

C.10 Utilization Management

REQUIREMENT: RFP Section 60.7.C.10

10. Utilization Management (Section 20.0 Utilization Management)

- a. Describe strategies the Vendor will implement to identify and reduce inappropriate utilization of services, including emergency departments. Address the following at a minimum:
 - i. Proposed approach to using data to inform the Vendor's efforts to improve appropriate use of service and cost efficiencies, as well as to identify potential Fraud and Abuse referrals.
 - ii. Overview of the Vendor's methods for monitoring appropriate health care utilization, including two examples of identified negative trends, initiatives undertaken to improve them, and the results of these initiatives.
 - iii. Frequency in which the Vendor proposes to re-evaluate its approaches to identify need for adjustments (e.g., re-evaluation of existing prior authorization requirement for appropriateness)?
- b. Describe the Vendor's proposed Utilization Management (UM) Program, assuring that it addresses requirements of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices." In the description, include information about the following, at a minimum:
 - i. Approach to align the UM Program with the Department's required clinical coverage policies.
 - ii. Proposed evidence-based decision support tool(s).
 - iii. Innovations and automation the Vendor will implement, for example, to reduce provider administrative burden under the UM Program.
 - iv. Methods and approach to balance timely access to care for Enrollees with the administration of the UM Program.
 - v. Approach to integrate medical and behavioral health services in the UM program.
 - vi. Approach to ensure UM Program is compliant with mental health parity.
 - vii. Approach to ensuring accountability for developing, implementing, and monitoring compliance with Utilization policies and procedures and consistent application of criteria by individual clinical reviewers.
 - viii. Processes and resources used to develop and regularly review Utilization Review (UR) criteria.
 - ix. Prior Authorization processes for Members requiring services from non-participating providers or expedited Prior Authorization, including methods for assuring services are not arbitrarily or inappropriately denied or reduced in amount, duration, or scope.
- x. How the Vendor will use its Utilization Management Committee to support Utilization Management activities.

Molina's approach to utilization management (UM) is founded on our belief that UM strategies and processes should ensure that Enrollees receive the right care, in the right location, and at the right time. Our approach will ensure a partnership between Enrollee, provider, and Molina to create a seamless, holistic, and efficient UM process that makes the best use of the Commonwealth's healthcare dollar.

As presented during a Medicaid MCO Provider Forum presentation, "Quality Strategy – It Is All in the Numbers," the Department's goals are to:

- Reduce substance use disorder (SUD) and improve behavioral health outcomes.
- Reduce chronic diseases by promoting evidence-based treatment that improves outcomes.
- Increase preventive services to improve population health.
- Promote access to high-quality care and reduce unnecessary and wasteful spending.
- Maintain timely access to high-quality, equitable care.

Based on the Department's draft Medicaid Quality Strategy, submitted to CMS in August 2019, Molina understands that, "the current healthcare system does not consistently achieve the outcomes Kentuckians expect for its expenditures." To address the Commonwealth's rising healthcare costs *and* improve health outcome, selected MCOs must implement effective UM strategies that improve Enrollee health outcomes while managing costs. Our approach to UM does exactly that: ***Molina delivers Medicaid benefits through a managed delivery system that is organized to manage quality outcomes, utilization, and costs.***

a. IDENTIFYING AND REDUCING INAPPROPRIATE UTILIZATION OF SERVICES

At Molina, facilitating exceptional care for Enrollees covered by government contracts like the Kentucky MCO Medicaid program is our only business, not just a line of business. ***As such, we understand our role as stewards of public resources, helping to ensure program viability for future generations.***

We developed our UM strategies to assure that high-quality care is delivered in the most appropriate setting, from the most appropriate provider, across the continuum of care. Molina uses nationally recognized, evidence-based criteria to guide clinical decision making. We collaborate with our provider network and community partners using this evidence base to ensure appropriate utilization of services.

We know that there is not a single approach to ensure comprehensive detection, monitoring, and evaluation of under- or overutilization, inappropriate utilization, and potential fraud, waste, and abuse (FWA) of services. We harness a combination of processes anchored by a plethora of data to achieve an effective UM program. For example, our affiliated health plans capture, trend, and present analyzed data weekly using a “flash report” to assess utilization data (e.g., data such as top services by utilization, select procedures, average length of stay, cost, and referral patterns). We will bring this Molina best practice to the Kentucky Medicaid program. Using the information in the flash reports combined with information about gaps in care, outputs from our predictive tools, and information about community needs, we will assess opportunities to improve outcomes for the Enrollees we serve and proactively and rigorously monitor utilization patterns and trends.

UM integration occurs across our spectrum of care—meaning Enrollees benefit from our in-house integration of physical health and behavioral health UM decisions and processes. For the Kentucky Medicaid program, Molina will implement the following UM strategies to identify and reduce inappropriate utilization of services, including emergency department (ED) use:

Integration of UM with Care Management to Support Enrollee Health. Our in-house physical and behavioral health care management program enables us to provide fully integrated behavioral health, physical health, and social support services effectively for individualized, optimal care that responds to changes in the Enrollees’ conditions. For example, Enrollees who have comorbid conditions—or co-occurring behavioral and physical health conditions—benefit from our integrated approach because we assess behavioral and physical health needs as well as social needs, like housing, which may be a barrier to getting care or preventing readmission.

