gathered the information each MCO needed as well as information required to comply with State and federal regulations. Upon approval by all the MCOs and collaborative provider training and education, the roster was introduced in June 2018***. In the first six months after the introduction of the Universal Roster, the time required to establish providers in the system was cut in half*** (from 60 days to 30). Providers have also reported high levels of satisfaction and a reduction in billing errors.

Engaging Community Stakeholders

Molina will build on the extensive resources that exist across the Commonwealth today to integrate our QAPI activities and interventions with solutions that complement the health plan's capabilities. For example, Molina is providing a grant to the Boys and Girls Club of Bowling Green to support health education by teaching their club kids "Healthy Habits". This program teaches children health nutrition by allowing them to sample food items, particularly fruits and vegetables, and also provides healthy snacks and exercise programs. By capitalizing on and investing in well-established and trusted community partners, Molina strengthens the overall infrastructure within Kentucky to address the social determinants of health. We will also welcome participation of key stakeholders and community agencies in committees, such as QMAC, to incorporate a diverse range of voices in our QAPI activity planning.

Methods for Addressing Department-Mandated Quality Measures (Contract Requirement 19.3.D)

Molina's QAPI Work Plan will incorporate the full array of quality performance measures, including those mandated by the Department. Our QI specialists, supported by our local quality data analytics staff, will monitor all measures and identify trends, solutions and interventions, and successes. The process for monitoring Department-mandated quality measures mirrors those for other QAPI measures, fostering consistency and ongoing monitoring using the tools and technology that we describe throughout this response.

Integration of Behavioral Health Indicators (Contract Requirement 19.3.E)

Molina directly manages behavioral healthcare and does not use a subcontractor or affiliated company. Our model of care fully integrates physical health, behavioral health, and social determinants of health in conjunction with a recovery-oriented system of care to coordinate high-quality benefits and services to drive positive health outcomes for Enrollees in Kentucky.

In addition to strengthening our ability to coordinate integrated care for Enrollees, this model enhances our ability to scrutinize our results since all data is housed on internal systems. All behavioral health quality data, including claims, authorizations, and providers is available in our health information system and integrated into our quality data analytics tools. Integration also makes us more agile in making operational or organizational changes necessary to improve outcomes.

As outlined in our Kentucky Medicaid QAPI Work Plan, we will monitor several behavioral health quality indicators and deploy our standardized processes to monitor, evaluate, and improve the quality and appropriateness of behavioral health services provided to our Enrollees. This includes monitoring of timely access to behavioral health providers, appropriate levels of care, effective coordination of care

between behavioral health providers and the PCPs, timely follow-up services and continuity of care, adequacy of the range of available across the continuum of care from widely used outpatient therapy to inpatient or comprehensive community-based care, and appropriate linkage to community supports.

We will monitor all behavioral health-related HEDIS measures, including, but not limited to:

- Antidepressant Medication Management (AMM)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- Follow-Up After Hospitalization for Mental Illness (FUH)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
- Diabetes and Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder (SSD, SMD, SMC)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

Complementing HEDIS, we will gather data about the Enrollee experience through focused behavioral health surveys for Enrollees who have received behavioral health services. Behavioral health indicators also include performance metrics that indicate behavioral health provider access and availability and adherence to behavioral health utilization management guidelines.

Supporting monitoring and analysis of behavioral health-related data and complementing our HEDIS Dashboard and Kentucky-specific dashboards described previously, three dashboards described earlier, to deliver behavioral health-related data to QI staff and inform QAPI activities. They are:

- **Executive Behavioral Health Dashboard.** Aggregate data of inpatient, outpatient, and professional service utilization
- **Behavioral Health Integrated Dashboard.** Medical costs for Enrollees with co-morbid behavioral health diagnoses
- **SUD Dashboard (Exhibit C.9-13).** Internal SUD utilization, non-fatal overdoses, and external parameters. Parameters will include the Bree collaborative—quality improvement metrics that focus on guideline-concordant prescribing (chronic opioid use, opioid dose, concurrent chronic sedative use and transition from short-term to long-term opioid use), mortality, overdose morbidity, and prevalence of opioid use disorder. They will also include the STOP Measure that assesses adherence with the Centers for Disease Control and Prevention Guidelines for Prescribing Opioids for Chronic Pain for PCPs.

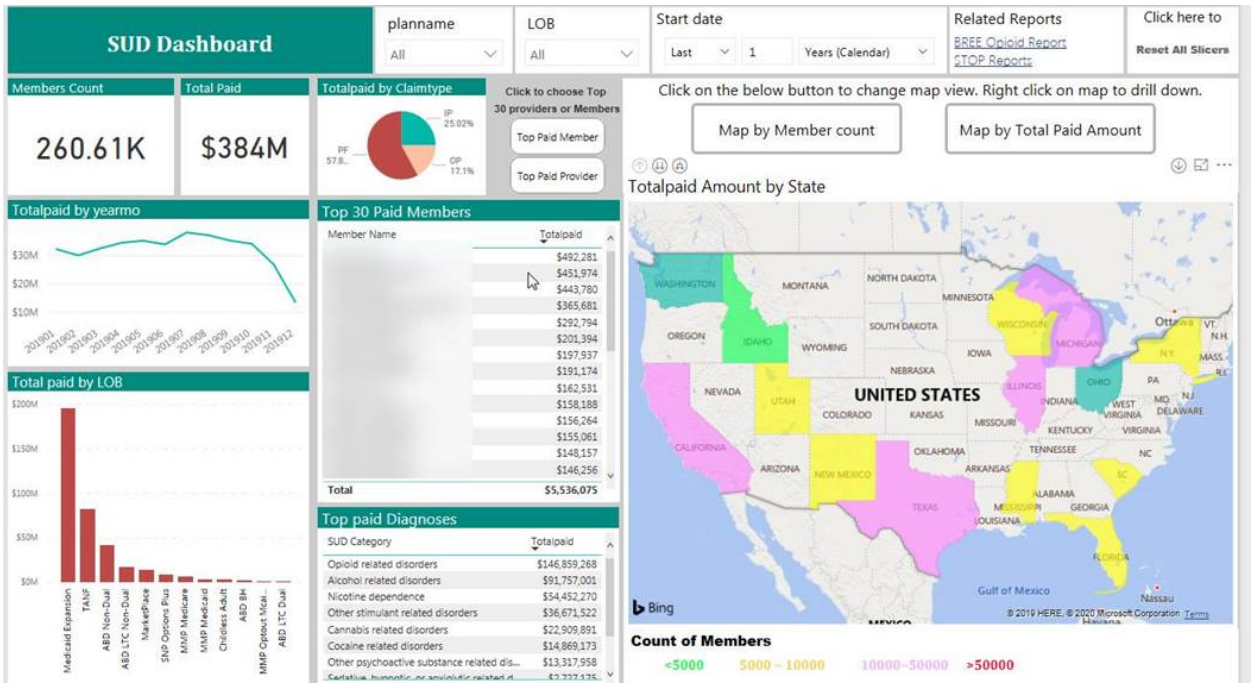


Exhibit C.9-13. Our SUD Dashboard Guides QAPI Activities

Armed with data from these dashboards, QI specialists can convene work groups with our behavioral healthcare management team, community-based Provider Services and Community Engagement representatives, and other health plan staff as appropriate to laser in on barriers to achievement of quality targets and brainstorm solutions and interventions, following our rapid cycle protocols.

For example, our Ohio affiliate initiated a QAPI initiative to boost scores for Follow-Up After Hospitalization for Mental Illness (FUH). They introduced a provider incentive for members who attended a 7-day visit and also collaborated with the Community Shelter to locate and engage Enrollees experiencing homelessness, both of which were identified as important barriers. ***As a result, the health plan exceeded NCQA's 75th percentile for both 7-day and 30-day FUH, exceeding both the Ohio and Kentucky state average for Medicaid.***

Methods to Monitor Improvements to Physical Health Care Outcomes through Behavioral Health Integration (Contract Requirement 19.3.F)

With a fully integrated care model, Molina will be well-positioned to monitor physical health quality outcomes resulting from behavioral health integration. The process to capture and monitor this data is consistent with all other quality data, offering us great flexibility in data evaluation and reporting.

Quality metrics include those HEDIS measures that focus on integration as follows:

- Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)
- Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

One example of our innovative programs to improve HEDIS scores for Enrollees with co-morbid physical and behavioral health diagnoses is our use of Care Connections nurse practitioners. Working with community-organizations and large providers, Care Connections team members conduct community-based diabetes screenings for Enrollees with schizophrenia, a common co-morbidity. Screenings include blood pressure and weight as well as point-of-care HbA1c testing.

Use of a Health Information System (Contract Requirement 19.3.G)

Molina's response to Proposal Section C.9.a.iv includes a comprehensive description of the health information system that will support Kentucky QAPI activities. Leveraging a vast array of data sources, including data related to Enrollees' social determinants of health, our QI team will apply powerful analytics tools to drive improvements in health outcomes and Kentucky Medicaid Program performance.

Method to Evaluate QAPI Program Activities (Contract Requirement 19.3.H)

In accordance with the Model for Improvement, Molina's QI team will continually evaluate our data and findings to assess the effectiveness of QAPI activities. On a strategic level, we will conduct an annual QAPI program evaluation to summarize our performance relative to the QAPI Work Plan, establishing the foundation for the following year's priorities.

Throughout the year, we will continually monitor each QAPI Work Plan measure, including PIPs, soliciting feedback from providers and Enrollees through the QIC, QMAC, and other less formal channels. As indicated by the data, our rapid cycle processes will support ongoing refinement of each initiative.

All of these program evaluation strategies are detailed in Proposal Section C.9.i.

f. IMPROVEMENTS IN QUALITY MEASURES FOR KENTUCKY MEDICAID POPULATION

Molina's QI team will lead our efforts to improve Department-designated priority quality measures with the support of cross-functional work teams and the QIC. Our strategies will be informed by feedback from Enrollees through the regional QMACs and providers through the QIC and other QAPI subcommittees, and activities such as surveys. Our entire health plan will focus on making sustainable gains in quality measures, promoting a healthier Kentucky in which Enrollees are empowered to take charge of their health and to participate in community engagement activities.

Our Kentucky health plan will receive support from Molina's regional HEDIS and quality measurement experts who will offer guidance and recommend best practices to ensure accurate and complete data capture for HEDIS measurement and reporting. The Department will benefit from our regional affiliates' experience capturing and reporting HEDIS. In addition, our local team will continually seek new ideas and successful initiatives that prove successful in other states where Molina affiliates serve Medicaid populations.

Below we summarize our approach to making improvements in Kentucky's Medicaid population for the following measures:

- Medication Adherence for Diabetes Medications
- Tobacco Use and Help with Quitting Among Adolescents
- Colorectal Cancer Screening

For each of these measures, we will adapt our strategies to reflect local communities' needs and resources. This includes identification of local partnerships to make the best use of existing resources and programs. For each measure, we will apply our QAPI best practices, leveraging the data analytics, tools, and strategies that we have detailed throughout this section to drive improvement.

f.i. MEDICATION ADHERENCE FOR DIABETES MEDICATION

Molina recognizes the high cost of diabetes, in both dollars and quality of life, in Kentucky. The Commonwealth has a statewide average prevalence of diagnosed diabetes of 12.9% with an adult rate as high as 17.0% in Appalachian counties compared to 11.2% in non-Appalachian counties. Promoting management and prevention of diabetes and improving health outcomes by increasing adherence to diabetes medications will have a significant effect in quality of life and cost.

Our approach encompasses an array of strategies, including specialized care management and medication therapy management programs, value-based payment programs to align provider goals, and collaboration with local organizations, such as the Department for Public Health (DPH), to amplify their efforts within each community. Table C.9-6 summarizes key elements of our approach.

Table C.9-6. Medication Adherence for Diabetes Medications

QAPI Elements	Molina's Approach
Strategies and interventions	**Enrollee Interventions:** • *Medication Therapy Management (MTM):* Eligible enrollees are identified using a pre-specified criteria which may include the following: yearly cost of medications, number of medications prescribed, number of chronic conditions, and distinct list of chronic conditions. – MTM is an Enrollee-centered service provided by a pharmacist over the phone. The pharmacist will perform a Comprehensive Medication Review (CMR) of all Enrollee medications to promote a holistic approach to the Enrollee's healthcare. – During the CMR, the Pharmacist may recommend certain services for the Enrollee to improve their health. Services offered by MTM include: care coordination such as request for 90-day medication supply (when covered), automatic refills, mail order pharmacy setup, local pharmacy delivery setup, medication synchronization, transportation scheduling and assistance, disease state education and management, medication adherence counseling, and referral to care management. • *Diabetes Health Management:* As detailed in Proposal Section C.24, Population Health Management, Molina's Diabetes Health Management program promotes an Enrollee-centered approach to improving outcomes such as suite of Comprehensive Diabetes Care HEDIS measures and other performance measures like Medication Adherence for Diabetes Medications. Using motivational interviewing techniques, care managers support Enrollees to build self-management skills so that Enrollees are empowered to take responsibility for their own health status, including nutritional counseling and coaching on taking appropriate medications as prescribed. By having Care Connections staff visit Enrollees to conduct HbA1c testing or complete a retinal eye exam, we help Enrollees understand their treatment plan, including medication adherence and adopt healthier lifestyles to improve outcomes. • *Community Health Workers and Care Connections Nurse Practitioners:* In rural communities, such as the Appalachian counties, we will deploy community-based supports to reach Enrollees that we have been unable to reach in other ways to educate and engage them in self-management activities and supporting the care management process, including identification and resolution of any social determinants of health. **Provider Interventions:** • *Value-based Payment to Providers:* The quality measures included in our proposed value-based payment model include HEDIS Statin Therapy for Patients with Diabetes – Statin Adherence 80% (SPD), orienting providers toward monitoring of Enrollee medication adherence. As detailed in Proposal Section C.9.k, we will offer providers valuable tools to track their performance.
Partners that will be necessary to achieve improvement	Molina will establish key partnerships to coordinate with to boost medication adherence, including the following: • Refer Enrollees to DPH's Diabetes Self-Management education and support programs available at local health departments throughout the Commonwealth

QAPI Elements	Molina's Approach
	• Promote diabetes-related support groups and resources available through the Kentucky Diabetes Resource Directory and train care managers on locally available resources and the referral process • Refer Enrollees to Weight Watchers programs as applicable through provision of vouchers (a value-added service) • Engage with other community partners identified as part of collaboration with statewide or local diabetes coalitions • Coordinate with community organizations for Enrollees experiencing food insecurity (such as Feeding America, Kentucky's Heartland) to obtain nutritious meals that reflect the dietary needs of Enrollees with diabetes or Boys and Girls Clubs of Kentucky to promote physical activity for youth with diabetes
Data analytics	Using our HEDIS Dashboard and similar tools, QI specialists will monitor the following: • Medication Adherence for Diabetes Medication Rate (adapted from the CMS Star measure) that will be calculated using the National Drug Code list maintained by the Pharmacy Quality Alliance. The measure includes the percentage of plan Enrollees 18 years of age and older with a prescription for diabetes who met the Proportion of Days Covered (PDC) threshold of 80% across the classes of diabetes medications during the measurement year. When an Enrollee falls into eligibility for this measure, telephonic outreach will be made by the Molina pharmacist team to initiate MTM. • HEDIS Statin Therapy for Patients with Diabetes – Statin Adherence 80% (SBD) collected and reviewed monthly
Anticipated timeframes for success	Based on our affiliate's success in Ohio with a similar program, we anticipate one year from the start of initiatives to achieve improvement, using available Kentucky data or data from our neighboring Ohio affiliate as the baseline.
Potential challenges and solutions	**Challenge:** Missing or inaccurate Enrollee contact information for telephonic outreach
	Solution: Use Mosaic tool, that combines contact information from multiple data sources into one location and allows users to indicate which information was used to make a successful contact with the Enrollee
	Challenge: Enrollees' lack of understanding of their condition and/or the medication's purpose and self-adjustment of dosage based on glucose readings
	Solution: One-on-one education about medication (purpose, dosage and refills) by Molina pharmacy staff through the MTM program
	Challenge: Lack of transportation to physician office visits
	Solution: Coordinate transportation
	Challenge: Provision of 30-day supplies impede regular refills
	Solution: Work with providers to encourage automatic mail order refills
Examples of successes	Between calendar years 2017 and 2018, our Ohio affiliate's Medicare Enrollees' Medication Adherence for Diabetes Medications score ***increased by more than 7%*** (almost 6 percentage points) and Medicare-Medicaid dual eligible member scores rose by three percentage points, representing a ***4% increase***.

QAPI Elements	Molina's Approach
Leveraging successes in Kentucky	We will apply similar interventions and strategies in Kentucky that led to our Ohio plan's success and add some new ones. Based on its effectiveness in Molina affiliates, we will immediately launch the MTM program to provide initial and ongoing support for Enrollees with diabetes. This personalized, high-touch program promotes medication adherence and Enrollee self-management. Complementing MTM, we will encourage Enrollee participation in our Diabetes Health Management Program in which they receive coaching about medication adherence and self-management to improve health outcomes. In Kentucky, Molina will also deploy Molina Community Health Workers to extend the reach of our care managers, especially in communities with the highest rates of care gaps for Enrollees with the highest risk level. We will exceed our Ohio affiliate's efforts by establishing partnerships with the DPH and local health departments to integrate our efforts, such as referring Enrollees to DPH Diabetes Self-Management Programs.

f.ii. TOBACCO USE AND HELP WITH QUITTING AMONG ADOLESCENTS

As one of the key focus areas outlined in the *Kentucky State Health Improvement Plan 2017 – 2022*, smoking and tobacco use among young Kentuckians have far-reaching implications for the Commonwealth. According to DPH, 26% of high school students and 7.6% of middle school students currently use tobacco products (including e-cigarettes). Molina's approach considers integration of community-based efforts, such as those at DPH, schools, and local health departments as well as targeted tobacco cessation programs as part of Population Health Management to reduce this measure.

Table C.9-7 outlines our approach for improving this quality measure.

Table C.9-7. Tobacco Use and Help with Quitting Among Adolescents

QAPI Elements	Molina's Approach
Strategies and interventions	**Enrollee Interventions:** • Participation in our Smoking Cessation Health Management program (detailed in our Proposal Section C.24, Population Health Management) in which Molina care managers work one-on-one to create Enrollee-centered care plans to quit smoking or tobacco use and educate them on available quit resources available • Telephonic outreach to Enrollees with AWC gaps (identified in our Gaps in Care reports) to engage and assist with appointment scheduling • Molina Days in communities where heat maps document low AWC rates • Medication Management Therapy Program prescribed smoking cessation medication for Enrollees who are not obtaining refills **Provider Interventions:** • VBP program to reward providers for improvement in their scores for HEDIS AWC, an opportunity for PCPs to screen and counsel for tobacco • Provider Engagement Team education of providers on the smoking cessation resources available (such as Molina's Smoking Cessation Health Management program, Quit Now Kentucky, Covered Services like pharmacological aids, and general best practices)
Partners that will be necessary to achieve improvement	• Collaborate with schools in counties with the highest rates of youth smoking (such as eastern and southeastern counties) to provide anti-tobacco educational programs and events, following DPH's *Best Practices for Youth Antitobacco Education, Updated and Annotated, 2019* (including providing K-12 education and including skills development in recognizing and refuting tobacco-promotions messages from media, peers, and adults) • Partner with local health departments and promote the Quit Now Kentucky Quitline • Harmonize efforts with the Kentucky Youth Advocates and its tobacco prevention efforts, including adolescent smoking • Incorporate tools and unified messaging supported by the Youth Engagement Alliance for Tobacco Control

QAPI Elements	Molina's Approach
Data analytics	To monitor and measure our performance and to inform QAPI activities, QI specialists will review: • CAHPS Measure – Medical Assistance with Smoking and Tobacco Use Cessation (with a goal of achieving NCQA's National 75th percentile) • HEDIS Dashboard monitoring of AWC scores • Monthly run charts created to support evaluation of success of targeted interventions by QI specialist and Provider Engagement Team and modification of interventions suggested by the data • Gap reports to identify eligible Enrollees who have not received their annual visit for outreach • Reports to track number of provider visits where tobacco counseling is discussed and number of school-based events
Anticipated timeframes for success	We anticipate that we can improve the CAHPS Medical Assistance with Smoking and Tobacco Use Cessation and HEDIS AWC scores within one-year measurement period.
Potential challenges and solutions	**Challenge:** Providers often feel there is not enough time to screen and counsel for tobacco.
	Solution: Provider Engagement Teams will educate providers on best practices and guidelines/ recommendations on screening and counseling.
	Challenge: Enrollees within this age cohort may lack the motivation to see their PCP for a well visit and only visit when they are sick and also have competing priorities or parents with limited time to take them.
	Solution: An incentive will reward Enrollees and motivate them to schedule and keep the wellness appointment, and we coach PCPs to conduct well visits when the Enrollee has a sick visit or sports or school physical.
	Challenge: Enrollees in areas with limited PCP access issues may experience long wait times for well visits.
	Solution: Our VBP program incentivizes providers to make well visits available within the standard timeframe. Our strategy to boost access to care in rural communities, detailed in Proposal Section C.18 Provider Network, considers contracting with school-based clinics, mobile health and pop-up clinics, and use of physician extenders.
	Challenge: Enrollees and providers may not be aware of the scope of available tobacco cessation services through Molina or within the community.
	Solution: Molina's care managers and Provider Engagement Teams will educate Enrollees and providers
Examples of successes	Molina's Michigan affiliate's Medicaid CAHPS rate for Medical Assistance with Smoking and Tobacco Use Cessation among Current Smokers **increased by 17%** between CAHPS 2017 and CAHPS 2018, **improving from the 25th to the 75th percentile** benchmark. The health plan's CAHPS 2018 rate exceeds the statewide average for both Michigan and Kentucky. Our Texas affiliate Adolescent Well-Care rate **improved to exceed NCQA's National 75th percentile** for HEDIS 2018 using similar methods and surpassed the Texas and Kentucky state average for Medicaid.
Leveraging successes in Kentucky	Our proposed approach follows the successful playbook set forth by our Michigan affiliate. Emphasizing the critical role that PCPs play in screening for and counseling adolescents, in Kentucky we will leverage the success of other Pay for Quality programs in our affiliates. Enrollee and provider incentives promote awareness and action to access the resources available to quickly mitigate barriers experienced in other markets. By collaborating with local partners, like local health departments and schools, Molina will take a holistic and evidence-based approach, ensuring anti-tobacco and quit messages and support are communicated through various modes.

f.iii COLORECTAL CANCER SCREENING

Implementation of Medicaid expansion in Kentucky led to significant increases in colorectal cancer screening rates, diagnoses, and overall survival in Kentucky Medicaid Enrollees, including improvements in Enrollees in Appalachian communities.[1] There continues to be ample opportunities for improvement, and Molina will bring an array of solutions to drive quality advances, and our approach is summarized in Table C.9-8.

Table C.9-8. Colorectal Cancer Screening

QAPI Elements	Molina's Approach
Strategies and interventions	**Enrollee Interventions:** • Coordinate In-home visits by Care Connections nurse practitioners for eligible Enrollees identified as having a colorectal screening care gap to complete a fecal occult blood test (FOBT) for colorectal cancer screening, if appropriate • Coordinate Molina Days at which Enrollees obtain FOBT screenings, if appropriate, using Heat Maps to pinpoint communities with low screening rates where we can partner with providers • Contact by telephone those Enrollees with care gaps to assist with scheduling colorectal cancer screening • Using HEDIS gap alerts, remind Enrollees calling Molina about preventive care gaps and offer scheduling assistance • Deploy reminders through our Molina Mobile app • Initiate Enrollee education initiative to emphasize the importance of colon cancer screening, including at community health fairs **Provider Interventions:** • Include VBP program rewards for colorectal screenings • Deliver Gaps in Care reports to PCPs (available online or delivered in-person by Provider Engagement Team) that identify Enrollees who are due for a colorectal cancer screening for provider outreach • Schedule Provider Engagement Teams to work with providers whose scores suggest the need for improvement to offer best practices, identify barriers, and discuss solutions to those barriers with staff • Utilize online continuing medical education (CME) programs, patient brochures, fact sheets and posters developed by the Kentucky Cancer Program, Kentucky Colon Cancer Screening Program (KCCSP), the Kentucky Cancer Consortium, and the Colon Cancer Prevention Project to synchronize our education and outreach with those of relevant organizations • Develop and administer an outreach campaign to educate providers and organizations about the KCCSP and the benefits of using fecal immunochemical test as part of a blended strategy for colon cancer screening
Partners that will be necessary to achieve improvement	• Join the Kentucky Colon Cancer Screening Advisory Committee and attend monthly meetings to harmonize our efforts with theirs • Invite related community organizations (for example, local health departments, local chapters of the American Cancer Society) to attend Molina Days and health fairs to share additional resources to influence healthy Enrollee behaviors, such as tobacco cessation programs and healthy eating • Collaborate with the Kentucky Cancer Program to collaborate on education and outreach to make efficient use of available community resources

[1] Impact of the Affordable Care Act on Colorectal Cancer Screening, Incidence, and Survival in Kentucky. Gan T, Sinner HF, Walling SC, Chen Q, Huang B, Tucker TC, Patel JA, Evers BM, Bhakta AS, *Journal of the American College of Surgeons*, https://www.ncbi.nlm.nih.gov/pubmed/30802505.

QAPI Elements	Molina's Approach
	• Align efforts with those of the American Cancer Society, local health departments, DPH, and Kentucky Colon Cancer Screening Advisory Committee, • Partner with the Kentucky Cancer Program at the University of Kentucky and the University of Louisville and its network of regional cancer control specialists, 15 district cancer councils, and community partners across the Commonwealth to establish a colorectal cancer screening education and outreach program in each of Kentucky's Area Development Districts
Data analytics	Molina's QI specialists will monitor: • HEDIS Dashboard for ongoing performance trends for the Colorectal Cancer Screening measure • Monthly run charts that summarize our performance relative to the target and compare month-to-month and year-over-year performance to quantify progress • Care gap listing produced by HEDIS reporting tool
Anticipated timeframes for success	Our experience suggests that we can achieve target performance within one to two years.
Potential challenges and solutions	**Challenge:** Difficulty reaching Enrollees due to inaccurate contact information
	Solution: Leverage MOSIAC tool to expand contact information for Enrollees
	Challenge: Lack of transportation to screenings.
	Solution: Coordinate provision of in-home FOBT and arrange transportation for physician or procedure appointments.
	Challenge: Lack of Enrollee awareness of the importance of colorectal cancer screening and the guidelines for receiving screenings or understanding of the procedures.
	Solution: Through VBP, encourage providers to discuss the need for screening with each eligible Enrollee using evidence-based guidelines. Also promote Enrollee education through community events and collaboration with community agencies across the Commonwealth.
Examples of successes	Applying similar interventions, an affiliate increased its HEDIS score by 27% between calendar years 2015 and 2018, demonstrating strong results.
Leveraging successes in Kentucky	In Kentucky, we will implement Enrollee and provider interventions that drove success in our affiliates. We will augment those interventions with extensive outreach and engagement of community agencies and organizations that are prominent across each service area to boost Enrollee awareness.

In Kentucky, Molina will continually work with the Department, our QIC, QMAC, and providers, and community agencies to identify new or emerging strategies to support quality performance improvements. We will also collaborate with the Department and its EQRO to verify that our efforts continue to align with the Commonwealth's objectives.

g. COLLABORATION ON EFFECTIVE PERFORMANCE IMPROVEMENT PROJECTS

Molina's 25 years of experience serving Medicaid managed care Enrollees through affiliates with a portfolio of nearly 3 million Enrollees across 14 states has provided us with a depth of experience implementing PIPs. Below we describe our approach to collaborating with the Department, other MCOs, and providers to ensure that PIPs are effective in addressing identified focus areas and improving outcomes and quality of care for Enrollees. Our PIPs will follow CMS protocol and meet all Department requirements.

In 2019 alone, Molina affiliates are **managing a total of 36 Medicaid PIPs across the country.**

Molina's PIP strategy will emphasize orientation toward the Department's goals to drive sustainable improvements for the Enrollees we serve. We welcome the opportunity to work with the Department, other MCOs and providers to partner together on PIPs. Collaboration across these organizations unifies Enrollee messaging, promotes sharing of best practices across all service regions, supports enhanced identification of trends or systemic issues that may impede success, and concentrates available resources identifying effective solutions. In addition, we value MCO collaboration as an opportunity to standardize provider requests and data gathering across all MCOs, easing their administrative burden. For example, creating a single provider training on cultural competency across all MCOs helps providers and fosters consistency.

For example, our South Carolina affiliate collaborated with the South Carolina Department of Health and Human Services (SCDHHS) and other MCOs. Beginning in HEDIS measurement year 2016, they developed Quality Indices in three clinical areas, rather than individual HEDIS measures, to calculate performance. The clinical areas were chosen in collaboration with the SCDHHS and the other Medicaid MCOs by identifying which areas were most important to the state, what was achievable, and which metrics were meaningful measures to demonstrate progress on the state's goals. These selected measures included broad categories of Comprehensive Diabetes Care, Women's Health, and Pediatric Preventive Care. Each MCO developed their own PIP to achieve the targets, but together they selected performance metrics and measurement methodologies.

Below we describe how we will identify, implement, and monitor PIPs through a highly collaborative process that emphasizes productive relationships and transparency with the Department, its EQRO, and other MCOs as appropriate. Molina's QI team will design our PIPs to reduce health disparities by focusing on Enrollees who have the greatest needs. We will identify and reduce barriers and tailor interventions that are culturally relevant and culturally sensitive.

g.i. LESSONS LEARNED, CHALLENGES, AND SUCCESSES WITH PIPS

With the Department and its EQRO, we will review available data to identify clinical and non-clinical PIP focus areas. Our PIP policies and procedures will meet all Contract requirements, including meeting at least quarterly with the Department to review our PIP's progress.

PIP Lessons Learned

Every PIP offers an opportunity to improve our protocols. Our Kentucky QI team will build on established policies, procedures, and supports from our affiliates. In addition, our QI directors regularly share ideas and successes through formal and informal interactions, broadening our ability to enhance our PIP processes based on lessons learned in other states.

Key lessons learned and our plans to consider them as we implement PIPs for Kentucky Medicaid are described below.

Lesson Learned: Enhanced Enrollee engagement establishes a strong PIP foundation.

PIP interventions are only effective if we can engage Enrollees (and providers when appropriate) to adapt their behaviors. Gathering input early in the process helps us understand the needs of Enrollees and providers in each community and their readiness for change. We can then develop meaningful and successful interventions by meeting Enrollees where they are and delivering messages that they will understand and respond to.

Application in Kentucky: We will gather input from Enrollees and other stakeholders early and frequently to ensure solutions reflect the voice of our stakeholders. Our QI team, with support from their regional Community Engagement Team, will engage our regional QMACs and relevant community-based organizations or advocacy groups early in the PIP planning process. Demonstrating our commitment to proactively seeking the voice of our customers, we have already held several Enrollee and provider focus groups to gather insight into their current perceptions and concerns about Kentucky's Medicaid MCOs.

Lesson Learned: PIPs are most successful when we partner with relevant community-based organizations to magnify the PIP's impact and efficiently share resources, such as materials and best practices.

Application in Kentucky: We will continue to build the breadth and depth of relationships with Kentucky State agencies and organizations in each service region. QI specialists will work with their regional provider services and community engagement representatives to engage local health departments, community-based organizations, and relevant State agencies (such as behavioral health departments) to promote an integrated and community-wide approach to PIPs, amplifying our ability to achieve measurable quality gains.

For example, to address potential food insecurity for Enrollees in rural areas, PIPs may include collaboration with organizations like God's Way that serves 50 counties in central and eastern Kentucky. Molina will support God's Pantry's pop-up clinics at distribution sites at peak periods and around back-to-school events. We also will support prescriptive pantries, through which they screen to identify individuals with food insecurity and special dietary needs (such as for diabetes). With these partnerships, we capitalize on existing community programs while addressing the social determinants of health as we plan PIP interventions.

Lesson Learned: Identifying champion provider partners to support PIP interventions and campaigns boosts participation and cooperation from clinic staff and fosters continued high visibility within the practice.

Application in Kentucky: QI specialists will maintain close working relationships with Provider Services representatives in their assigned region who know the community providers and will be invaluable in helping identify potential PIP champions. Ongoing communication with PIP provider champions will offer valuable insight into increasing participation from provider champions on future PIPs.

Lesson Learned: During PIP planning, it is essential to identify and address potential solutions for a wide array of potential barriers.

Application in Kentucky: When planning PIPs, QI specialists will establish cross-functional work groups that include staff from all relevant departments within the health plan to conduct barrier analysis. A multidisciplinary team of health plan staff will be instrumental in obtaining a broad perspective about barriers and solutions.

Lesson Learned: Testing changes on a small scale to verify their effectiveness promotes a more agile PIP process in which we can quickly measure, adapt, and test new or modified interventions before a broad implementation.

Application in Kentucky: Molina's QI team will use rapid cycle processes to manage all PIPs so that we can quickly identify what works and what does not at increasing the PIP quality measures before a broader roll-out of implementations.

PIP Challenges

As with lessons learned, Molina's QI team will continually enhance our PIP protocols to address the challenges which are often consistent across our affiliate health plans. We will apply our solutions to our Kentucky Medicaid PIPs.

Challenge: Engaging Enrollees can be difficult due to missing, outdated, or inaccurate contact information.

Application in Kentucky: We will implement our innovative Mosaic internal data analytics tool that provides a quick and simple user interface to retrieve Enrollee contact information. The tool aggregates contact information from multiple data sources and systems and presents it in a single view along with other Enrollee demographics. The system also displays secondary contact information, such as a pharmacy or PCP that the Enrollee recently visited. This enables our outreach and education staff (with valid security credentials) to search for an Enrollee and display all available contact information to improve the likelihood of a successful contact. Enhancing Mosaic's effectiveness, we will integrate Enrollee contact information on the HIE.

Challenge: Quality performance metrics may be delayed due to the lag in submission of claims and encounters from providers, impeding our ability to evaluate the real-time effect of our PIP interventions and delaying any changes suggested by the data.

Application in Kentucky: Using the data analytics tools described earlier in this section, including our HEDIS Dashboard, QI staff will monitor performance measures monthly and compare results to the same period in the previous year, providing a clearer picture of performance trends as we wait for claims and encounter data to mature.

PIP Successes

Exhibit C.9-14 illustrates PIPs that have demonstrated results with Medicaid populations in our affiliate health plans, and value-based payments with providers have had an especially significant impact on PIP results. We will implement similar initiatives focused on increasing preventive care in Kentucky.