Additionally, our UM team works closely with our care management team to ensure Enrollees receive the services and supports they need when moving care settings or when complexity of care and services are identified. ***A high-touch, Enrollee-centric care environment supports better health outcomes and reduces the need for institutional care.***

Depending on our Enrollee’s health needs and identified risk, our care managers may have frequent, direct telephonic or face-to-face interactions with Enrollees and/or their caregivers. In addition to conducting face-to-face visits, care managers also consult and collaborate with Enrollees within the multidisciplinary team to address the needs of the whole person and identify and address drivers for hospitalization and avoidable ED visits. This includes knowledge deficit, access to healthcare, lack of formal and informal support, access to social support services, advanced care planning, and disease progression.

Integration of UM to Address Social Determinants of Health. We understand Kentucky has one of the nation’s highest rates of poor health outcomes. We recognize that social determinants, such as housing and food, significantly affect Enrollee health, particularly when discharged from an inpatient stay. During

Holistic, Integrated Services and Care Management

The goal of our UM strategies is to ensure Enrollees receive high-quality, holistic, integrated services and care management in the right amount, at the right time, and in the right setting.

discharge planning, Molina works with an Enrollee, caregivers, providers, and the facility's staff to ensure there is a clear and documented plan to address the Enrollee's social needs before discharge. Discharge planning that considers Enrollees' social needs helps ensure they continue to recover and adhere to medication schedules—and reduces the likelihood of readmission.

Molina Community Health Workers, whom we will hire from local Kentucky communities they will serve, will engage Enrollees in addressing social needs, such as housing, food, clothing, and transportation, and help schedule appointments and identify resources for financial needs. Community Health Workers observe first-hand any issues that may contribute to avoidable ED visits and hospitalizations and increased utilization. For example, when we identify an Enrollee as a high utilizer of services (e.g., high rate of ED visits), we will deploy a Molina Community Health Worker to locate and engage the Enrollee, identify health and social concerns, inquire what resources can help him/her, and inform the Enrollee on urgent care, telehealth, behavioral health hotline, and nurse advice line options. Molina Community Health Workers also work with care managers to ensure Enrollees connect with their primary care provider (PCP) to prevent Enrollees from using the ED as the primary or only source of healthcare.

For Kentucky Medicaid, Molina will also offer a Housing Assistance Program to include ***four dedicated housing specialists who will work with Enrollees who are homeless or at risk of losing shelter.***

Individuals who are homeless or at risk of losing permanent housing often have increased rates of ED visits and hospitalizations and poor continuity of care. Housing specialists will assess needs and help Enrollees access appropriate supportive housing, identify funding assistance, and ultimately move towards self-sufficiency. Our Kentucky housing specialists will have expertise in working with individuals with behavioral health diagnoses to find specialized housing and financial assistance.

Molina has also partnered with and donated \$525,000 to leading community-based organizations (CBOs), such as Audubon Area Community Services, Kentucky Heartland Food Bank, Family Scholar House, Goodwill Industries of Kentucky, and United Way of Northeast Kentucky, that help Enrollees with social supports such as food insecurity, self-empowerment, and housing. In addition, we will establish a ***Molina Community Innovation Fund in Kentucky to provide \$625,000 in contributions per year for the initial four-year contract term (up to \$2.5 million) to CBOs that serve the community and social needs of Kentucky Medicaid Enrollees.***

Integrating UM and Quality for Targeted Intervention and Better Outcomes. We monitor Enrollee utilization across all settings based on quality standards and performance measures, using a multistep approach and leveraging available utilization data. In addition to healthcare services data, we review all HEDIS measures to identify which ones fall into the 10th or 90th NCQA national percentile to determine if there was potential over- and/or underutilization. Our Kentucky-based Healthcare Services Committee, co-chaired by our Kentucky medical director and vice president of quality, will:

- Review data reported on outcomes and trend studies and recommend additional studies and/or changes in data collection
- Monitor under/over utilization by select diagnosis and practice type
- Evaluate Enrollee and provider satisfaction
- Make recommendations to improve relationships with Enrollees and community providers
- Monitor inter-rater reliability for each clinical review group annually
- Monitor compliance with regulatory requirements and accreditation bodies
- Review utilization information from delegated vendors, if applicable