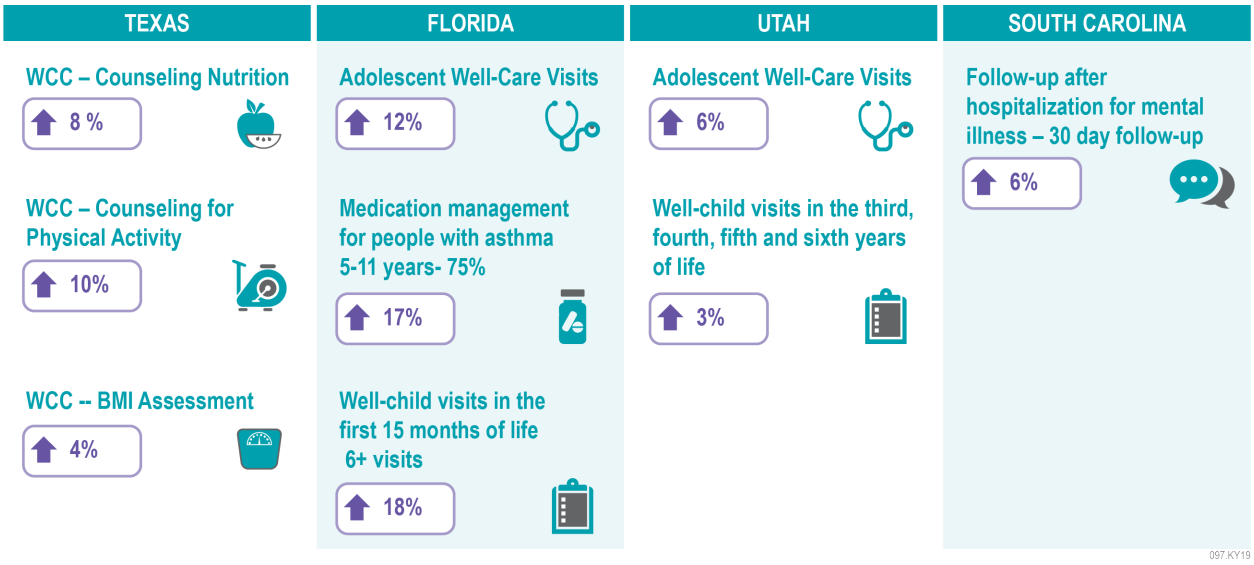


Exhibit C.9-14. Significant Percentage Gains for Affiliates' PIPs

Below we describe just a few detailed examples of PIP successes at our affiliate plans that will inform our Kentucky PIPs.

Demonstrating Success with Boosting Wellness Services for Children. To enhance wellness for their Enrollees, our Florida affiliate's PIP targeted Well Child Visits in the First 15 Months of Life as their baseline rate fell below NCQA's 25th Percentile. The PIP implemented several solutions to address the identified barriers, including:

Over three years, the health plan's **HEDIS score improved by 55%.**

- Conducting home visits by Molina Community Health Workers to reach members who are missing contact information and then assist with coordinating appointments, beginning with prenatal appointments so they were more likely to complete the baby's well visits
- Engaging providers to expand awareness about the need for timely visits, develop rapport, and educate them on missing services, provide billing or coding tips, and alert them to members with upcoming or missed visits
- Creating educational materials for providers (including billing codes and best practices) and Enrollees (with incentive reminders)
- Calling households with children with care gaps to offer assistance with scheduling visits and transportation
- Rewarding members who completed all wellness visits with a gift card incentive provided upon completion of all visits

Improving Outcomes for Enrollees with Diabetes. Our Washington affiliate initiated a PIP to improve its HEDIS score for Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) testing that fell below the benchmark of NCQA's 75th percentile. The QI team identified the key barriers, such as provider awareness and documentation of such services. The health plan established a value-based payment program with targeted providers that rewarded them for provision of appropriate testing, educated those

Providers who participated in this initiative **achieved HEDIS scores that exceeded their peers by 3%.**

providers about evidence-based practices related to the value of preventive screenings for Enrollees with diabetes (such as regular HbA1c testing), and coached them about best practices for documentation and proper coding so that we could more accurately identify Enrollees for whom testing was conducted.

Collaborating with Other Medicaid MCOs on PIPs

Molina is eager to collaborate on PIPs with the Department, its EQRO, and other MCOs to identify regionally-based PIPs to optimize the impact of PIP efforts across the Medicaid system. In our experience, this approach streamlines efforts, promotes provider engagement in the project by simplifying their administrative processes, and makes most efficient use of available MCO and community resources.

Molina's Kentucky strategies will encourage the best results and outcomes. Table C.9-9 summarizes key challenges and lessons learned when collaborating with MCOs.

Table C.9-9. Best Practices for MCO PIP Collaboration

Challenge	Best Practice for MCO Collaboration
MCOs may not work on a similar SMART (specific, measurable, attainable, resources, and time) goals.	Clearly define the Department's expectations in a kick-off meeting to ensure a strong voice of the customer and establish MCO leadership support
MCOs may be hesitant to share proprietary processes or to standardize processes.	• Focus on activities and data that are common among MCOs • Allow flexibility to reflect varying practices
MCOs may require quality data in different formats.	Adopt common tools for PIP data gathering, such as the health information exchange to promote consistent data sharing methodologies, easing provider administrative responsibilities and strengthening data integrity and consistency
MCOs may have varying QI methodologies and cultures.	• Implement QI training that sets forth common strategies and terminology • Identify a Department QI lead to engage with the MCOs and handle questions, fostering trust and collaborative relationships
Provider and MCO goals may not align.	Establish consistent goals and benchmarks so that providers and MCOs share the same goals and targets

Our Kentucky QI team will leverage these best practices to develop regionally based collaborative PIPs, following all Department requirements.

Our affiliate in Washington has participated in two collaborative PIPs with the other MCOs. In the first, as part of the barrier analysis, the MCOs convened numerous focus groups across the state to identify factors that influence Washington Medicaid parents' success in completing well-child visits for their children. As a result of solutions implemented after the focus groups, the state experienced a 3.4% increase in Well-Child Visits 3-6 years between calendar years 2017 and 2018. In the second, a Disparity Workgroup that includes participation from all MCOs identified an important disparity regarding Antidepressant Medication Management (AMM) rates for Spanish-speaking Medicaid members, as compared to English-speaking Medicaid members. As a result of this collaborative and result findings, the MCOs worked with several community-based organizations to successfully bring the National Alliance for Mental Illness' *In Our Own Voice* program to the state. *In Our Own Voice* presentations were delivered in Spanish throughout the community, providing a voice for the state's Spanish-speaking community to discuss stigma, challenges, successes and treatment for depression. To reduce barriers for program participation, dinner and childcare were offered to participants.

g.ii. RECOMMENDED FOCUS AREAS

According to the Department's *2018 External Quality Review Technical Report*, there is a clear opportunity for improvement (based on weighted state averages relative to NCQA averages) in the following HEDIS measures as each score hovers around the National NCQA 25th percentile.

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)
- Adult Body Mass Index Assessment (ABA)
- Cancer screenings (BCS, CCS, and COL)
- Controlling High Blood Pressure (CBP)
- Comprehensive Diabetes Care (Hemoglobin HbA1c testing, HbA1c control [<8.0%], and eye exam [retinal] performed) (CDC)
- Follow-Up After Hospitalization for Mental Illness (FUH)

Based on our experience on the ground in Kentucky talking with providers, Enrollees, and community-based organizations, Molina recommends three clinical focus area (Follow-up After Hospitalization for Mental Illness, Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents, and Comprehensive Diabetes Care) and two non-clinical focus areas (Provider Satisfaction and Use of Opioids at High Dosage) for statewide or regional collaborative PIPs for the first two years of the Contract. To obtain baseline data in the first year of the Contract, Molina will use state weighted averages of all Kentucky MCOs from the most recent Kentucky External Quality Review Technical Report, where applicable. We describe each proposed PIP below.

PIP Focus Area #1: Follow-up after Hospitalization for Mental Illness (FUH)

Enrollees who obtain timely follow-up care after a behavioral health admission have better health outcomes but are also better prepared to engage in community activities such as employment or job training. In this statewide PIP, Molina will collaborate with the Department and other MCOs to build on solutions that have proven effective with similar populations in other states, including:

- Tailored Transitions of Care programs that promote improved aftercare planning
- Telepsychiatry services to expand access in underserved communities
- High-touch Enrollee interactions to promote healthy behaviors and improve self-management skills, including engagement by our Molina Community Health Workers who help identify and resolve barriers, including social determinants of health that impede follow-up care
- Collaboration with community organizations such as the Homeless and Housing Coalition of Kentucky and the Coalition for the Homeless to locate and engage Enrollees
- Care management program that centers on promoting psychotropic medication adherence and engagement in treatment and recovery, especially important for Enrollees with co-occurring mental health and substance use disorders who may be ambivalent about treatment
- Provider incentives for completion of seven-day follow-up visits

Molina will measure performance improvement using the HEDIS Follow-up After Hospitalization Measure for Mental Illness (FUH) measure, which is the industry standard for measurement of transitions in care between inpatient and behavioral health outpatient levels of care. According to America's Health Rankings, 17% of Kentucky adults reported frequent mental distress in 2019. Each year, on average, 60% of adults do not receive the mental health services they need.

Enrollees will be positively impacted by the outcome through improved continuity of behavioral health care between inpatient and outpatient settings, which is a hallmark of a well-developed behavioral health care system (see references). Improved outcomes are expected, as research indicates that patient access to

follow-up care within seven days of discharge from an inpatient psychiatric facility is a strong indicator in the reduction of hospital readmissions. Other studies indicate that the crucial time period for follow-up after hospitalization is within the first 2-3 weeks post-discharge.

Our Ohio affiliate has improved their associated HEDIS scores to reflect the 75th percentile of NCQA's Quality Compass with similar interventions. We expect to achieve similar results in Kentucky.

Rationale

The 2018 External Quality Review Technical Report indicates that Kentucky Medicaid's weighted state average for HEDIS 2017 FUH rates (both 7- and 30-day) fell just above the 25th percentile for NCQA's National benchmark, suggesting the potential for improvement in this measure. Improving this score enhances each affected Enrollee's ability to maintain treatment and achieve recovery so that they can successfully engage in their community through employment, job training, or volunteering. It will also reduce each affected Enrollee's potential impact on the social service and justice systems, offering an excellent opportunity to also reduce the Commonwealth's costs. Given our affiliate's success in Ohio at achieving about the 75th National NCQA benchmark, we are confident that this PIP will have far-reaching success across the Commonwealth.

PIP Focus Area #2: Provider Satisfaction Rates

Providers who are satisfied and engaged in identifying and implementing solutions to quality and health outcomes will result in stronger and more sustainable results for the Department and Kentucky Medicaid Enrollees. Molina has been building collaborative relationships with all types of Kentucky providers, including holding two focus groups with Kentucky providers (in Louisville and Pikeville/Auxier) to gather insight into their perceptions of the current Medicaid managed care landscape. In our focus group discussions as well as in less formal interactions with Kentucky providers, we learned that many are dissatisfied with the current managed care environment and eager to work with MCOs who will listen and address their concerns.

Within two years, our Ohio affiliate experienced a **72% increase in Overall Satisfaction with Utilization/Case Management and a 49% rise in Overall Satisfaction with Claims/Billing.**

As we detail in our Proposal Section C.9.e, our QAPI program will include clear protocols for measuring provider satisfaction and for deploying solutions to address the root causes of any dissatisfaction. When Molina's national survey results indicated provider dissatisfaction, we analyzed the data to identify the underlying issues and implemented solutions such as onsite visits by Our Provider Engagement Team and operational enhancement to our Call Center (each of which is described later in this section) to improve health plan performance.

To bolster provider satisfaction in Kentucky, this PIP would incorporate the following:

- Deployment of Provider Engagement Teams that pair regional QI specialists with community-based Provider Services and Community Engagement representatives so that we blend a detailed understanding of the quality and performance data in that region with community-based staff who have strong relationships with providers and community organizations, so we can tailor interventions to the local or regional landscape
- Adoption of monthly "It Matters to Molina" Provider Forums, conducted via WebEx, in which we invite Kentucky providers and their staff to talk with provider service staff about their questions, concerns, or recommendations to improve service
- Identification of regional trends or issue areas identified by providers (through provider services representatives or the QIC), community-based organizations, and Enrollees as we gather feedback during interaction in the community, grievances and appeals, provider satisfaction surveys, QMAC feedback, or CAHPS

- Establishment of monthly and ad hoc meetings in which our regional Provider Engagement Teams review quality results within their assigned regional QI specialist to identify emerging trends or priority topics; apply QI strategies and tools to examine barriers/root cause; and identify potential solutions that they may escalate to their leadership or the QIC as appropriate
- Implement testing of small-scale refinements and regional solutions with providers and community-based organizations to test for effectiveness using PDSA protocols
- Monitor the resulting changes in quality measures during the first one to two years and beyond, engaging the Provider Engagement Team to monitor for concerns that may span across all MCOs so that we can share with the Department and evaluate the potential for a regional collaborative PIP

Molina Healthcare of Ohio's Provider Satisfaction Survey shows how Molina works to improve Provider overall experience with our network. Our affiliate met or exceeded the 25th percentile for the following measures on the Provider Satisfaction Survey: Finance Issues, Utilization Management, Network and Coordination of Care, and Provider Relations. The health plan also met the 50th percentile for the Call Center Service Staff.

Rationale

With the feedback garnered during our provider focus groups, we believe that MCOs should prioritize engagement of Kentucky Medicaid providers as active partners in creating solutions for Kentucky Medicaid. Molina will continually seek to develop mutually beneficial provider partnerships and take the steps necessary to bolster provider satisfaction across all service regions.

PIP Focus Area #3: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)

Obesity during childhood and adolescence can lead to health issues as well as increase the potential for health conditions in adulthood. Promoting healthy diet and exercise early can help create a lifestyle that people carry into adulthood to prevent health issues. In this statewide PIP, Molina will build on solutions that have proven effective with similar populations in other states, including:

- Outreach by the HEDIS Intervention Team to Enrollees via telephone and providing education on available incentives/programs related to wellness exams and schedule appointments.
- Educational postcards sent to Enrollees on the importance of preventive care and comprehensive well-care visits. Enrollees are eligible to receive incentives if they receive a well-visit or comprehensive well-care visit.
- Offer incentives to providers for completing a visit that includes BMI percentile, counseling for nutrition or counseling for physical activity.
- Hold Molina Days at local Department for Public Health (DPH) offices or provider clinics to encourage Enrollees to obtain timely well-child visits and age-appropriate immunizations and offer education about the importance of healthy eating and being active.

Rationale

Kentucky ranks 45th in the nation for obesity rates. Additionally, the 2018 External Quality Review Technical Report indicates that Kentucky Medicaid's weighted state average for HEDIS 2017 WCC rates (BMI percentile, counseling for nutrition and counseling for activity) fell below the 25th percentile for NCQA's National benchmark, suggesting the potential for improvement in this measure. Improving this measure ensures that our child and adolescent Enrollees maintain a healthy weight and understand the importance of nutrition and physical activity.

PIP Focus Area #4: Comprehensive Diabetes Care (Hemoglobin HbA1c testing, HbA1c control [<8.0%], and eye exam [retinal] performed) (CDC)

The Commonwealth has a statewide average prevalence of diagnosed diabetes of 12.9% with an adult rate as high as 17.0% in Appalachian counties compared to 11.2% in non-Appalachian counties. Promoting management and prevention of diabetes and improving health outcomes by increasing adherence to diabetes medications will have a significant effect in quality of life and cost. To improve the health of Enrollees with diabetes, our PIP will include the following:

- Deploy Care Connections nurse practitioners to conduct annual comprehensive exams, comprehensive diabetes care, and postpartum visits through home visits, mobile clinics, or pop-up clinics in partnership with local community organizations
- Support prescriptive pantries that screen individuals to identify food insecurity and special dietary needs (such as for diabetes) and prescribe them fresh and healthy food tailored to their condition
- Encourage Enrollee participation in our Diabetes Health Management Program, in which they receive coaching about medication adherence and self-management to improve health outcomes
- Coordinate with community organizations for Enrollees experiencing food insecurity (such as Feeding America, Kentucky's Heartland) to obtain nutritious meals that reflect the dietary needs of Enrollees with diabetes, and with Boys and Girls Clubs of Kentucky to promote physical activity for youth with diabetes
- Promote diabetes-related support groups and resources available through the Kentucky Diabetes Resource Directory and train care managers on locally available resources and the referral process
- Refer Enrollees to DPH's Diabetes Self-Management education and support programs available at local health departments throughout the Commonwealth
- Join the statewide Kentucky Diabetes Network and attend coalition events in communities with the highest prevalence rates (such as the Southeast region) and high rates of diabetes care gaps to link our outreach and engagement efforts with those of community coalitions
- Offer value-based payment to providers for HEDIS measures related to diabetes

Demonstrating the impact of Care Connections, our Utah affiliate used this team of nurse practitioners to conduct in-home visits for HbA1c testing for Enrollees with diabetes who had care gaps, driving their HEDIS score beyond the 75th percentile. For HEDIS 2019, our Ohio affiliate experienced a 5% increase in Postpartum Visits using Care Connections to visit Enrollees and conduct in-home visits in 13 counties.

Rationale

The 2018 External Quality Review Technical Report indicates that Kentucky Medicaid's weighted state average for HEDIS 2017 CDC rates (Hemoglobin HbA1c testing, HbA1c control [<8.0%], and eye exam [retinal] performed) fell just above or below the 25th percentile for NCQA's National benchmark, suggesting the potential for improvement in this measure. Improving this measure ensures that our Enrollees with diabetes manage their diagnosis to maintain a healthy lifestyle.

PIP Focus Area #5: Use of Opioids at High Dosage (UOD)

Dependence is a known risk factor associated with opioid use. Since Region 8 has the highest prevalence of opioid use, Molina will include a regional PIP to address the population specific issue. In this regional PIP, Molina will use previously implemented solutions that have proven effective with similar populations in other states, including:

- Utilizing Molina's Substance Use Disorder Model of Care with Opioid Use Disorder Focus. Among the many facets of the program that allows us to combat this emergency are the positions of SUD navigator and peer support specialist. Our SUD navigators are care managers who specialize in

working with Enrollees with SUD. Our peer support specialists have lived experience in recovery and are trained and certified to serve as counselors and motivators to those currently in recovery.

- Collaborate to train local DPH staff about Molina's SUD Model of Care with OUD Focus, and to coordinate referrals and care management practices.
- Deliver data on Molina Enrollee outcomes (such as the number of Enrollees on methadone treatment programs).
- Partner to host a drug take-back event.
- Co-sponsor a statewide opioid conference.

Rationale

Kentucky has the 5th highest drug death rate nationally. Molina believes that MCOs should prioritize engagement of Kentucky Medicaid Enrollees as active partners in creating solutions for the overuse of opioids.

g.iii. MONITORING AND EVALUATING PROGRESS AND EFFECTIVENESS

Throughout the PIP process, Molina's QI team applies Model for Improvement protocols to monitor and evaluate our PIPs. This data-driven model acts as our foundation to drive and accelerate improvement. Using the core component of this framework (PDSA cycle), we will systematically monitor and identify opportunities for improvement, test changes on a small scale, and refine interventions to implement changes on a broader scale. Led by the medical director and overseen by designated QI specialists, a cross-functional PIP team, reflecting participation from relevant health plan departments, will contribute to the PIP to promote a holistic and comprehensive approach.

Each PIP sets forth the metrics used to measure the PIP's impact, such as related HEDIS scores or CAHPS or other Enrollee satisfaction survey data, in accordance with the PIP's SMART goals. Following rapid cycle protocols, the PIP's assigned QI specialists reviews those PIP measures monthly using run charts or other tools to identify month-over-month improvement and compare to the previous year's performance. Shared with the PIP team, the monthly report documents progress and informs the PIP team's evaluation of the PIP's effectiveness, including identification of successful and unsuccessful interventions so that we can adapt our PIP interventions as the PIP proceeds. The QI specialist delivers PIP progress reports to the QIC at least quarterly to gather their feedback to strengthen results. The PIP team and the QIC provide ongoing recommendations, driven by the PIP's results data, about opportunities to enhance results through new or modified interventions.

We will meet with the Department at least quarterly to review PIP results and deliver a progress report at least 14 days before the meeting to guide our PIP progress review discussion. We will also tailor our reporting to reflect the Department's approved format. In addition, we will work with the EQRO as appropriate, sharing progress and participating in audits to verify the integrity of our PIP methodology. Working collaboratively, Molina will share PIP best practices with Kentucky MCOs as we team up on regional or statewide collaborative PIPs.

h. COLLABORATION WITH DEPARTMENT FOR PUBLIC HEALTH

Molina has identified several opportunities to collaborate with the Department for Public Health (DPH) to support improvement in public health outcomes. To foster a system-wide approach to improving outcomes and align our QI initiatives with those across Commonwealth agencies, we will focus our collaboration efforts around Kentucky Public Health's *State Health Improvement Plan (2017-2022)*. Our Kentucky team will engage with local DPH staff to identify opportunities that are responsive to local needs as

Molina will establish an active and dynamic relationship with DPH staff across the Commonwealth to improve the health of the Kentuckians we serve.

priorities may vary among service regions. More strategically, we envision collaboration on topics and initiatives on which our efforts intersect and complement each other, avoiding duplication of resources or fragmentation of care and service delivery for Enrollees.

Leading our efforts for DPH collaboration will be Molina's local Community Engagement Team. Embedded in the community, team members will cultivate relationships with staff in their region's DPH to identify their regional priorities. Regionally-focused QI specialists will develop a deep understanding of the quality data, trends, culture, and healthcare landscape of their assigned region (applying the tools and data that are detailed earlier in this section). Working hand-in-hand with their regional Community Engagement representatives, QI specialists will share data about quality performance opportunities so Molina can link with each DPH office on programs that overlap.

OPPORTUNITIES TO SUPPORT IMPROVEMENT IN PUBLIC HEALTH OUTCOMES

Working together, Molina and DPH can amplify both our organizations' efforts by integrating priority topics within each region. Initially, we believe that the Commonwealth would benefit from collaboration on the health conditions that represent the greatest opportunity for improvement in Kentucky: opioid use disorder, diabetes, tobacco cessation, maternal and child health, and obesity and nutrition, as summarized in Table C.9-10. In addition to more strategic initiatives described in the table, ***Molina will support DPH by coordinating health fairs, community Baby Showers for pregnant Enrollees and new moms, and events like Molina Days (community-based mini-wellness fairs at provider offices to encourage Enrollees to come in for well visits, immunizations, and other preventive services) to increase provision of preventive care services to Molina Enrollees in their communities.***

Table C.9-10. Collaborating on Kentucky's Most Pressing Health Challenges

Condition	Collaboration Opportunity
Opioid Use Disorder (State Health Improvement Plan Area of Focus: Substance Use Disorder)	• Collaborate to train local DPH staff about Molina's substance use model of care with a focus on opioid use disorder and coordinate referrals and care management practices • Deliver data on Molina Enrollee outcomes (such as number of Enrollees on methadone program enrollment counts) • Partner to host a drug take-back event • Co-sponsor statewide opioid conference
Diabetes (State Health Improvement Plan Areas of Focus: Obesity and Smoking)	• Refer Enrollees with diabetes to DPH's Diabetes Self-Management Program and other available classes at local DPH offices • Refer (and pay for) Enrollees with pre-diabetes to Diabetes Prevention Program classes at local health departments and community organizations. **Referral of Enrollees to this program at our affiliates in California, Wisconsin, and New Mexico resulted in an average weight loss of 4.8% for participants**
Tobacco Cessation (State Health Improvement Plan Area of Focus: Smoking)	• Coordinate with DPH for referral of Enrollees into Molina's tobacco cessation program which complements Quit Now Kentucky's program services and includes person-centered tobacco cessation care plans (including stress management and addiction, habit, and psychological dependency) • Collaborate with local DPH staff for Enrollees who are enrolled in care management and receive services at DPH office • Partner with schools in counties with the highest rates of youth smoking (such as eastern and southeastern counties) to provide anti-tobacco educational programs and events, following DPH's *Best Practices for Youth Antitobacco Education, Updated and Annotated, 2019* (including providing K-12 education and including skills development in recognizing and refuting tobacco-promotions messages from media, peers, and adults) • Educate Kentucky Medicaid providers about DPH's Quit Now Kentucky – Quitline and the range of tobacco cessation resources available through Molina and the community

Condition	Collaboration Opportunity
Maternal and Child Health (State Health Improvement Plan Area of Focus: Obesity)	• Leverage Care Connections nurse practitioners to conduct postpartum pop-up clinics at DPH offices to encourage optimal outcomes, including boosting breastfeeding rates and adherence to timely postpartum visits • Collaborate with Women, Infants and Children (WIC) to host community Baby Showers for pregnant Enrollees and new moms that include breastfeeding information and support importance of attending prenatal and postpartum appointments, well visits for infants, healthy eating, and overall wellness • Host Molina Days at local DPH offices or provider clinics to encourage Enrollees to obtain timely well child visits and age-appropriate immunizations and offer education about the importance of healthy eating and being active
Obesity and Nutrition (State Health Improvement Plan Area of Focus: Obesity)	• Initiate school-based education initiatives/programs such as nutrition, physical activity, and tobacco and drug use prevention • Promote the evidence-based *5-2-1-0 Healthy Numbers for Kentucky Families* program that is designed to give parents, healthcare professionals and day care operators a memorable way to talk about the key evidence-based behaviors that reduce childhood obesity through our school partnerships, community events, and provider education channels • Join the Partnership for a Fit Kentucky, the public/private partnership that supports the Kentucky Department for Public Health's Obesity Prevention Program, through which we will support farmer's markets (through our Farm to Table program) and implement Step It Up, Kentucky at our six Molina One-Stop Help Centers across the Commonwealth (promoting employee walking programs, conducting a walkability audit around our office locations, and using point-of-decision prompts) • Sponsor local farmer's markets to offer fresh fruits and vegetables at our outreach events such as health fairs, Molina Days, and Baby Showers at DPH locations, FQHCs, RHCs, or other provider locations • Establish school partnerships to create local vegetable gardens

We are also prepared to work with DPH staff to promote health literacy (Area of Focus: Integration to Health Access) to develop materials in conjunction with DPH to simplify and standardize health insurance language and host focus groups for material development (including leveraging our regional QMACs as appropriate).

MOST IMPACTFUL INITIATIVES FOR IMPROVING QUALITY AND OUTCOMES

Based on the success of our affiliates serving Medicaid populations in other states, Molina believes that focusing our collaborative efforts on tobacco cessation and maternal and child health will have the most impact in addressing quality of care and outcomes for Medicaid Enrollees.

Tobacco Cessation

As detailed in our response to Proposal Section C.9.g above, Molina has well-established tobacco cessation programs to link with DPH, and our Community Engagement representatives will extend the reach of both DPH and Molina by working closely with potential partners, including schools and other community partners, to promote DPH programs.

As a testament to our success, our Michigan affiliate's HEDIS score for Medical Assistance with Smoking and Tobacco Use Cessation increased 17% between 2017 and 2018, improving from the 25th to the 75th percentile benchmark. The health plan's rate exceeds the Michigan and Kentucky state averages for Medicaid.

Among our Medicaid affiliates in NCQA's Quality Compass U.S. South Central Region Medicaid (that includes Kentucky):

75% **exceeded the 90th percentile** for CAHPS Advising Smokers to Quit

50% **exceeded the 90th percentile** for CAHPS Discussing Cessation Medications

50% **exceeded the 90th percentile** for CAHPS Discussing Cessation Strategies

Using similar solutions that we plan for Kentucky, our Texas affiliate moved beyond HEDIS 2018 75th percentile, exceeding both the Texas and Kentucky state averages.

Maternal and Child Health

By joining forces with DPH, Molina's strong maternal and child health program, which includes our High-Risk OB Care Management program, will complement the supports available to Enrollees through DPH's WIC program, enhancing the effectiveness of both. We are confident that close coordination between Molina's Community Engagement team and DPH on the initiatives described above will drive gains in related HEDIS scores for moms and babies.

Molina affiliates' strong results in other states set a solid foundation for our maternal and child health outcomes that we believe will be enhanced by integrating DPH WIC initiatives into our Population Health Management model for pregnant Enrollees and their newborns. Our successes include the following:

- The Postpartum Visits HEDIS rate in California improved by 11% in California between HEDIS 2018 and HEDIS 2019 and showed a 37% improvement for African-American women between 2016 and 2017 as a result of home visits by our Care Connections team
- Almost 10% improvement in Timeliness of Prenatal Care HEDIS rates scores for our Wisconsin affiliate between HEDIS 2017 and HEDIS 2018
- The Postpartum Visits HEDIS rate in our South Carolina affiliate increased by almost 5% between HEDIS 2018 and HEDIS 2019, moving above the 75th percentile

RATIONALE

Molina believes that tobacco cessation and maternal and child health represent the health topics offer the most significant collaboration opportunity with DPH because they represent the strongest intersection of our services. Rather than duplicating efforts, integrating our initiatives will intensify the overall results for each initiative.

Tobacco Cessation

Smoking is linked to multiple chronic conditions, such as asthma and high blood pressure. A reduction in smoking among adults and youth in Kentucky will reduce the prevalence of long-term health issues and lead to better health outcomes. As presented on the kentuckyhealthfacts.org site, 24.2% of adults in Kentucky smoke, compared with 16.1% of adults throughout the United States. Among high school students, 14.3% smoke cigarettes in Kentucky compared with 8.8% in the U.S. More than 8,000 Kentuckians die each year of illnesses caused by tobacco use, and treatment of smoking-related conditions costs $1.2 billion annually in the Commonwealth.

We will priorities our improvement initiatives in the counties where smoking rates are exceptionally high, as shown in Table C.9-11. These same counties have higher rates of chronic conditions as well.

Table C.9-11. Kentucky Counties with Higher Smoking Rates

County	Smoking Rate Among Adults	Asthma Prevalence	Heart Disease Deaths	Hypertension Rate Among Adults
Estill	34%	16%	269	48%
Montgomery	34%	16%	235	48%
Powell	34%	16%	291	48%
Breckinridge	33%	15%	204	42%
Hancock	33%	15%	175	42%
Meade	33%	15%	182	42%
Ohio	33%	15%	232	42%

County	Smoking Rate Among Adults	Asthma Prevalence	Heart Disease Deaths	Hypertension Rate Among Adults
Bell	32%	20%	294	48%
Clay	32%	20%	270	48%
Harlan	32%	20%	278	48%
Knox	32%	20%	230	48%
McCreary	32%	20%	255	48%
Whitley	32%	20%	302	48%

Our implementation plan will be to decrease the smoking prevalence rates through community-based strategies. We will work with Kentucky's Tobacco Prevention and Cessation Program and QuitNow Kentucky to implement specific solutions.

Maternal and Child Health

Improved maternal health is linked to improved quality of care and outcomes for newborns. Low birth weight infants (less than 2,500 grams at birth) are at increased risk for infant mortality and various complications. Preterm birth is also a leading cause of infant mortality. Better prenatal care can reduce infant mortality and low birth weight rates and improve overall maternal and child health. According to 2019 America's Health Rankings, Kentucky ranked among the top 20 states for rate of low birth weight (8.8%) and among the top 10 states for preterm birth (11.1%).

We will concentrate our efforts on counties shown in Table C.9-12 where the rate of women receiving adequate prenatal care is significantly lower than for the Commonwealth as a whole. By addressing this gap in care, we envision a reduction in poor birth outcomes.

Table C.9-12. Kentucky Counties with Low Birth Weights

County	Adequacy of Prenatal Care	Low Birth Weight	Infant Mortality
Allen	36%	11%	11%
Union	37%	11%	6%
Todd	40%	9%	7%
Hart	42%	8%	8%
Henderson	42%	10%	10%
Logan	42%	7%	8%
Simpson	43%	10%	5%
Warren	43%	9%	5%
Butler	46%	7%	5%
Webster	48%	10%	12%
Barren	49%	8%	6%
Monroe	49%	9%	10%
Metcalfe	50%	8%	5%

Our implementation plan will be to increase adequacy of prenatal care rates while reducing rates for low birth weight babies and infant mortality through community-based strategies.

i. MONITORING AND EVALUATING PROGRESS

Molina will apply rigorous quality improvement protocols to establish quality performance targets, continually evaluate our progress toward those targets, and refine our interventions as appropriate. Below we describe our approach to monitoring and evaluating progress in improving the quality of healthcare and outcomes on an ongoing basis.

As detailed throughout this section, our adoption of the Model for Improvement drives Molina's QI processes. Our Kentucky QI team will monitor and evaluate our quality improvement progress through a continuous cycle that leverages the PDSA principles. We will collect and report data on all clinical and non-clinical quality measures outlined in the annual QAPI Work Plan, including all measures that are priorities for the Department. These include HEDIS and CAHPS.

i.i. USING DATA TO INFORM AND PRIORITIZE INITIATIVES

In all our QAPI activities, Molina will use data to inform and prioritize initiatives to address Enrollee needs. For our data-driven QAPI program, we will clearly define performance targets for all quality measures, including HEDIS, CAHPS, provider satisfaction surveys, EPSDT reports, care management metrics (such as Enrollee satisfaction), patient safety data, quality of care metrics, Department-specific measures, and non-clinical measures. Our targets will include stretch goals, such as NCQA's National 75th Percentile, and target goals like the State's 75th Percentile. In developing the annual QAPI Work Plan, Molina's QI team will prioritize inclusion of measures that are most important to the Department and represent the Commonwealth's priorities.

Inform Initiatives

Using the tools described above, our quality analytics team will produce monthly or quarterly reports (as outlined in the Work Plan) that document the status of each performance measure and shares them with our QI specialists. For measures that are not achieving the target, the QI specialist will seek potential barriers, for example, leading cross-functional work groups or presenting findings to the QIC for brainstorming. Using quality improvement tools like fishbone and other key driver diagrams, we will document and analyze potential barriers and solutions or interventions to address each barrier, considering local or regional variations as suggested by the reports. For example, when conducting PIPs, we will deploy Failure Mode Effects Analysis (FMEA) process mapping (Exhibit C.9-15) through which potential failures are prioritized according to how serious their consequences are, how frequently they occur and how easily they can be detected. The purpose of the FMEA is to take actions to eliminate or reduce failures, starting with the highest-priority ones.

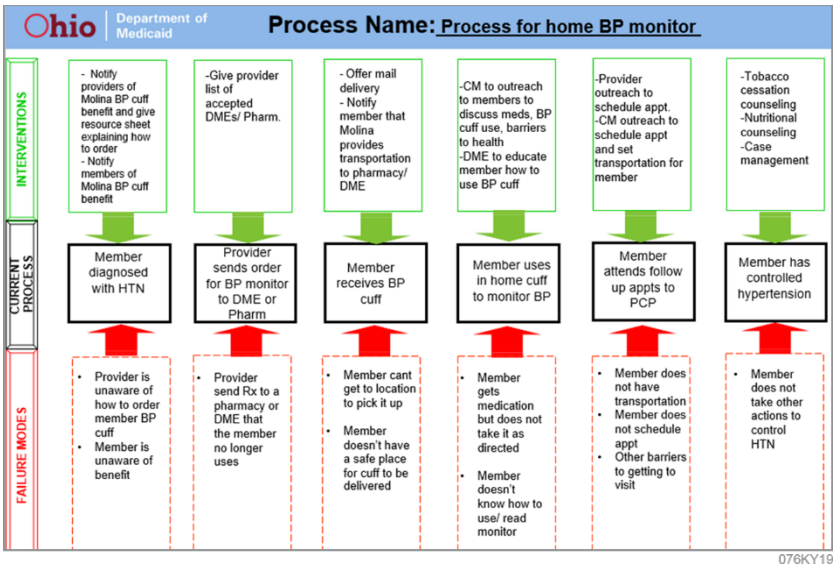


Exhibit C.9-15. Molina PIP Tracking through FMEA and Process Mapping

To ascertain specific barriers, QI specialist, with the support of cross-functional work groups when appropriate, will look to multiple information or data sources. These may include Enrollee focus groups, our regional QMACs, Enrollee and provider feedback, grievance and appeals reports, the QIC, Molina's national and regional QI experts, peers at affiliates, and analysis of social determinants of health identified in our annual community health needs assessments. We will continually seek data on potential barriers, for example by contacting Enrollees when they miss appointments so we can understand why. During monthly Provider Engagement Team meetings, the QI specialist will also seek local insight into the community about potential barriers from their regional provider services and community engagement representatives. QI specialists will also regularly talk with community-based Care Connections staff to gather their feedback. ***In Ohio, our affiliate's Care Connections team identified last-minute loss of transportation as a top reason for their members missing appointments, so they are modifying their processes to prospectively verify member transportation needs before scheduled appointments.***

Prioritize Initiatives

We will deploy Key Driver Analysis to prioritize initiatives. For example, as part of our behavioral health Enrollee satisfaction survey analysis, Key Driver Analysis will inform our understanding of the impact of different aspects of care have with overall satisfaction with the health plan so that we can focus on those issues that have more significant impact on the score *and* have an opportunity for improvement.