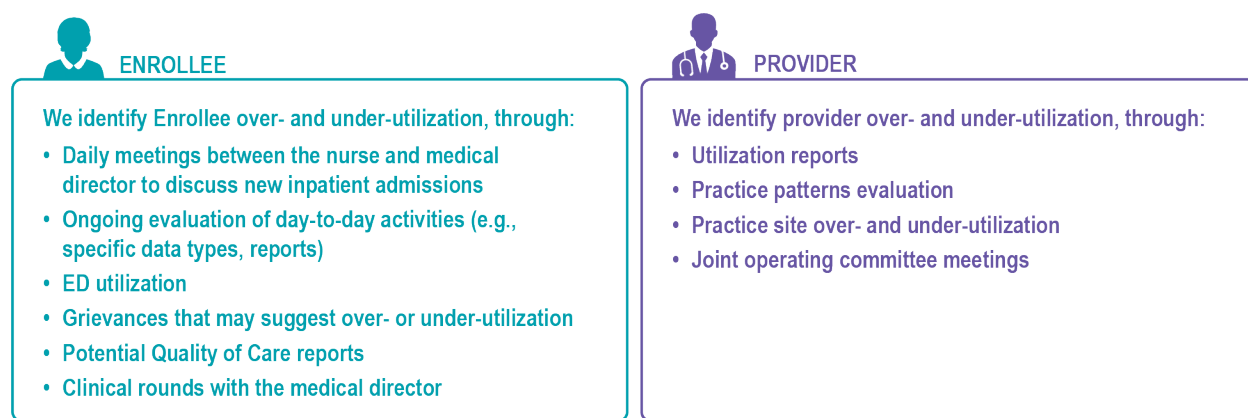
Our Healthcare Services Committee recommends interventions when trends are identified and monitors the efficacy of interventions taken. They review and approve all UM standards, including third-party based authorization criteria, clinical guidelines, and programs to ensure our accountability for developing, implementing, and monitoring compliance with utilization policies and procedures.

To achieve sustained quality improvements across Kentucky, we will rely on the active engagement of our Quality Improvement Committee, which will bring together a collaborative, multidisciplinary team to plan and evaluate our quality improvement efforts. We will submit any recommended modifications to our Kentucky UM processes or criteria to the Quality Improvement Committee for review and approval.

Streamlining UM to Support Kentucky Providers. Efficient UM practices drive effective cost control and minimize administrative burden associated with obtaining prior authorizations. Through partnerships with providers, other MCOs, and the Department, we will work to reduce provider administrative burden pertaining to service authorizations. For example, we do not require prior authorization for behavioral health assessments, outpatient visits (with no caps on office visits), medication assisted treatment, opioid treatment programs, or long-acting injectable antipsychotic medications, buprenorphine-naloxone, naltrexone, naloxone (Narcan), and acamprosate.

Enrollees' PCPs support us in bringing all care elements together to facilitate interaction between the Enrollee and healthcare system. Our quality improvement and UM teams collaborate to monitor utilization patterns across practices and provider sites, including PCPs and high-volume specialists, for potential quality issues related to over- or underutilization.

In addition to monitoring HEDIS performance measure reports, Exhibit C.10-1 illustrates how we identify potential over- or underutilization patterns through the whole-person care of our Enrollees and relationships with our providers.



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Exhibit C.10-1. Methods to Identify Enrollee and Provider Over- or Underutilization

Additionally, our *telehealth network provides new access points to bridge gaps in accessibility and availability, especially in rural areas*. Through our parent company, we leverage our national service provider, Teladoc, to provide a robust telemedicine program of Kentucky-licensed providers for both physical health and behavioral health needs of Enrollees that integrates best practices and adheres to URAC and American Telemedicine Association guidelines. By integrating telehealth into our service offering, Enrollees have another convenient, accessible choice over using the ED.

a.i. USING DATA TO INFORM AND IMPROVE APPROPRIATE UTILIZATION USE OF SERVICE AND COST EFFICIENCIES

As dedicated stewards of public funds, Molina's goal is to optimize the allocation of funds to achieve the best clinical outcomes for Enrollees by using data effectively from departments across our organization and data supplied by our network providers and subcontractors.

We emphasize appropriate utilization in the least restrictive setting necessary to provide safe, cost-effective services. Molina performs stringent analyses of medical utilization trends by area of healthcare service, including inpatient, outpatient, professional, pharmacy, therapies, and durable medical equipment (DME) to identify and address over- and underutilization of services. We developed our standard UM

reports based on our clinical practice guidelines (CPGs) and will use them to perform analysis and gain insight to address trends in over- and underutilization for the Kentucky Medicaid program. Because our standard UM reports are flexible, we can customize them to ensure we are monitoring what the Kentucky Medicaid program needs (e.g., behavioral health inpatient stays and outpatient utilization trends by county, by age, and by provider type). Frequent collaboration between our analytic, medical, and UM functions is key to leveraging reports and subsequently translating the information into action.

To ensure the most up-to-date, accurate information is available for analysis in the most intuitive, comprehensive manner, we leverage best-in-class partnerships for advanced systems and reporting capabilities. We describe these systems and support software in more detail below.

Advanced Data Systems and Reporting

Molina's integrated platform for UM, care management, pharmacy, and care access and monitoring aggregates and organizes data from disparate sources into a single integrated platform.