To prioritize initiatives, Molina's local leadership team (with input from various QI committees, including those with provider or Enrollee participants) evaluates potential initiatives by evaluating the following factors:

- Potential to impact high volume, high cost utilization trends
- Availability of scientific research to evaluate the technology
- Potential for service or care to have a high risk of harm
- High level of important to Enrollees or providers
- Potential impact on quality of life and health results, including social determinants of health
- Data indicating suspected or demonstrated over-utilization or inappropriate usage

When developing initiatives to address barriers, we will integrate our efforts with those already established in the community to foster continuity and efficient use of available resources. Where indicated, we will partner with community-based organizations and local DPHs to promote a holistic

approach to quality improvement. For example, we have partnered with Audubon Area Community Services, a community action agency serving 34 Kentucky counties, to support their pop-up clinics to expand health services outside their immediate footprint. The initiative will target back-to-school and other events to include behavioral health screenings and referrals.

In accordance with rapid cycle improvement protocols, we will test solutions on a small scale and refine them based on the data results as we advance to implement solutions on a broader scale. Additionally, we will incorporate feedback and responses from network providers and Enrollees into our interventions. For example, based on Enrollee feedback across Molina affiliates and a detailed QI analysis, we implemented a multi-faceted strategy to boost Enrollee and provider satisfaction ratings, including a cross-functional Experience Improvement Team, comprised of plan leaders, to regularly review Enrollee and Provider Services call center and complaint/grievance data and address most significant opportunities for improvement, incentives for call center staff demonstrating superior customer services, and initiated a "Do the Right Thing" campaign to empower customer service representatives to do all they can to assist Enrollees to access care and services.

We will present data and reports quarterly to our QIC and senior leadership to develop a course of action based on those recommendations.

i.ii. MEASURING PROVIDER PERFORMANCE AGAINST CLINICAL PRACTICE GUIDELINES

Molina's QAPI program will incorporate monitoring and measuring providers' performance against clinical practice guidelines (CPGs) and preventive health guidelines adopted by the QIC. Clinical practice and preventive health guidelines promote evidence-based care and drive continual quality gains. Molina actively identifies, reviews, and disseminates CPGs to our network providers. We also incorporate those guidelines into our Population Health Management program, facilitating Enrollee access to evidence-based care whenever possible.

Our Kentucky QIC (that includes Kentucky providers) will be responsible for reviewing and updating clinical and preventive health guidelines at least annually and more frequently as clinical evidence is updated. We monitor evidence-based consensus statements, guidelines from nationally recognized healthcare organizations, and published peer-reviewed medical journals regularly to ensure our guidelines include the most current industry information. Locally, we will review the guidelines approved by our national Quality Improvement Committee, which is chaired by our national medical director, to ascertain their appropriateness for Kentucky. We will distribute all guidelines across the organization***. We welcome requests from providers on our QIC or other Kentucky Medicaid providers for new CPGs based on local healthcare needs or practices.*** For example, our local QIC may review adoption of the colon cancer screening recommendations from the Kentucky Cancer Program, administered jointly by the University of Louisville James Graham Brown Cancer Center and the University of Kentucky Lucille Parker Markey Cancer Center.

Monitoring Provider Performance

Annually, our Kentucky QI team will select at least two clinical guidelines, two behavioral health guidelines, and two preventive health guidelines to audit. For each guideline, we develop methods for monitoring its implementation. To measure adherence, we will evaluate:

- Clinical health outcomes measurement using metrics (for example, HEDIS)
- Claims and encounter data
- Utilization management statistics
- Potential over- and under-utilization information
- Poly-pharmacy data
- Appeal trending
- Quality of care information

When the data indicates a provider may not be adhering to a CPG, our medical directors outreach to educate and address barriers preventing adherence.

Following our quality improvement protocols, if our CPG adherence measure falls below the target, our QI team conducts a root cause analysis and lead a work group, as appropriate, to identify barriers and solutions to drive improvement.

For example, an affiliate determined that providers were not following the asthma management CPG. A QI specialist worked with colleagues and identified barriers, such as lack of provider education to Enrollees about effective asthma management including limited use of asthma action plans, lack of understanding about importance of charting, and value in maintaining medication adherence. In addition, a noted barrier was limited reporting to providers about asthma care gaps. The health plan identified and implemented two high priority initiatives. They intensified provider education about the CPG and condition management (including asthma action plans and use of educational materials and toolkit) and delivered Care Gap reports that listed Enrollees who were not refilling medications.

Table C.9-13 highlights sample CPG adherence rates from affiliates.

Table C.9-13. Monitoring CPG Adherence

Condition/ Disease	Guideline Title & Source	Identified Measure	Organization HEDIS 2018 Rate	Goal: NCQA 75th Percentile	Goal Met or Not Met
Immunizations	Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, United States, 2018 – Centers for Disease Control and Prevention Advisory Committee of Immunization Practices	Childhood Immunization Status – Combo 4	78.97% (Texas CHIP)	73.48%	Met
		Immunizations for Adolescents – Combo 2	42.33% (Utah CHIP)	24.62%	Met
Asthma	Guidelines for the Diagnosis and Management of Asthma – National Institute of Health & National Heart, Lung, and Blood Institute	75% Asthma Medication Compliance – Ages 5-11	34.40% (Ohio)	32.80%	Met
Obesity	Recommendations for Preventive Pediatric Health Care – Bright Futures/ American Academy of Pediatrics	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents – BMI Percentile Documentation – Total	85.50% (Florida)	80.54%	Met

i.iii. ANNUAL QAPI PROGRAM EVALUATION

Emphasizing continual quality improvement, Molina maintains a rigorous process to conduct an annual evaluation of the QAPI program and use the findings for continuous quality improvement efforts. As documented in our QAPI Program Plan, our QI team will conduct an annual program evaluation and present a written report to the Department. Our QAPI program evaluation will meet all Department requirements, which are consistent with our affiliates' best practices for annual program evaluation.

Rather than relying only on an annual evaluation, Molina's QI processes described throughout this response emphasize continual monitoring so that we can initiate rapid cycle testing to be agile in

identifying and addressing potential impediments to our QI goals. We value the annual evaluation as an opportunity to strategically evaluate and document our progress and identify priorities and initiatives for the upcoming year.

As part of the annual evaluation, we will also assess our alignment with the Department's goals and objectives, including any emerging issues that may influence our QAPI program. For example, the QI team at our Ohio affiliate identified the opportunity to strengthen the QI team's performance. They integrated the quality analytics team, previously reporting to another department, into QI and trained the team on the Model for Improvement to align their skills with those of the QI specialists. ***As a result, the quality analytics team is now more focused on producing data analytics that drive results rather than simply producing requested reports.*** We will adopt this best practice in Kentucky.

Our QI specialists, data analytics team members, and external experts (such as CAHPS or provider satisfaction survey vendors) will collect, analyze, and report on our quality performance for the year including all performance relative to targets. The evaluation will include documentation of annual performance relative to HEDIS; Enrollee experience (CAHPS and ECHO); provider experience (satisfaction survey); network access and availability; Enrollee safety; addressing Enrollees' cultural, racial, ethnic, and linguistic needs; and PIP results. We will also evaluate HEDIS measures by Kentucky Medicaid Region, Medicaid eligibility category, race, ethnicity, gender, and age to identify disparities.

When measuring our performance for the evaluation summary, we review our QAPI program activities and detail program outcomes. During our evaluation, we:

- Review QI activity implementation during the year and identify quantifiable improvements in care and service
- Produce a trended indicator report and brief analysis of changes in trends, barriers that impact the rates, and improvement actions taken as a result of the trends and to mitigate barriers
- Identify opportunities to strengthen Enrollee safety activities
- Evaluate resources, training, scope, and content of the program and practitioner participation
- Identify limitations and barriers and make recommendations for the upcoming year, including identification of activities that will carry over into next year
- Evaluate indicators that focus on authorizations and referral patterns, clinical data for case management and care coordination, satisfaction data, and additional information
- Evaluate the overall effectiveness of the QAPI program

Our QI team then determines appropriate actions based on the results of QAPI activities. We undertake our systematic process to develop and initiate actions to improve performance. This process is used throughout Molina to support and improve procedures, systems, quality of service, cost, and health results. The process to identify actions to take includes the following steps:

- Conducting qualitative barrier analysis on the measures to identify the issue(s) and define priority areas, defining measures to monitor progress
- Developing activities and interventions aimed to address the issue(s)
- Establishing standards, performance goals, and benchmarks to assess effectiveness
- Performing ongoing analysis to monitor performance levels and sustained improvement

For example, in our Ohio affiliate's 2018 Program Evaluation, they noted those HEDIS measures that met their target of NCQA's 75th percentile and identified as an area of focus for 2019 to identify additional interventions for prioritization of identification of interventions to improve the clinical measures not yet meeting the 75th Percentile goals. That goal will be filtered down to the QAPI work groups for follow-up and continued work.

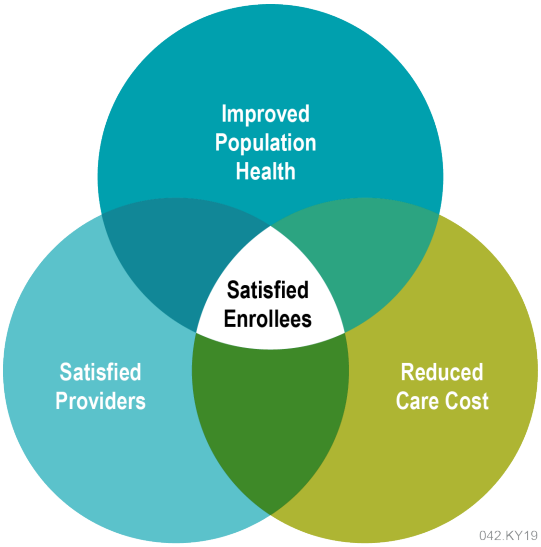
Governing Body Review and Approval

Molina's QI team will report all QAPI program activities to our Kentucky Board of Directors on a quarterly and annual basis. The QAPI Program Plan and QAPI Work Plan will be approved for the coming year. The QAPI Program Evaluation from the previous year will also be submitted to the Board of Directors for review and approval.

j. VALUE-BASED PAYMENT PROGRAM

The philosophy and strategy driving Molina's value-based payment (VBP) models for Kentucky Medicaid and for our affiliate health plans enterprise-wide are built on years of challenges, successes, and lessons learned. We believe properly aligned provider incentives can transform healthcare to a value-based care model that lowers costs, supports population health management, and improves the overall quality. Our models are designed to achieve the ***"Triple Aim" of Enrollee satisfaction, improved population health, and healthcare cost reduction, as well as provider satisfaction.***

We understand that a "one-size-fits-all" approach can often be counterproductive. As such, we emphasize "meeting providers where they are" across the continuum of services and capabilities to develop VBP arrangements that foster successful provider performance and support improved health outcomes. This approach promotes accountability through VBP arrangements that:



- Rewards providers who help meet or exceed relevant quality performance measures such as HEDIS
- Measures provider performance in evidence-based clinical quality, efficiency, and Enrollee satisfaction, and clearly assigns provider accountability for that performance
- Invests in practices that seek to expand team-based and coordinated care models such as the patient-centered medical home (PCMH)
- Recognizes contributions towards improved efficiency and outcomes to take advantage of greater risk sharing and accountable care payment models tied to quality performance
- Emphasizes collection, submission, exchange and utilization of sound analytics, standardized and vetted data, and transparency
- Closely aligns VBP targets and performance metrics with specific Medicaid program requirements, Medicaid agency priorities, and quality measurement priorities and goals
- Standardizes reporting, modeling, claims and data configuration to ensure provider success
- Leverages our dedicated Provider Engagement Team that provides comprehensive support to providers serving our Enrollees under VBP arrangements, to improve quality outcomes and promote efficiencies through implementation and support of new programs/initiatives. The Provider Engagement Team supports providers by accessing and evaluating comprehensive cost, utilization, and quality data, and identifying and proposing performance improvement opportunities and related resources
- Tracks providers' performance relative to their peers through our ***dedicated 3M Transformation Suite*** which provides comprehensive risk-adjusted claims data analysis that drives improved Enrollee care by identifying opportunities to lower resource utilization, track costs, coordinate care and reward quality improvements

j.i. LESSONS LEARNED IN DEVELOPING AND IMPLEMENTING VBP MODELS

Molina will leverage our affiliates' experience and lessons learned in VBP program development and implementation, as well as from collaboration with Medicaid agency partners and other MCO vendors in other states. The following are examples of successful collaborations between our affiliate health plans, Medicaid agencies, and other vendors with the goal of improved member outcomes and provider performance tied to effectively managed VBP programs and approaches.

Collaboration with State Medicaid Agency – Molina Healthcare of Ohio

Molina Healthcare of Ohio manages a range of VBP models across HCP-LAN Framework categories. The plan has observed that healthcare providers across the state are realizing a range of benefits and challenges in working through disparate Medicaid MCO VBP model approaches. While single provider/health plan VBP arrangements offer unique flexibility and negotiation of terms, they can sometimes lack uniformity and consistency across MCOs and providers, creating barriers to maximizing adoption, broader participation, and improved practices.

In recent years, CMS and various states (including Ohio, through State Innovation Model [SIM] grants) have worked closely to create uniform VBP programs developed in partnership with significant MCO, provider, and member advocacy stakeholder input. These various models offer some VBP program uniformity that is broadly offered across state and federal (that is, Medicare) programs to maximize provider participation.

As an example, in 2017 the Ohio Department of Medicaid launched a PCMH-based VBP model, ***Comprehensive Primary Care (CPC),*** encompassing five Medicaid MCOs and fee-for-service providers. The CPC program currently ***includes PCPs with more than 50% of all attributed Medicaid members (approximately 1.4 million) and creates a broad standardized program with adoption from multiple MCOs and covering a sizeable percentage of membership.*** It has further funded and incentivized primary care practices to a degree that true practice transformation can occur. Since launching the Ohio CPC program in 2017, the state has already experienced a lower trend in healthcare spending and higher quality performance as compared to non-participating primary care practices.

For Molina, key lessons learned have included:

- Participation and communication across stakeholders (health plan, providers, advocates) through state leadership are critical to program success
- Leveraging established VBP programs already developed helps reduce the time to develop models (for example, use as a starting point and tailor to the specific needs of the Kentucky Medicaid population overall or specific covered population)
- Aligning the VBP model (structure, practice/plan expectations, payments, cost/quality thresholds and outcomes) across as many health plans as possible (such as Kentucky Medicaid at a minimum, participation of commercial/Medicare plans would increase the adoption rate) to eliminate program inefficiencies
- Implementing VBP models which are simple, easily accessible, and include meaningful/actionable data help drive program success
- Establishing reasonable expectations, especially at the beginning, and increasing performance targets over time to achieve meaningful change and maximize providers' interest and eligibility in participating
- Best-practice sharing between practices and health plans help drive better improved Enrollee outcomes and provider performance

Collaboration with Medicaid Agency, other Vendors – Molina Healthcare of Texas

Molina Healthcare of Texas worked collaboratively with other Medicaid MCOs, the Texas Health and Human Services Commission (HHSC), the Dell Medical School, and the Episcopal Health Foundation to advance Medicaid-focused VBP methodologies. Through workgroups and discussions, information was shared about how to achieve consistent reporting for Advanced Payment Models (APMs) to accurately reflect MCO efforts across the state to improve health outcomes as well as to appreciate the level of impact the efforts had on Medicaid enrollees. Molina's affiliate also collaborated with other MCOs to continue to support providers as they move along the APM model readiness continuum.

For example, our affiliate worked with several other MCOs to structure a per member per month payment methodology and bonus withhold for achieved metrics for relocation providers. These providers help to support Molina's affiliate's members as they transition from nursing facilities back to the community. Our affiliate helped lead a stakeholder committee that included other MCOs to identify barriers and break down the work to manageable parts. This effort contributed to the statewide collection of data to demonstrate the value of relocation services. It assisted relocation contractors to strengthen financial performance and, more importantly, assisted individuals with disabilities to transition to the most integrated setting to best meet their needs.

Our affiliate also collaborates with other MCOs to improve HEDIS measures through PIPs. For example, in several areas of the state over the past year, Molina has worked to increase the HEDIS score for Weight Assessment and Counseling for Nutrition and Physical Activity for members age 3-17 in collaboration with other health plans also operating within those service areas. ***In fact, in 2018 our affiliate worked collaboratively with two other MCOs to improve A1C testing and control for STAR and STAR+PLUS members across the state.***

Collaboration with Other Vendors – Molina Healthcare of Washington

As part of its participation in the Washington State Health Care Authority's statewide Integration Managed Care program (IMC), ***Molina Healthcare of Washington and a fellow IMC program MCO were selected by Summit Pacific Medical Center to jointly create and implement a primary care-centered VBP.*** Our affiliate health plan began collaboration with Summit Pacific and the other MCO in 2016 to begin identifying common measures, including:

- HEDIS
  - Adult Access to Preventive Care/Ambulatory Services: All Enrollees
  - Adolescent Well Care Visits
  - Cervical Cancer Screening
  - Comprehensive Diabetes Care: Retinal Eye Exam
- Health Services and Resource Administration (HRSA)
  - Depression Screening and Follow Up: Age 12 and Older

The partnership included participation by senior leadership from our affiliate and the other MCO, representing Quality, Health Care Services including care/case management and disease management), Behavioral Health, Provider Contracting, and Community Engagement. These leaders met quarterly with Summit Pacific leadership to review performance data related to the above measures, share lessons learned and best practices related to Enrollee outreach and health management, identify linkages to local community benefit organizations, and discuss initiatives to best collaborate with the Summit Pacific care team.

For our affiliate, key lessons learned from this collaborative partnership have included:

- The critical need for reliable and usable quality data (and supplemental data, as needed) as well as a standardized technical approach to data collection (that is, common data sets, file formatting, etc.)
- Adherence of all quality measures to standard HEDIS reporting in a compliant data format manner; Summit Pacific had wanted to include self-reported data which was difficult track and standardize.

j.ii. RECOMMENDED GOALS AND FOCUS AREAS

Provider practices operate in significantly different ways throughout the Commonwealth in areas including practice patterns, use of evidence-based medicine, focus on key quality metrics, and outcomes. To promote consistency of care and to maximize participation, we agree with the Department's aim to identify goals and focus areas. Because Kentucky has experienced a positive trend with the dramatic 65% reduction (15% to 5.3%) in the uninsured rate in the past five years[2], provider practices and MCOs have a greater opportunity for alignment towards a VBP model.

Recommended Goals

Molina recommends that the Commonwealth ensures its VBP program and MCO participation aligns with federal programs and national accrediting bodies to minimize provider burden and maximize interest. Of note:

- Medicare has launched a PCMH model (CPC+) which has already generated participation by key northern Kentucky providers and health plans. Like the Ohio Comprehensive Primary Care program, elements of CPC+ may be considered and leveraged for the Kentucky Medicaid VBP model.
- Medicare has launched a variety of other VBPs as well, including bundled payments and the Quality Payment Program
- NCQA accredits practices across multiple levels of PCMH, and there are nearly 1,100 clinicians already recognized as PCMHs in Kentucky

In addition, we propose that the Commonwealth select a discrete group of priority metrics in both utilization and quality.

Recommended Focus Areas

We recommend the following measures as focus areas for VBP:

- **Utilization:** Preventable admissions, readmissions, and ED visits
- **Quality:** HEDIS and CAHPS rates related to Child/Adult Access to Preventive Services, immunizations, Follow-up After Hospitalization for Mental Illness, tobacco use screening and cessation, Weight Assessment and Counseling, women's health (breast and cervical cancer screening), and chronic disease management (diabetes, high blood pressure)

j.iii. PROPOSED COLLABORATION APPROACHES

Molina will be an experienced and valued collaborative partner with the Department and other MCOs to create, implement, and successfully manage the Kentucky Medicaid VBP program in compliance with requirements set forth in Attachment C., Draft Medicaid Managed Care Contract and Appendices, Section 19.9, Value-based Payment.

[2] AmericasHealthRankings*.org*

Collaboration with Department and Other MCOs

We recommend scheduling regular meetings, preferably face-to-face, with key stakeholder groups, including the Department, MCOs, and providers during VBP development. These meetings should be geared towards developing initiatives that support adoption, contribution to, and understanding of the model design. In preparing for and following implementation, scheduling frequent key operational stakeholder meetings will be valuable to raise awareness and address any operational questions or concerns that may arise.

In addition, regularly scheduled stakeholder meetings, either monthly or quarterly, will offer useful forums for sharing best practices and lessons learned, reviewing population health data/trends and priorities around which to develop potential new VBP programs, and identifying funding mechanisms to address potential shortfalls will help drive VBP progress.

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**.

MCO attendance at and participation in (as needed) in Department-sponsored forums and Technical Advisory Committee meetings will provide additional arenas to report program performance, exchange information, and introduce/develop innovations and/or pilots germane to the VBP program.

Coordinated Approach to Achieve Statewide Outcomes

Close coordination of approach and messaging by the Department and MCOs will be critical to effectively supporting practices throughout implementation of the VBP program.

Molina highly recommends a "lead MCO" approach in which participating providers have access to a single MCO point-of-contact for VBP program information and to get program questions answered, learn effective ways to collaborate with other participating providers, and more.

Following implementation, the Department and MCOs will need to support participating providers through integrated, standardized, and actionable MCO data sharing and reporting to drive practice transformation and performance improvement, opportunities, and positive evolution of the VBP program. Accurate, standardized data exchange and reporting will also drive understanding.

j.iv. ADDRESSING POTENTIAL VBP CHALLENGES SPECIFIC TO KENTUCKY

Fundamental to successful VBP collaboration will be ensuring MCOs have a deep understanding of the Department's priorities and needs in full alignment with the Commonwealth's population health needs. This shared granular knowledge will foster development of a VBP model designed to drive consistent and achievable improvements to Enrollee health outcomes and provider satisfaction.

We believe, however, there are key potential challenges specific to Kentucky that warrant consideration and close collaboration between the Department and MCOs well ahead of implementing a Kentucky Medicaid VBP model.

Potential Challenge: Data Exchange

Challenge: Compilation of timely, accurate, and standardized data across MCOs in a format useful to practices is a complex proposition.

Proposed methods to address challenge: Kentucky has been exemplary in promoting Kentucky Health Information Exchange (KHIE) connectivity, with more than 100 hospitals and approximately 2,500 ambulatory care sites currently connected to the system. Moreover, electronic health record (EHR) adoption rates in Kentucky are equally impressive, with more than 96% of hospitals adopting certified EHR and 83% of physicians adopting some form of EHR through a range of software platforms.

A key challenge for HIE systems in our other affiliate markets, such as Washington, Michigan, and Mississippi, is that participating providers often submit disparate, non-standardized quality, claims, and encounters data, negatively impacting an HIE's ability to achieve "meaningful use" and negatively impacting utilization and efficacy. The Kentucky Medicaid VBP model should be designed to drive higher provider KHIE adoption than includes submission of standardized KHIE-defined data sets. In the meantime, incenting EHR utilization for clinically integrated providers and transmission of records between providers would drive a sound short-term solution.

In addition, with development of an integrated platform through a data intermediary, MCOs should exchange clinical, social support, and claims data through a single platform accessible to providers for all enrollees tied to the VBP. In Ohio, Molina is participating with a data intermediary, The Health Collaborative, which is supporting the Medicare CPC+ and Ohio Comprehensive Primary Care programs in Ohio and northern Kentucky.

Potential Challenge: Collaboration/Coordination Among Providers

Challenge: While Molina recommends an initial VBP model wholly focused on primary care, services and healthcare needs outside of a primary care scope have significant implications on overall population health in the Commonwealth. Without the aligned purpose of other key providers, a primary care initiative will not be as successful. Moreover, PCPs may well struggle to have their VBP objectives affirmed in the broader healthcare community.

Proposed method to address challenge: Following development and implementation of a primary care VBP model, implementation of additional models, especially targeting hospital/high volume specialists and behavioral health, soon after will be highly beneficial to promoting a broader population health focus.

Potential Challenge: Rural Access

Challenge: The Commonwealth has 110 Health Provider Shortage Areas (HPSAs), including serious shortages of PCPs, dentists, and behavioral health providers per 100,000 residents.

Proposed method to address challenge: VBP models should consider initiatives and incentives (for example, telehealth participation/infrastructure development) that specifically drive improved access for Medicaid Enrollees in rural areas.

Potential Challenge: SUD/Opioid Interventions

Challenge: Kentucky has an alarming rate of opioid-related deaths, non-fatal overdoses and related ED utilization. While the drug death rate showed substantial improvement in 2018, this remains a top priority concern.

Proposed method to address challenge: Attention should focus immediately on VBP-supported interventions to increase access to medication-assisted treatment in primary care.

j.v. ANALYZING PERFORMANCE TO MODIFY INTERVENTIONS THAT ARE NOT MAKING PROGRESS

Molina takes a focused approach to analyze performance against targets using specific and detailed tools that will be provided to our providers included in the VPB program.

Our Provider Engagement Team—including provider services representatives, QI specialists, Medical Affairs, and Healthcare Services—will work with key provider offices to implement the VBP program to improve health outcomes, access, and Enrollee satisfaction based on selected program measures. This team will also work closely with these provider offices to interpret and act on quality data to improve their health.

Molina will implement the VBP program based on the approved design by the Department. The proposed program will include a variety of performance measures to improve quality and health outcomes in key priority areas for Kentucky, such as maternal and child health; management of chronic or long-term

health issues such as diabetes, asthma, obesity, and heart disease; behavioral health; and ED utilization. Potentially, other topics such as Enrollee satisfaction may be introduced into the long-term program.

Analyzing Performance Against Targets

Molina supports providers in using data to analyze performance, measure progress, and implement targeted interventions through a variety of modalities. Providers will have real-time access through our provider portal to retrieve eligibility, claims, and reports and obtain HIPAA-compliant performance monthly reports, including variance to target. This access to data and analytics in the portal enables the provider to manage financial risk and understand their monthly risk position and performance. Providers will also have access to customizable dashboards and functionality in our online Clinical CareAdvance 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.

Moreover, we leverage ***3M Transformation Suite technology*** offering powerful analytics tools that strengthen our ability to evaluate VBP effectiveness by identifying opportunities to lower resource utilization, tracking costs, improving care coordination, reporting quality metrics, and rewarding quality improvements. For more details on the 3M Suite please refer to Proposal Section C.9.k below.

Frequency of Analyses

Molina's Provider Engagement Team, including quality experts, will initiate provider scorecard development for the VBP program that will be produced monthly for provider offices. The initial scorecards will include missing services lists that show individual Enrollees who are due for key tests and exams along with aggregate rates for their offices for these key quality measures as compared to available national targets. In addition, agreed-upon improvement targets will be measured using these scorecards so providers can see where they are on an ongoing

Our Provider Engagement Team will also conduct in-person Joint Operating Committee meetings with providers to review operations, quality metrics, and education. The meetings will be monthly or quarterly depending on the VBP agreement's complexity (and HCP-LAN APM Framework category) and provider preference. We will collaboratively review utilization trend and top utilizers (which helps identify overall trend and top utilizers within the provider group), gaps in service, and pharmacy data (which helps identify top medications used by Enrollees). We will also identify the mix of chronic conditions for Enrollees and claims processing and denial trends and utilization at the Enrollee level, including top ED and inpatient utilizers.

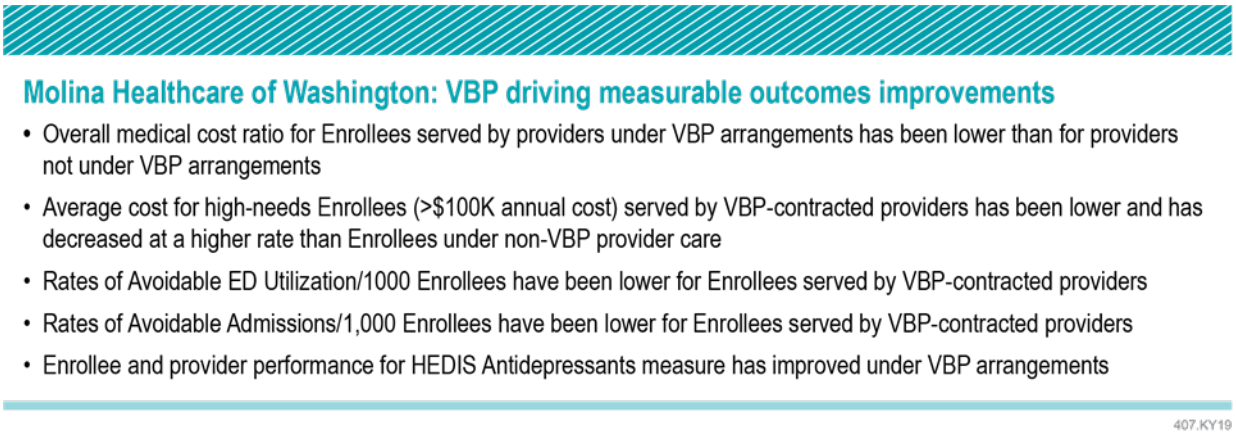
Reporting Results to DMS

Upon implementation of an agreed-upon VBP model, we will provide real-time information to the Department focused on VBP initiatives we are undertaking to achieve required targets on a monthly and quarterly basis. We will submit reports to the Department annually based on agreed-upon reporting requirements as well as provide related VBP ad hoc reports to the Department upon request.

Use of Analysis to Modify Interventions

During monthly Joint Operating Committee meetings, Molina's Provider Engagement Team and the provider office staff will review the current quality measure rates and interventions being employed by Molina and the provider. Quality and clinical experts within Molina and the provider office will jointly review ongoing rates and improvement interventions. If the rates are not improving in key areas and/or the rates are not meeting improvement targets, we will perform additional drilldown analysis at the provider levels, as needed, to determine new approaches that can be taken. Analysis will focus on demographic and other factors that may impact the rates/interventions. We will review factors such as age, sex, Enrollee residence, PCP, and race/ethnicity to identify potential factors that impact the rates. Our team will continue to use the Model of Improvement to design and implement key improvement initiatives that are based on continuous QI principles.

We will modify interventions based on this joint analysis and discussion of influencing factors. This process will continue on an ongoing basis to implement continuous QI.



k. VALUE-BASED PAYMENT TO PROVIDERS

Molina and our partner subcontractors will work collaboratively with the Department and other Kentucky Medicaid MCOs to develop and implement VBP arrangements that align provider financial incentives to high-quality, cost-efficient Enrollee care, access, and satisfaction.

Our VBP programs will be aligned to improve provider performance and satisfaction, support key Department healthcare outcomes priorities, and work synergistically with our QAPI program initiatives and quality measures for Kentucky Medicaid.

k.i. VBP ARRANGEMENTS MOLINA AND OUR SUBCONTRACTORS PLAN TO USE

As depicted in Exhibit C.9-16, ***we will offer the full spectrum of VBP arrangements and are fully prepared to enter into a range of carefully developed risk-based arrangements with willing and capable Kentucky Medicaid providers.*** These arrangements, which Molina Healthcare, Inc. also offers in its affiliates with Medicare-Medicaid Programs (MMP) for dual eligibles, will be specifically tailored to support our Kentucky Medicaid providers' varied states of readiness for VBP adoption, moving them along the VBP continuum to improved Enrollee outcomes, accountability, and potential for increased rewards based on increased levels of risk.

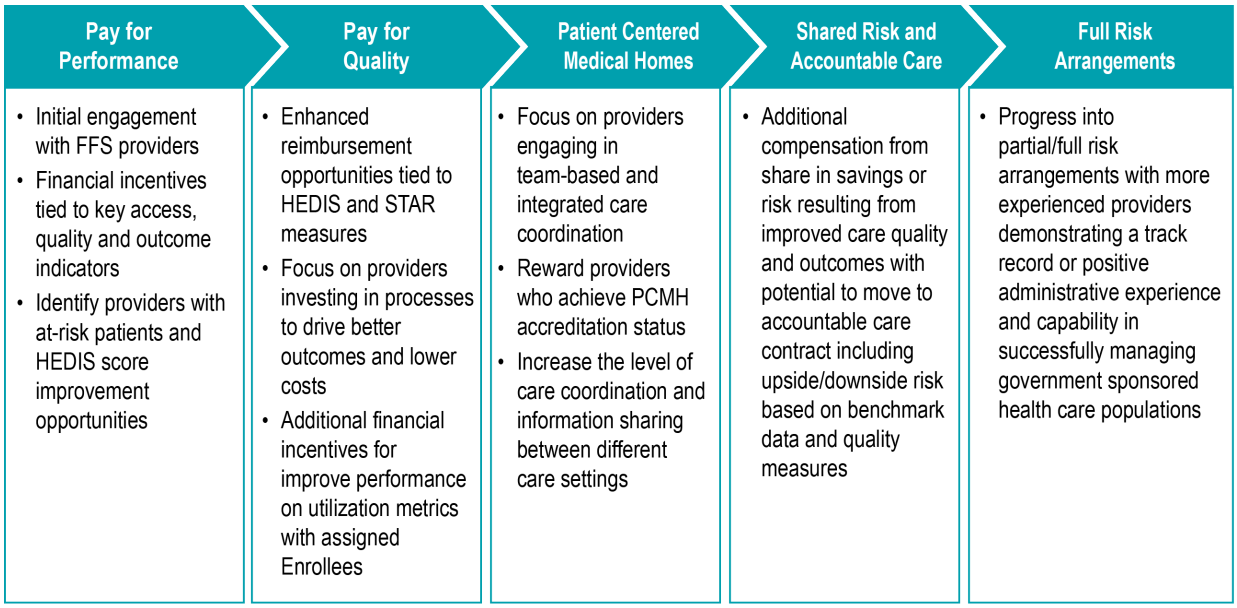


Exhibit C.9-16. Molina's VBP Continuum

We recognize that there is a 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, we tailor our VBP models to specific primary and/or specialty types, risk tolerance, and the amount of control providers have over referral patterns. Our models encompass the following elements:

Tiered Approach. Our approach is designed to initially engage providers where they are beginning within the VBP continuum. For those not currently familiar with value-based payment, Molina can work to implement basic VBP elements such as pay-for-reporting initiatives and provide ongoing supports to providers to advance toward more complex VBP arrangements. This effort begins with a prioritization assessment of each provider to determine where they fall on our VBP spectrum.

Specific Goals. Our VBP program prioritizes improving health outcomes by: (1) reducing potentially preventable admissions; (2) reducing readmissions; (3) avoiding ED visits; (4) promoting preventive care measures for Enrollees with chronic conditions; and (5) tailoring vital care and resources to an Enrollee's behavioral health needs, especially post-hospitalization follow-up and medication adherence. In close coordination with our QI department, our Kentucky Medicaid VBP contracts will be centered on select HEDIS measures that have historically underperformed in the Commonwealth, driving our mission to "move the needle" to improve overall quality and Enrollee outcomes. Moreover, we traditionally incentivize our VBP program providers to meet and exceed the HEDIS 75th percentile, and the CAHPS 75th percentile.