Our web-based workflow management system, illustrated in Exhibit C.10-2, is one of the primary tools we use to monitor utilization, support prior authorization, perform concurrent review, and inform care management, pharmacy, and behavioral health activities. The system integrates with clinical guidelines and our core claims engine (for eligibility information) and has configurable escalation rules, a user access management function, and comprehensive search functions.

Care Management. Our robust care management application, Clinical Care Advance, integrates all systems related to care coordination, care management, disease management, claims history, and UM, providing integrated information sharing among appropriate staff. Clinical Care Advance also provides a systematic, objective means to monitor, measure, and evaluate Enrollee care, services, and outcomes at the individual and systemic level.

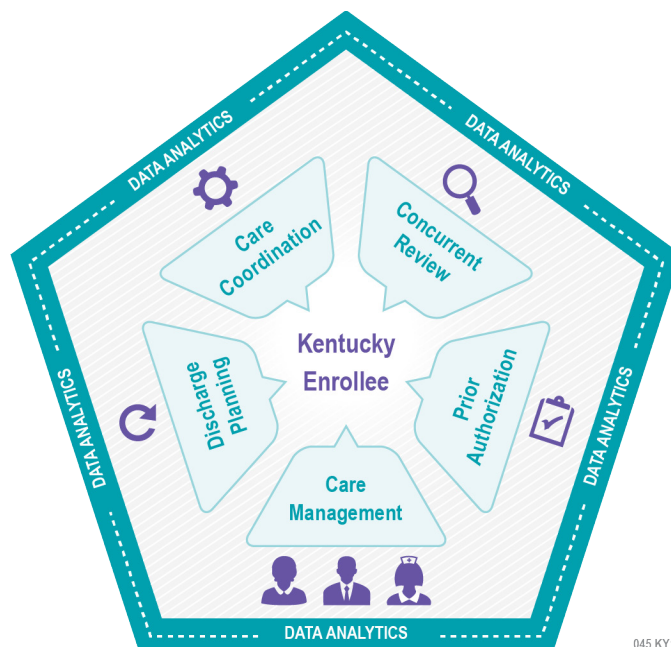


Exhibit C.10-2. Web-Based Workflow Management System

Our QNXT Claims Engine is our core system application that includes claims, membership, provider, authorization, and encounter data for physical health, behavioral health, and pharmacy covered services. Key features of our core claims engine include simplified data retrieval from a centralized database, synchronized data in one central location, and a flexible, powerful, and user-friendly Windows interface.

Our suite of health information technologies enables our care managers and other clinicians to manage services effectively and monitor utilization trends for Enrollees regardless of the complexity of their health or social needs.

Advanced, Comprehensive Reporting for In-depth Utilization Analysis

Our advanced Power BI and Executive Dashboard captures system data and presents it in easy-to-use, in-depth reports that enable us to analyze and ensure appropriate utilization and optimal, cost-effective care delivery. Our reporting capabilities enable us to filter service utilization trends by geographic area,

provider name and provider type, Enrollee sub-population, and HEDIS measures for appropriate interventions.

Power BI. Power BI is a business analytics service that provides interactive visualizations with self-service business intelligence capabilities, allowing end users to create reports and dashboards by themselves without depending on IT staff or database administrators. Our Executive Dashboard uses Power BI for visualization.

Executive Dashboard. The Executive Dashboard displays key performance indicators, such as inpatient admissions, ED visits, and pharmacy scripts. The dashboard highlights key performance indicators when they exceed targets by a pre-identified percentage. The dashboard then allows users to drill into the data by provider, bed type, diagnosis, and drug class to identify root causes that we use to design interventions.

In addition to flagging overutilization opportunities for improvement, the dashboard identifies underutilization opportunities, such as well-care and treatment of chronic conditions. For example, we track immunization utilization for well-child care and HbA1c testing for diabetes. Our care managers contact Enrollees with underutilized care to help them receive the appropriate service. Our provider outreach team also engages providers to coordinate efforts.

Leveraging Reports to Drive Appropriate Action

Utilization Metrics. We use our reports to identify specific Enrollees with underutilization of primary care and/or preventive services and gaps in care and overutilization of services to provide us insight to address trends. Report data includes separate results by admission type, breaking down key specialty services such as NICU, behavioral health, and maternity admissions where the length of stay translates directly to the cost of the admission. We monitor for ED utilization, rate of bed days/1,000, admissions by assigned service, outpatient service utilization, pharmacy utilization, HEDIS clinical measures, and average length of stay. Analyzing these utilization metrics allows our UM team to identify drivers of various trends.

Using the raw utilization metrics, we aggregate the data into specific levels, such as claim type or service category, episodic grouping, clinical classifications, diagnostic categories, major practice categories, generic product identifiers, and therapeutic classes. Analysis of these various categories provides options for in-depth understanding of the utilization drivers, both under- and over-utilized.

By using our data analytics and comprehensive reporting tools to monitor both Enrollees' use of services and our UM processes, we will confirm Enrollees receive the level of care that is medically necessary. We will use data such as utilization by service, utilization by facility type, referral patterns, and prescribing patterns to inform our efforts to improve appropriate use of service and cost efficiencies, as well as to identify potential fraud and abuse for referral.

We will leverage this data to collaborate with facilities on transition plans to minimize delays in moving Enrollees to less intensive levels of care. When information and data indicate Enrollees are at risk of requiring higher levels of care, we will work with outpatient providers to secure services, so Enrollees can remain in the community.

Diagnostic Level Reports. Diagnostic level reports use clinical classification software to group admissions by condition to identify trends at the condition level. We use drill-down data to identify specific diagnoses clusters driving negative Enrollee results. Using inpatient and outpatient reports, we monitor for unusual changes between specific periods of time and perform detailed analytics to identify any disparities or inequities in Enrollees' utilization of services.

Key Indicator Reports. We review key indicator reports that compare inpatient and outpatient services requested and authorized from the current period to the prior month and year-to-date utilization. In addition to serving as a forecaster of future claims activity, these reports allow our UM team to identify

trends and variances from national norms and prior performance periods. We provide an example of our inpatient utilization report in Exhibit C.10-3.

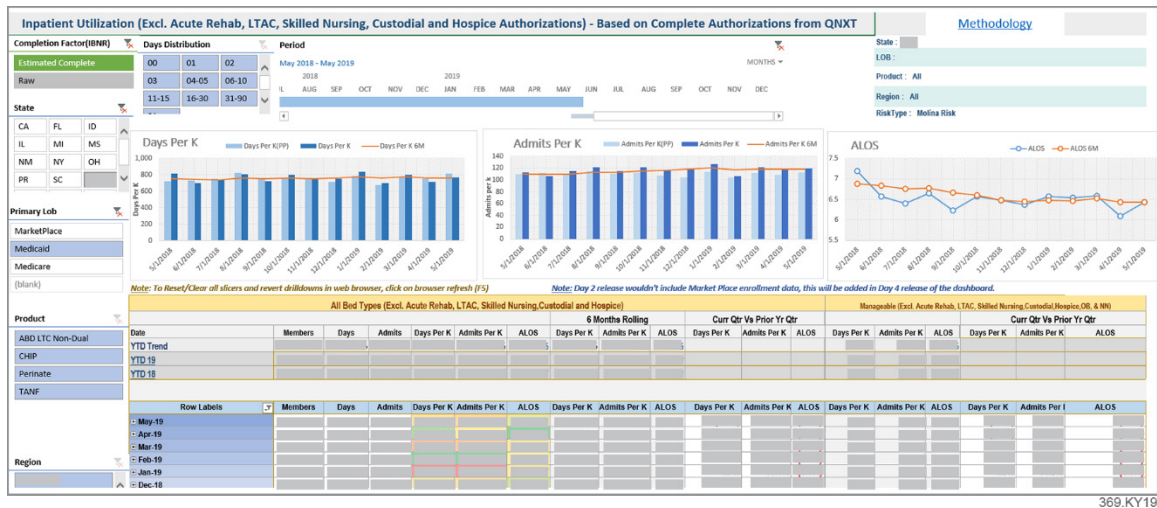


Exhibit C.10-3. SAMPLE Inpatient Utilization Report

Prior Authorization Data. Enterprise-wide resources and experience allows us to offer the Commonwealth a highly vetted baseline prior authorization list, based upon review of several different data sources to determine the procedure codes requiring prior authorization. The foundation for our prior authorization list is an in-depth procedure code utilization analysis of data from our claims database, including both paid and unpaid claims. We then conduct a longitudinal analysis to compare utilization trends across health plans and compare the results to national norms from CMS, other health plans and payers, and information from peer-reviewed professional journals. We will review our baseline prior authorization list with the Department to determine any customization required.

Integrated Behavioral Health Reports. Although we have reports dedicated to behavioral health, because our behavioral health is managed in-house, all Enrollee physical and behavioral health utilization data is available through integrated reports. Exhibit C.10-4 provides an example of the kind of comprehensive inpatient utilization reporting we will leverage for Kentucky.