Continuous Development. Our approach is designed for continuous development over the life of the provider contract. For providers starting out at a basic pay-for-reporting or pay-for-quality level, our goal is to move providers into more complex contracts each contract year with the final goal of developing innovative programs that include comprehensive population-based payment arrangements. Continuous improvement will be accomplished by including VBP progress requirements in our provider contracts, developing programs that have tiered implementations and ongoing provider education on VBP.

Exhibit C.9-17 depicts the six core operational components that support and drive our VBP model development and management.

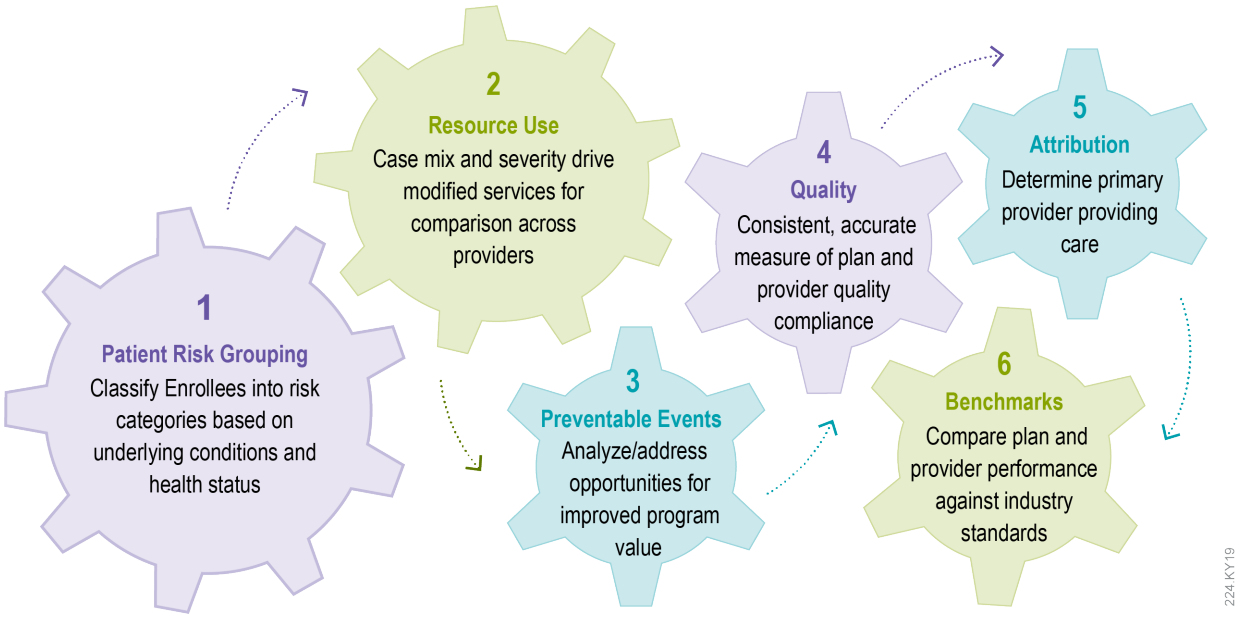


Exhibit C.9-17. VBP Core Operational Components

In accordance with Draft Contract Section 6.5, Capitation Payments, 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 includes the assumption of risk by the subcontractor or provider.

Targeted Provider Types for VBP Contracting

The following are specific VBP arrangements by provider type we intend to implement with our provider partners to promote the Department's goals for Kentucky Medicaid.

Primary and Specialty Providers

- **Pay for Performance (P4P).** Initial engagement with fee-for-service 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 will also collaborate with the Department and other vendors on P4P arrangements that may include incentivizing providers to establish KHIE connectivity and submission of standardized data sets and encourage provider adoption and use of EHRs.
- **Pay for Quality.** Enhanced reimbursement opportunities tied to relevant HEDIS measures; this model 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).** Focused on providers engaging in team-based and integrated care coordination; this model will reward providers who achieve NCQA, The 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.** Provider may earn additional compensation from a share in savings or risk resulting from improved care quality and outcomes (that is, providers paid a portion of any share in healthcare savings when financial targets are met) with potential to move to an accountable care arrangement that include upside/downside risk based on benchmark data and quality measures.

- **Partial/Full Risk Agreements.** Providers can progress into partial/full risk arrangements, (that is, a provider may 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 or positive administrative experience and capability in successfully managing government-sponsored healthcare populations.
- **Bundled/Episodes of Care (EOC) Payments.** Tailored specifically for specialty providers, this model 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 (P4P).** 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 ***P4P incentive for hospital partners to submit/utilize standardized KHIE-defined data in the KHIE system.***
- **Pay for Quality.** Enhanced reimbursement opportunities will be tied to relevant HEDIS measures. This model focuses on providers investing in processes to drive better outcomes and lower costs, and additional financial incentives will be available for improved performance on utilization metrics with assigned Enrollees.
- **Shared Risk and Accountable Care.** Additional compensation may be available from a share in savings or risk resulting from improved care quality and outcomes with potential to move to an accountable care arrangement that include upside/downside risk based on benchmark data and quality measures.

A number of our affiliate health plans currently offer these types of hospital-focused VBP arrangements, ranging from tailored P4P/Pay for Quality to shared savings/gain sharing models and could provide a viable framework for similar VBPs in Kentucky.

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 OUD crises. These models could include, but may not be limited to:

- **Pay for Performance.** Initial engagement with fee-for-service 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.** Enhanced reimbursement opportunities tied to relevant HEDIS measures; this model 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.

Behavioral Health-Focused VBP Models – Molina Healthcare of Ohio

With the state of Ohio facing many of the same behavioral health challenges as Kentucky, including alarming rates of opioid use, overdoses and related ED visits, and drug-related deaths. Our affiliate, Molina Healthcare of Ohio, has taken a leading role in developing behavioral health-focused VBP models that could be leveraged for Kentucky Medicaid, including:

- **Pay-for-Performance (P4P).** In partnership with its key community behavioral health providers, Molina of Ohio offers a P4P program rewarding these providers for members who receive a 7- and 30-day Follow-Up After Hospitalization for Mental Illness (HEDIS). This program has been successful in incentivizing behavioral 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 and under the leadership of the Ohio Department of Medicaid, Molina and other Medicaid MCOs are launching a Behavioral Health Care Coordination program focused on Enrollees with significant mental health and/or SUD diagnoses. Currently slated for go-live July 2020, ***the program creates a behavioral health-focused patient-centered medical home (PCMH)*** 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 behavioral health and medical needs 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 manner of practice, Molina systematically reviews its approach to prior authorization codes to discern the utilization, approval rates, and impact on both quality and cost. Molina regularly performs an extensive review of all codes that require prior authorization to identify those that we may be able to build into our value-based programs to relax, or in some instances, eliminate the requirements of prior authorization to remove barriers to Enrollee 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. Subsequent to 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.

Kentucky Health Information Exchange (KHIE) Connectivity/EHR Adoption

Recognizing the importance of supporting the exchange of meaningful clinical data across the continuum of care, Molina applauds the Commonwealth's successful effort to drive KHIE connectivity, with some 95% of Kentucky hospitals and their contracted 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.[3]

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

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

Molina will therefore 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 would include:

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

Common data-sharing and data set guidelines will allow the KHIE system to facilitate better communication between MCOs and providers. Better communication, better data, and better collaboration helps incentivize providers in VBP arrangements 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 EHR better positions 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 an EHR.

Molina understands EHR implementation and maintenance costs can be cost prohibitive for providers. To encourage EHR adoption, ***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.*** We will use Epic Community Connect to extend EHR systems to our network providers in Kentucky. The system promotes a community record for Molina and will offer our network providers access to an industry leading EHR system at a significantly reduced cost. Community Connect provides a cost affordable mechanism to simplify access to EHR, 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.

Our efforts in other states to promote EHR adoption and utilization have included P4P initiatives based on providers using electronic tools to manage their practices and exchanges of information. We have also designed value-based contracting methodologies that align with Medicare Access and CHIP Reauthorization Act (MACRA) and state guidelines that encourage providers to identify and resolve gaps in care, best accomplished when providers make optimal use of an EHR.

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.

Initial VBP arrangements with Key Kentucky Providers – KPCA

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

framework, incorporating clinical and provider gain share and risk share methodologies that support transparency, comparability, and innovation, drives improved outcomes, and control costs.

KPCA's network provides Kentucky Medicaid Enrollees with ***access to more than 1,000 sites across the Commonwealth, comprising more than 430 total clinic 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-up standardized Quality Incentive Measures are achieved.

Molina Subcontractors – VBP for Kentucky Medicaid

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. Avesis does not currently offer VBP programs for contracted providers in the Commonwealth. However, 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.

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

CVS Health. Our PBM, CVS Health, does not currently offer any VBP models to the Kentucky provider community, but the company does have experience managing similar value-based arrangements in other states. CVS Health 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.

March Vision Care. Our vision benefit subcontractor, March Vision, has partnered with our affiliate health plans since 2001 and currently administers vision services for D-SNP plans in the Commonwealth, which include Medicare and Medicaid-eligible Enrollees. At this time, March Vision does not offer VBP models to providers in the Commonwealth. However, 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.

Lucina Analytics. Headquartered in Louisville, Lucina Analytics is our high-risk maternity data analytics and risk assessment technology subcontractor. The company does not directly offer VBP models to providers; however, it 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.

VBP Arrangement Types by HCP-LAN APM Framework Category

Table C.9-14 outlines our proposed Kentucky Medicaid VBP programs for willing and capable provider partners, along with related health outcomes improvements and efficiency goals, as mapped to HCP-LAN APM Framework maturity levels.

Table C.9-14. VBP Programs and Goals by HCP-LAN Framework

VBP Program	HCP-LAN APM Category	Description	Outcomes and Efficiency Goals
Care Coordination Program	2A	A PMPM coordination of services fee to cover outreach and education services, coordinating referrals, tracking tests and doing patient follow-up and coordinate with our care coordination teams.	Improved Enrollee experience and quality of care through development of basic infrastructure needed for delivery of care enhancements. KPCA partnership: Meet Medicaid medical cost ratio one or all agreed-up standardized Quality Incentive Measures
PCMH Program	2A	Incentives to establish PCMH recognition or at a minimum complete five core courses of the NCQA PCMH credential.	Transformation of primary care practices into PCMHs leading to improved Enrollee quality of care, lower costs, and optimized Enrollee experiences. Provider's improved ability to move to VBP programs in APM Categories 3 and 4.
Practitioner Pay for Performance/ Pay for Quality	2C	Provides a quarterly bonus payout to providers that prioritize preventive care, screening measures, and value-driven results for our Enrollees and bonus payments to hospitals that collaborate with Molina care coordinators on discharge planning and reduce preventable/avoidable ED visits. Incentives for provider adoption of EHR and/or telehealth infrastructure development and service delivery	Achieve at least 75th percentile on selected HEDIS measures. If baseline is at or above 75th percentile, goals are set to require maintenance and improvement. Mental health providers—complete 7- and 30-day visits related to HEDIS Follow-Up After Hospitalization for Mental Illness Verified EHR utilization
Hospital Pay for Performance/ Pay for Quality	2C	Provides a quarterly bonus payout to provider groups that prioritize preventive care, screening measures, and value-driven results for our Enrollees and bonus payments to hospitals that collaborate with Molina care coordinators on discharge planning and reduce preventable/avoidable ED visits.	Maintain or improve its Hospital Safety Score that is conducted through the Leapfrog Hospital Survey during each measurement period. It is acceptable for a provider to maintain its Hospital Safety Score if its Hospital Safety Score is a "B" or better. If its Hospital Safety Score is less than a "B", the provider must improve its Hospital Safety Score. 95% of health plan Enrollees who were admitted and/or seen by the hospital were given a discharge plan and hospital cooperated with our transition of care program Have a program to identify and educate patients inappropriately using the ED
Pay for Reporting Program	2B	Bonuses for reporting clinical and quality data. Typically entered into with smaller provider practices with little to no experience with VBP.	Providers familiarize themselves with performance metrics, build internal resources to collect data, and better navigate our reporting system. Mandatory transition to Category 2C within one year at a minimum.

VBP Program	HCP-LAN APM Category	Description	Outcomes and Efficiency Goals
Shared Savings Program	3A	Share savings in medical expense targets with qualifying providers. The providers must achieve quality-of-care benchmarks to achieve shared savings. Under this model, providers are paid a FFS base rate. The total cost of care is then compared to pre-determined benchmarks to determine shared savings.	Metrics include overall medical cost ratio, reduction in inpatient days/1,000, reduction in avoidable ED visits/1,000 and reductions in readmissions/1,000. Shared savings is distributed only if all quality indicators and performance metrics are met. Special emphasis is on reducing preventable hospital stays and avoidable ED utilization.
Bundled Payment Program	3B	Bundled Based Payment program built upon the FFS reimbursement foundation with retrospective shared savings opportunities based upon the cost of care for specific procedures. This approach gives the accountable provider the opportunity to be rewarded for quality and savings relative to market benchmarks for the cost per episode. Programs typically focus on critical, high-cost procedures such as joint replacement.	Quality measures include complications during the hospital stay, re-admissions of Enrollees for post-surgery complications, and ED visits related to post-surgery complications.
Episodic Payment Program	4A	Condition Specific Population Based program approach gives the primary accountable provider for a specific procedure the opportunity to be rewarded for quality and savings relative to market average benchmarks for the cost per episode on a retrospective basis.	Maternity Episodic Payment Program: Quality metrics include but are not limited to: number of prenatal visits and screening tests, reducing rates of elective cesarean sections, reducing pre-term and early elective births, and reducing rates of newborn complications. Transplant Program: Quality metrics include but are not limited to patient/graft survival rates (1, 3 and 5 years), and surgical complication rate.
Partial / Shared / Full Risk Arrangements	4B	Partial/Shared/Full Risk Arrangements include capitated or population-based for the patient's total cost of care.	Payout based on achieved MLR/quality targets; we pay a monthly capitation as well as an annual incentive based on demonstrated MLR performance metrics. Metrics include but not limited to HEDIS measures as well as Enrollee satisfaction.

k.ii. ADDRESSING HEALTH OUTCOMES IMPROVEMENT THROUGH VBP ARRANGEMENTS IMPLEMENTED

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

To track and address health outcomes improvements for Kentucky Medicaid Enrollees, our VBP strategy thus considers 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 PIPs, special initiatives, and quality measures
- Proposed Enrollee incentives
- VBP model designs tailored to support specific provider types

Table C.9-15 below depicts our select quality measures supporting our VBP and Enrollee ***incentive programs***.

Table C.9-15. VBP and Enrollee Incentive Quality Measures

DMS Priority Area	VBP Measure	Enrollee Incentive/Measure
Colorectal Cancer (Model Contract priority for PIPs)	Colorectal Cancer Screening (COL)	
Cervical Cancer Screening (Model Contract priority for PIPs)		Cervical Cancer Screening (CCS)
Obesity (Department for 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 • WW Weight Watchers Program
Diabetes (Model Contract priority for PIPs)	• Comprehensive Diabetes Care – Eye Exam • Comprehensive Diabetes Care – HcA1c testing	• Comprehensive Diabetes Care – Eye exam (retinal) • Comprehensive Diabetes Care – HcA1c testing
Diabetes Medication Adherence (Department priority)	Statin Therapy for Patients with Diabetes (SPD) – statin adherence 80%	
Tobacco use cessation/prevention – adolescents (Department for Public Health priority)	Adolescent Well Care (AWC)	
Behavioral Health (Model Contract priority for PIPs)	• Follow-Up After Hospitalization for Mental Illness (FUH) – 7-day follow-up • Antidepressant Medication Management (AMM) – effective acute phase and effective continuation phase treatment	PCP Follow-Up within 7 days after inpatient hospitalization or behavioral health stay

To align with the Department's desired VBP model, we identify specific performance measurement methodologies that provide the most meaningful measure of healthcare delivery performance. For example, our VBP models that are enterprise-wide focus on, among other measures, improving health outcomes by:

- Avoiding potentially preventable admissions, readmissions, and ED visits
- Emphasizing preventive care measures for Enrollees with chronic conditions
- Supporting maternal and child 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.

Exhibit C.9-18 provides an example of how our affiliate in Ohio VBP program led to improved outcomes.

Molina Healthcare of Illinois' Quality Incentive Program (QIP) VBP program includes 13 HEDIS quality measures chosen to align with the state's existing P4P program. In 2018, providers participating in the QIP helped drive outcomes improvements in the following key measures:

↑ Adults' Access to Preventive/Ambulatory Health (AAP)	improved by 3.5 percentage points and 5.3% improvement year over year (YOY)
↓ Ambulatory Care – ED visits (AMB)	decreased by 3.8 visits per 1000 member months and 5.6% improvement YOY
↑ Comprehensive Diabetes Care – HbA1c Good Control <7%	improved by 1.8 percentage points and 21.6% improvement YOY
↑ Timeliness of Prenatal Care	improved by 2.9 percentage points and 3.5% improvement YOY

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Exhibit C.9-18. Improving Preventive Care through VBP

k.iii. METHODS FOR EVALUATING THE EFFECTIVENESS OF VBP

A valuable lesson in our journey from volume to value has been recognizing the need to harness the power of data in our VBP contract arrangements. This is critical to evaluating VBP efficacy which, in turn, helps us successfully and effectively manage the care of Enrollees and advance population health across all our affiliate health plans. Recent successes with improved data sharing include:

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

We ***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.9-16 depicts ways the 3M Transformation Suite allows Molina to enhance provider and stakeholder engagement and, in turn, improve cost and quality outcomes tied to value-based payment.