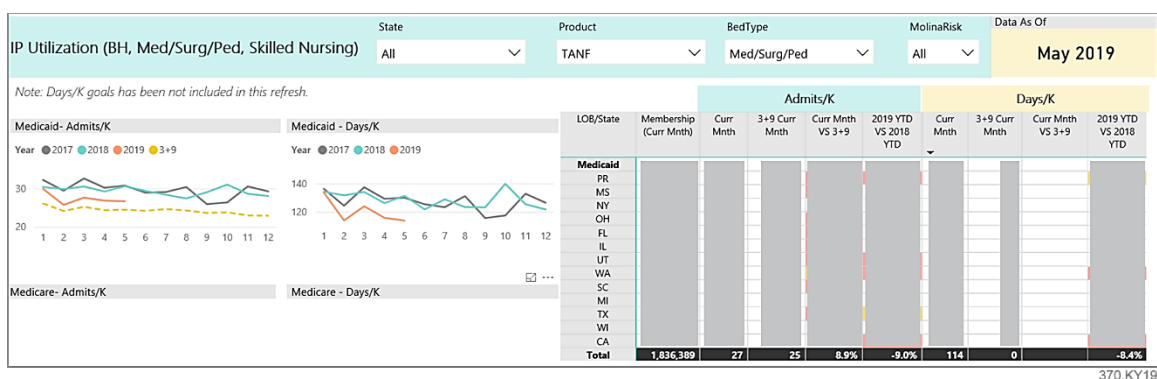


Exhibit C.10-4. SAMPLE Integrated Inpatient Utilization Report

Dedicated Behavioral Health Reports. Our Behavioral Health department has a variety of mechanisms to monitor utilization trends in behavioral health services, including database reports, targeted chart reviews, pattern analysis, provider participation in the monitoring review process, and census track reviews. Other reports include an Executive Dashboard, Behavioral Health Integrated Dashboard, and SUD Dashboard.

Our SUD Dashboard will allow us to track in real time the cost-effectiveness of our integrated care programs in Kentucky by treatment and cost. Molina is constantly re-evaluating reporting and metrics to provide up-to-date and most useful information.

Provider Reporting. Our quality improvement and UM areas collaborate in monitoring utilization patterns across practices and provider sites, including PCPs and high-volume specialists. We monitor individual providers and provider practices for potential quality issues related to over- or underutilization as well. Through our established suite of reports, each month, *we monitor denial trends by every provider, claim form used, and by specialty, and use the reports to proactively spot trends in denials before providers bring them to our attention.* For example, unusually high denial rates for an individual provider can signal an error in provider setup, change in the provider's billing address causing claims to deny, need for provider education, change in the provider's billing department, or in the case of a specialty provider, there is a configuration error that needs to be addressed. Our reporting capabilities allow us to drill down into the details of provider activities to analyze trends and ensure proactive provider engagement.

Using UM Reports to Help Providers

Our Illinois affiliate recently identified a spike in claims from a large hospital foundation. Before the hospital realized there was an issue, the health plan analyzed the data and determined the hospital switched the National Provider Identification (NPI) number they included on claims, a change implemented at their clearinghouse. **Our affiliate provided the hospital with a list of more than 12,000 claims impacted so they could quickly bill them correctly and be reimbursed over \$1.2 million for services performed.**

For example, our Illinois affiliate reviews trends in specialty care denials and conducts monthly webinars in areas where billing education is needed. The webinars are recorded and posted on the provider website for 24/7 access. They have completed webinars on behavioral health, nursing facility, transportation, hospice, and oral surgery billing practices. *The denial reports, in combination with their billing webinars, have been identified as “best practice among all Managed Care Organizations in Illinois” during a quarterly business review meeting with the Illinois Department of Health and Family Services.* We look forward to bringing these best practices to the Kentucky Medicaid program.

Our affiliate then reports the utilization data analysis, including the outcomes and trend studies, to the Quality Improvement Committee and the Healthcare Services Committee for review and discussion. The committees act on the findings, recommend interventions when trends are identified, and subsequently monitor the efficacy of the interventions taken and outcomes. These actions drive our Illinois affiliate's ability to more accurately determine services requiring authorization as well as the frequency of review required.

We provide a sample of our inpatient utilization report by provider in Exhibit C.10-5.

Inpatient Utilization By Provider - Based on Complete Authorizations from QNXT																							
Completion Factor (IBNR) ▾		Bed Type	Days Distribution			Is Network	Period																
Estimated Complete		ACUTE R...	BH	00	01	02	Y	May 2018 - May 2019															
Raw		Hospice	ICU/CCU	03	04-05	06-10	N	2018															
State		LTAC	MED/SU...	11-15	16-30	31-90	Unknown	2019															
		NICU	OB	91+	SEP OCT NOV DEC JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC																		
		CA	FL	ID																			
		IL	MI	MS																			
		NM	NY	OH																			
		PR	SC	TX																			
Primary Lob ▾		Discharge Facility	Days	Days (PP)	Variance (%)	Admits	Admits (PP)	Variance (%)	Days Per K	Days Per K (PP)	Variance (%)	Admit Per K	Admit Per K (PP)	Variance (%)	ALOS	ALOS (PP)	Variance (%)						
MarketPlace		GrandTotal	1,633,761	1,677,247	-2.6%	293,017	306,598	-4.4%	508.0	489.4	3.8%	91.1	89.5	1.8%	5.6	5.5	1.9%						
Medicaid			22,022	30,667	-28.2%	4,522	5,923	-23.7%	6.8	8.9	-23.5%	1.4	1.7	-18.6%	4.9	5.2	-5.9%						
			23,939	20,644	16.0%	4,165	3,434	21.1%	7.4	6.0	23.0%	1.3	1.0	29.1%	5.8	6.0	-4.3%						
Medicare			11,960	12,513	-4.4%	3,185	3,174	0.3%	3.7	3.7	1.9%	0.9	0.9	6.9%	3.8	3.9	-4.7%						
(blank)			16,838	17,948	-2.9%	3,114	3,306	-6.8%	5.2	5.1	1.9%	1.0	1.0	5.4%	5.4	5.3	1.5%						
			14,433	14,341	0.6%	3,098	3,166	-2.1%	4.5	4.2	7.2%	1.0	0.9	4.3%	4.7	4.5	2.8%						
Product			14,193	13,817	2.7%	2,847	2,722	4.6%	4.4	4.0	8.5%	0.9	0.8	11.5%	5.0	5.1	-1.8%						
ABD BH			15,985	15,690	1.9%	2,700	2,613	3.3%	5.0	4.6	8.6%	0.8	0.8	10.1%	5.9	6.0	-1.4%						
ABD Kids			12,328	16,238	-24.1%	2,610	3,570	-26.9%	3.8	4.7	-19.1%	0.8	1.0	-22.1%	4.7	4.5	3.8%						
ABD LTC Non-Dual			11,172	15,018	-25.6%	2,541	3,362	-24.4%	3.5	4.4	-20.7%	0.8	1.0	-19.5%	4.4	4.5	-1.6%						
ABD Non-Dual			12,020	11,158	7.7%	2,446	2,285	7.1%	3.7	3.3	14.8%	0.8	0.7	14.1%	4.9	4.8	0.6%						
			15,250	14,618	4.3%	2,301	2,264	1.6%	4.7	4.3	11.2%	0.7	0.7	8.3%	6.6	6.5	2.7%						
			15,461	19,252	-19.7%	2,290	2,619	-12.6%	4.8	5.6	-14.4%	0.7	0.8	-6.8%	6.8	7.4	-8.1%						
			10,124	15,881	-36.3%	2,196	3,229	-32.0%	3.1	4.6	-32.1%	0.7	0.9	-27.5%	4.6	4.9	-6.1%						
Region			19,447	19,395	-0.2%	2,169	2,095	3.5%	6.0	5.7	6.8%	0.7	0.6	10.3%	8.9	9.3	-3.6%						
CA - IMP			8,508	9,703	-12.3%	2,152	2,326	-7.5%	2.6	2.8	-6.6%	0.7	0.7	-1.4%	4.0	4.2	-5.2%						
CA - LA			10,957	11,572	-5.3%	2,132	2,029	5.1%	3.4	3.4	0.9%	0.7	0.6	11.9%	5.1	5.7	-9.9%						
CA - RIV			9,564	9,735	-1.8%	1,916	1,927	-0.6%	3.0	2.8	4.7%	0.6	0.6	5.9%	5.0	5.1	-1.2%						
CA - SAC			7,532	8,246	-8.7%	1,792	1,981	-9.5%	2.3	2.4	-2.7%	0.6	0.6	-3.6%	4.2	4.2	1.0%						
CA - SVC			10,054	11,876	-15.3%	1,768	2,007	-12.9%	3.1	3.5	-9.8%	0.5	0.6	-6.1%	5.7	5.9	-3.9%						
			9,483	10,318	-8.1%	1,751	2,084	-15.9%	2.9	3.0	-2.1%	0.5	0.6	-10.2%	5.4	5.0	9.3%						
			7,620	5,752	32.5%	1,710	1,377	24.2%	2.4	1.7	41.2%	0.5	0.4	32.4%	4.5	4.2	6.7%						
371.KY19																							

Exhibit C.10-5. SAMPLE Inpatient Utilization Report by Provider

Identifying Potential Fraud and Abuse Referrals

Molina uses a combination of the information, data, and reports listed above to identify potential fraud and abuse for referral, including comprehensive data monitoring, proactive data analytics, investigative activities, care tracking, regulatory reporting, and reports from Molina's 24/7 fraud AlertLine.

Reports of Fraud and Abuse. All staff are required to report potential fraud, abuse, neglect, or exploitation related to the Medicaid program. We log tips in our online module or via the AlertLine, and triage FWA leads within our in special investigation unit. We perform comprehensive research and investigate as appropriate.

Proactive Data Analytics. We apply complex algorithms and machine learning models to data to identify over- and underutilization, changes in billing behaviors, and possible schemes. We develop leads, triage, and risk assess for care development, and conduct investigations as appropriate.

Investigative Activities. By performing background research and conducting internal and external audits and pre-payment reviews, we identify potential fraud and abuse. We make referrals to state agencies and law enforcement as appropriate.

Care Tracking and Regulatory Reporting. Our integrated care management database houses all investigative activity, files, notices, and communications and provides automated reporting. We track key performance indicators, monitor care production controls, and extract all state regulatory reporting from the database.

a.ii. METHODS FOR MONITORING APPROPRIATE HEALTHCARE UTILIZATION

We use the UM analysis tools described in the previous section for early and frequent collaboration between the analytic, medical, and UM functions—the key to leveraging reports into actionable information. We identify physical health and behavioral health utilization trends through ongoing reporting and review of data and reports, such as ED utilization, top diagnosis reports, readmission reports, and prevalence reports.