Table C.9-16. 3M Transformation Suite Features

3M Transformation Suite VBP Design and Analytics Competencies
• Leverages proprietary groupers that include potentially preventable readmissions, population-focused preventable, and potentially preventable events • Features analytics tools that accurately capture relevant utilization datasets (e.g., complications, readmissions, admissions, ED visits, ambulatory services) • Provides detailed and expert analysis of risk-adjusted claims data, starting with analysis of Molina's current VBP arrangements, to set a meaningful baseline and comparison among populations; • Uses 3M proprietary methodology combined with Molina's 35+ 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 plan of action to make improvements • Identifies Enrollees at high risk as well as identifying Enrollees who exhibit early signs of being at a substantial risk of emerging as persistently high needs, projecting utilization and setting equitable (risk-adjusted) VBP goals and incentives • Provides detailed and expert analysis of risk-adjusted claims data, starting with analysis of Molina's current VBP arrangements, to set a meaningful baseline and comparison among populations

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 reduce 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 that clinicians and other health professionals can understand and act on information

By applying 3M's methodology, we are shifting from a traditional strategy that typically only reviewed the top 1% of high cost Enrollees (or "spenders") or simply focused on specific diseases or events (e.g., hospital admits, surgery, ER visits). With the 3M Suite, we can now target Enrollees who are consistently ranked in the top 25% of all spenders relative to persistent high-needs eligible Enrollees, consider all chronic conditions, and analyze and predict high cost or utilization over time.

The 3M Suite screenshots depicted in Exhibit C.9-19below show intervention opportunities pursued by our affiliate health plan in Florida, in which 280 members have been identified as persistent high needs (PHN) with $2.6 million in potential cost savings stemming from potentially preventable events (PPEs).

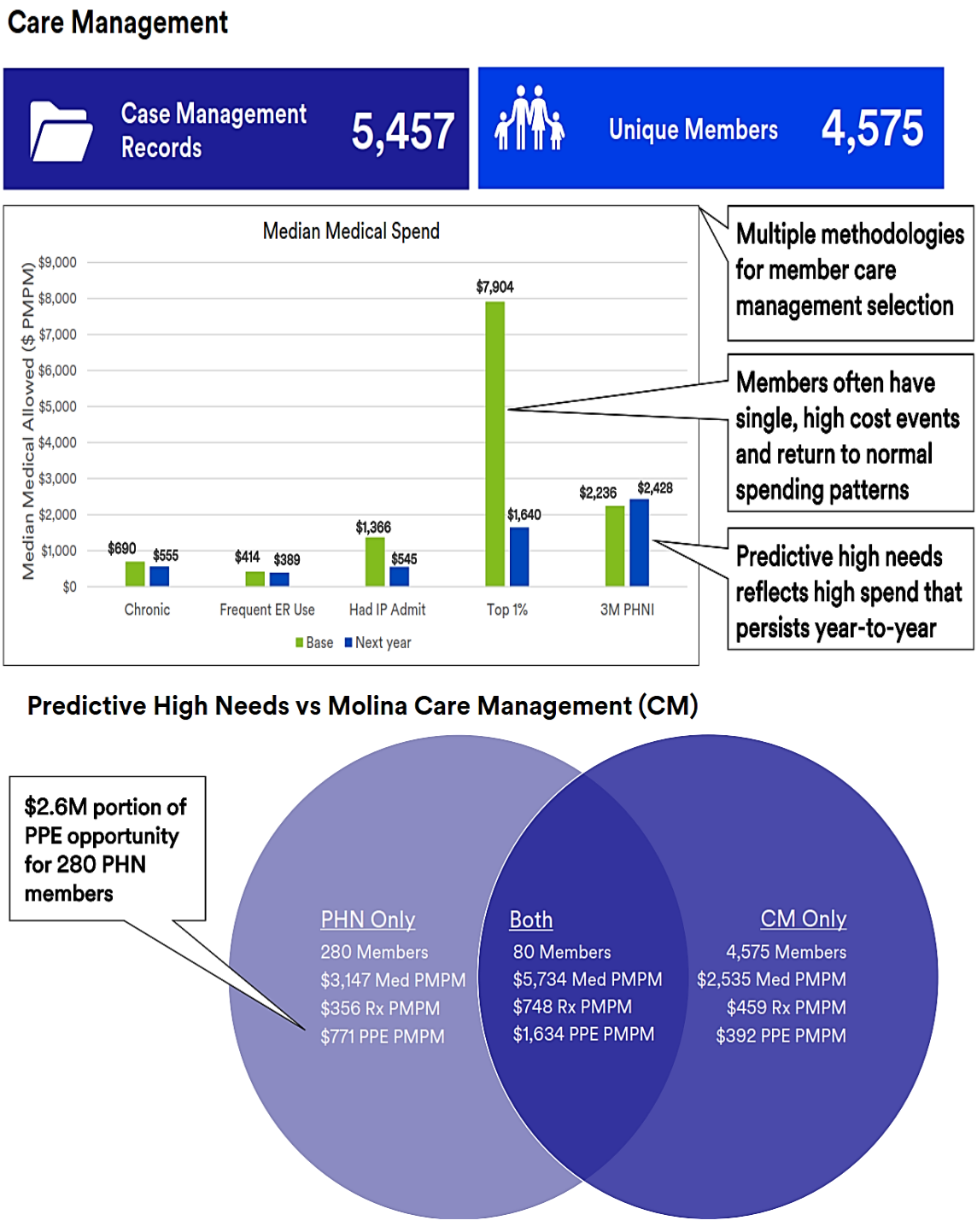

Exhibit C.9-19. 3M Platform Targeted Intervention Opportunities

The two screenshots depicted in Exhibit C.9-20 illustrate examples of 3M Suite analysis of patient-focused episodes (PFE) for profiling or payment to motivate behavioral change that leads to lower costs, better care coordination, and better quality. The stratification of the risk helps identify the underlying burden of illnesses and provides a meaningful basis for evaluating care delivery and the associated financial impact of post-acute care practice patterns.

- Example: A knee replacement episode comprises the inpatient stay, the 7 days prior and the 30 days afterward
- Average payment during the episode is $25,671 when the patient's baseline health status is single chronic but $30,219 when it is multiple chronic

	Single Chronic	Multiple Chronic
3022 - Knee Replacement		
Average Allowed	$25,671	$30,219
PPR Rate	0.8%	5.3%
3011 - Hip Replacement		
Average Allowed	$24,776	$31,226
PPR Rate	1.2%	13.6%

- Example: Depression is captured as an EDC based on diagnosis coding through 365 days of claims history
- Average payment during the episode is $3,103 when the patient's baseline health status is single chronic but $6,434 when it is multiple chronic

	Single Chronic	Multiple Chronic
7550 - Depression		
Average Allowed	$3,103	$6,434
7520 – Major Depression		
Average Allowed	$5,236	$9,798

Exhibit C.9-20. Analysis of Patient-Focused Episodes

Finally, the two screenshots depicted in Exhibits C.9-21 and C.9-22 illustrate the 3M Suite's ability to identify the key drivers of the total cost of care for targeted provider groups. This capability helps identify those provider groups where price is largely driving above-risk-adjusted expected medical costs (groups 2, 4, and 12 depicted below) and higher inpatient utilization driving above expected for group 5.

Combining cost, utilization, and quality performance detail at the Enrollee and PCP level, we can monitor and reward provider quality with emphasis on potentially preventable event (PPE) reductions, and/or supplement or enhance an existing program's ER measure with 3M's potentially preventable criteria, including Potentially Preventable Admissions (PPA) and Potentially Preventable ER Visits (PPV).

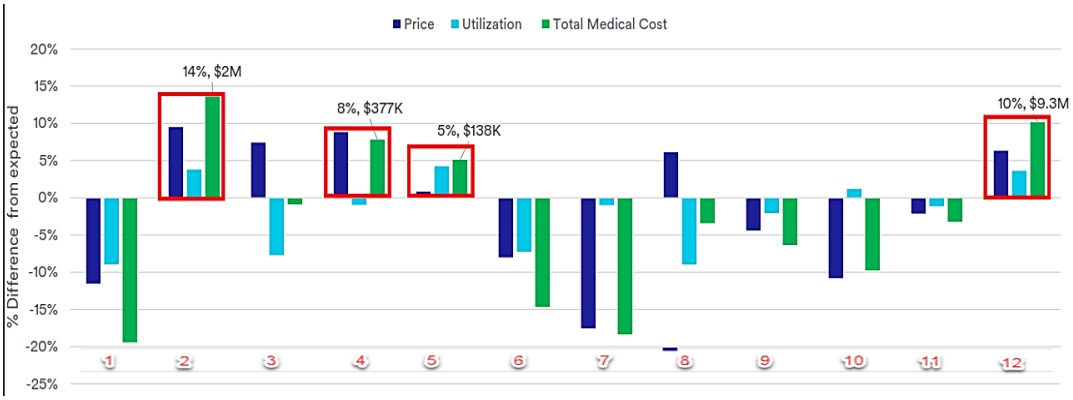

Exhibit C.9-21. Total Cost of Care Analysis

Members	Total Cost of Care	Utilization	Quality (3M VIS)	Measure Scores		
				Tertiary Prevention (PPA/PPV)	PPA	PPV
10,288			2.91	2.69	3.36	2.16
8,457			2.88	2.27	3.09	1.66
3,668		IP	2.44	1.21	1.64	0.90
2,226			N/A	N/A	N/A	N/A
1,411		IP	2.98	2.58	3.29	2.03
1,287			2.16	1.05	1.53	0.73
1,272		OP	3.80	3.05	4.39	2.12
1,209			2.82	2.11	2.83	1.58
1,143			2.48	1.70	2.42	1.20
1,139			2.56	1.08	1.21	0.96

Tertiary domain has the most opportunity for improvement among selected physician groups.

All groups scored under 2.5 in the PPV measure – recommend tracking and working with PCPs to improve PPV scores.

Exhibit C.9-22. Total Cost of Care Analysis

With our successful onboarding of 3M's proprietary methodologies, we can provide smarter VBP goals and incentives that align with Kentucky Medicaid Program and Department population health goals, as well as provider needs and care objectives. We will also share robust data with our providers via our secure Provider Portal, allowing access to dashboards and actionable reports for greater transparency.

I. PROVIDER SATISFACTION SURVEY RESULTS

Building collaborative relationships with providers enhances provider satisfaction and boosts Enrollee outcomes. Molina is proud of our affiliates' long-term success promoting positive provider relationships, and we welcome the opportunity to achieve similar strong results in Kentucky. We have already held two focus groups with Kentucky providers (in Louisville and Pikeville/Auxier) to gather insight into their perceptions of the current Medicaid managed care landscape and to ascertain how we can cultivate strong relationships from the outset. We carefully listened to our focus group participants and will implement solutions to relieve their perceived MCO issues, as described below. Our commitment to excellent service and collaboration promotes provider retention, network stability, and continuity of care for Enrollees.

In addition to provider satisfaction surveys, Molina's QAPI program will monitor performance metrics on activities that generally contribute to provider satisfaction, such as claims payment timeliness and accuracy, credentialing timeliness, prior authorization denials, grievances and appeals, and prior authorization timeliness. Focus group feedback confirms these as the most significant impediments to Kentucky provider satisfaction with MCOs. We also will monitor feedback received from providers who terminate their network contract to identify and address any emerging trends as part of our QAPI program.

PROVIDER SATISFACTION SURVEY RESULTS

Our affiliates conduct annual provider satisfaction surveys, and we will implement similar protocols in Kentucky. Table C.9-15 summarizes provider satisfaction survey results from our Ohio affiliate health plan over the last three years. By applying a series of solutions described below, we achieved more than 11% improvement between 2016 and 2018 across the indicators that are most reflective of provider satisfaction with Molina. Additionally, in our Michigan affiliate health plan, we saw a 10% gain from 2016 to 2017, with 84.3% willing to recommend Molina to other physicians. As we also describe below, we continue to implement solutions to continue the trend of rising provider satisfaction.

Table C.9-17. Demonstrating Strong Provider Satisfaction in our Ohio Affiliate Health Plan

Year	Recommend Molina to Other Patients	Overall Satisfaction with Molina
2016	74.4%	73.7%
2017	76.4%	72.9%
2018	88.7% **19% gain over 2016**	81.9% **11% gain over 2016**

In a 2018 Provider Survey, performed by an external CMS-certified vendor, 90% of providers expressed their satisfaction with one of our affiliate health plans by indicating they would recommend us to other providers.

IMPROVING PROVIDER SATISFACTION

Molina is committed to optimizing provider satisfaction. Across Molina affiliate plans, provider satisfaction survey results in 2016 were below targets. Nationally, Molina undertook an initiative to evaluate the data and explore opportunities to enhance satisfaction levels at every affiliate. After a careful analysis of the root causes of dissatisfaction, the team recommended operational changes such as the following:

Our Illinois affiliate led efforts to establish a single standardized application for all nine Medicaid MCOs. Launched in June 2018, **the Universal Roster cut in half the time to load data into the provider database**, resulting in high levels of provider satisfaction and a reduction in billing errors.

- **Initiated Provider Engagement Team visits** to provider offices to strengthen provider education, increase provider contracting support, enhance provider training on resources available through the provider portal, and offer personal assistance with claims or authorization issues
- **Enhanced provider Call Center operations** to reduce the number of calls requiring transfer, boost first call resolution, limit use of Interactive Voice Response technology (as providers preferred talking with a representative)
- **Updated our provider and encounter data management processes** to better confirm Enrollee and provider information matches to reduce the need for claim edits, enhanced provider data handling (including provider data loads received from the state), expanded staff cross-training, and strengthened encounter data processes to increase process automation
- **Automated appeals and grievances processes** to expedite processing, enhance reporting and analytics to more precisely identify and address the top reasons for grievances and appeal, and implement staff communication practices to foster consistency and timeliness

Improving Provider Satisfaction

Molina Healthcare of Illinois has established a pattern of **proactive provider engagement.** Over the past two years our sister health plan in Illinois has seen significant improvement in provider satisfaction. Health plan leadership listened to providers concerns and implemented several large scale operational changes.

As a result of our actions we have seen the following improvements in provider satisfaction scores from 2016 to 2018:

- % of providers who would refer patients to Molina increased by ↑ 35%
- % of providers who recommend Molina to other physicians increased by ↑ 40%
- Overall Satisfaction increased by ↑ 43%

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EXAMPLES OF EFFECTIVE STRATEGIES

Between 2016 and 2018, after implementation of the above described enhancements to our provider services strategy, our Ohio health plan experienced a ***72% increase in Overall Satisfaction with Utilization/Case Management and a 49% rise in Overall Satisfaction with Claims/Billing***. Molina will adopt these best practices in Kentucky to encourage strong provider satisfaction and engagement.

A COMMITMENT TO COLLABORATIVE RELATIONSHIPS

In Kentucky, Medicaid providers in our focus groups indicated that their greatest sources of dissatisfaction with the current Medicaid MCOs are lengthy credentialing processes, peer reviews for prior authorizations, and poor claims performance. Providers in Pikeville/Auxier also cited poor customer service. As detailed in those sections of our proposal, Molina proposes alternatives to improve providers' perceptions of MCOs. For example, our Louisville-based Provider Services call center means providers will talk with provider service representatives who know Kentucky and its diverse communities and cultures. In addition, our community-based Provider Services representatives and Provider Engagement Teams will extend the reach of our regional QI specialists by working in the community with providers to help them boost quality scores to earn incentives.

As our affiliates do in other states, Molina will implement a strong foundation on which to foster superior provider satisfaction rates. Our initiatives include the following strategies:

- **QI performance monitoring of key provider metrics.** Charged with monitoring provider satisfaction rates as well as those metrics that drive satisfaction and sharing ideas for boosting results, our QI specialists will identify the root causes of any provider dissatisfaction and implement solutions to improve performance.
- **High quality provider services.** Identified as a key concern for Kentucky Medicaid providers who participated in our focus groups, Molina aims to develop personal relationships and emphasize strong provider services, both in person and through our Louisville-based Provider Services call center. Provider Services representatives will meet with our participating providers on a regular basis face-to-face, which allows them to discuss and address any questions, concerns, or issues. This personal approach is one that was strongly endorsed by our focus groups. For large provider groups and health systems, we will conduct monthly Joint Operating Committee meetings where they solicit feedback about any operational, claims, or utilization management challenges. Representatives will respond to provider inquiries with a final resolution or timeline for resolution in two business days or less and report issues and trends to our QI team.
- **Opportunities for Ongoing Feedback.** We will institute monthly "It Matters to Molina" Provider Forums, conducted via WebEx, in which we invite Kentucky providers and their staff to talk with provider services staff about their questions, concerns, or recommendations to improve service. A

cross-functional group follows formal processes to review all provider feedback received through this initiative, reporting results and actions to the QIC.

- **Strong Administrative Support.** We will continually strive to minimize the administrative burden on our providers. For example, in 2019 our affiliate health plans ***nationwide processed and paid an average 98.68% of claims within 30 days*** of receipt.
- **Integration of quality improvement efforts.** Molina will foster collaboration with providers on all quality improvement initiatives. Rather than approaching them multiple times with unrelated quality improvement initiatives (such as HEDIS or EPSDT Gaps in Care), we work with providers to improve quality scores through one strategic initiative, easing their administrative burden.
- **Strong voice of providers in plan operations.** We will also invite feedback from providers through quarterly meetings of our Provider Advisory Workgroup. These meetings provide a forum for open dialogue on issues related to the relationships and interactions between, and among, providers and our staff as well as solicit provider input and suggestions. The Provider Advisory Workgroup will be facilitated by provider services representatives and comprised network providers. We will identify and escalate potential opportunities for performance improvement to the QI team.
- **Ongoing requests for feedback.** Our Provider Outreach Program includes a postage-paid card that representatives make available at provider offices, meetings, seminars and association meetings to obtain feedback from providers on how we can enhance the provider's experience. We have implemented several improvements based on the feedback received from providers in our other health plans, including enhancements to our provider Web portal and eligibility documents.

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