We will identify utilization trends that may impact our Enrollees monthly, quarterly, and annually. Our medical director, behavioral health director, and UM leaders along with the other members of our Healthcare Services Committee will select indicators to monitor over- and underutilization in the Kentucky Medicaid program. Once selected, we will seek feedback and recommendations on the indicators from internal physicians and network providers.

Additionally, we will monitor for underutilization in areas with high minority populations, producing reports that identify specific Enrollees with underutilization of primary care and/or preventive services who may benefit from specialized programs, such as population health, care coordination, medical care management, or complex care management. We will also evaluate gaps in care for Enrollees with chronic conditions and those receiving care management for population health interventions.

Monitoring Appropriate Utilization through Providers and Provider Engagement

Molina uses provider scorecards to offer feedback to providers on their performance. The scorecard results are useful for establishing goals and benchmarks and comparing providers' performance to a prior reporting period or other similar providers' performance. Scorecards also reflect when we are monitoring a provider or a provider is under a corrective action plan (e.g., high ED utilization) or quality improvement plan (e.g., improving the rates of outpatient follow-up for Enrollees with severe and persistent mental illness after hospitalization for mental illness).

Provider scorecards enhance our ability to monitor and educate providers that, in turn, will improve healthcare quality for Enrollees. Based on trends and specific areas of focus, we customize scorecards by specialty and practice. We calculate provider performances monthly and report this data to providers, our Healthcare Services Committee, and ultimately to peer review as necessary for further action.

Care managers and PCPs receive specific Enrollee results for appropriate intervention and follow-up. We monitor the effectiveness of individual interventions by evaluating the Enrollee's current health status, satisfaction, and utilization compared to when they were first identified as an under/high-utilizer or with emerging high-risk factors. We also provide care coordination staff who monitor documentation of interventions to confirm we meet standards.

Our provider engagement team reviews utilization data at least quarterly, addressing potential problems that result from under- or overutilization. The provider engagement team is a cross-functional unit that includes providers, clinical, and administrative staff that allows us to engage our provider community in continuously improving care.

Case Study Example

During routine monitoring of providers, one of our affiliate health plans identified an irregular pattern of increased allergy testing in PCP offices. Using analytic tools in conjunction with their team's clinical expertise, they concluded that the high volume of allergy testing was inappropriate. Additionally, the provider scorecards indicated that a subset of the providers submitting allergy testing claims were low performers in managing appropriate member care when compared to their peers.

Our affiliate subsequently terminated 15 PCPs with the highest inappropriate utilization based on the allergy tests billed. Combined, the 15 PCPs had approximately \$3 million in annualized allergy testing spend. The provider engagement team educated the remaining providers, and the health plan saw an immediate decline in inappropriate allergy testing. As part of their ongoing monitoring, our affiliate identified other PCPs with unusual spikes in allergy testing and have been able to intervene quickly and educate them successfully.

Because of this identified utilization pattern, they added allergy testing to their prior authorization requirements.

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Managing Unnecessary ED Utilization

According to the Kaiser Family Foundation's 2017 data, Kentucky has the 6th highest ED visit rate in the U.S., and Kentucky's Medicaid beneficiaries have an ED visit rate 185% higher than Kentuckians with private insurance.¹ Given the Commonwealth's need to reign in Medicaid spending, programs to reduce unnecessary ED use are critical to Kentucky's financial stability, Enrollee population health, and

¹ <https://www.hcup-us.ahrq.gov/faststats/StatePayerEDServlet?state1=KY>

Medicaid program success. Because many Kentucky Medicaid beneficiaries often reside in areas with health professional shortages or providers are reluctant to accept and treat Medicaid beneficiaries, many families are accustomed to using EDs as their primary source for healthcare services.

We know unnecessary ED use often stems from underlying conditions left untreated. For example, we observed that a significant percentage of high ED utilizers in our affiliate plan in Puerto Rico suffer from behavioral health issues and have not adhered to prescribed non-emergent care. Changing those behaviors requires an ongoing partnership between our network providers, local communities, and the Commonwealth. Timely access to primary healthcare is a key component of this behavior change.

Since our UM approach is integrated across the spectrum of care and focuses on whole-person care, care managers work closely with Enrollees to monitor, educate, and refer them to other methods of care and supports. Molina Community Health Workers engage Enrollees face-to-face and assist them with navigating the healthcare system and connecting them to community-based resources, education, advocacy, and social support. We assist Enrollees with housing, food, clothing, transportation, scheduling appointments, medication refills, and obtaining DME. By addressing their social determinants of health, we enable Enrollees to make choices other than the ED for their physical health, behavioral health, and other support needs.

We will work with our contracted Kentucky Medicaid hospital partners, such as the University of Louisville Hospital and UK HealthCare, to facilitate real-time notification when an Enrollee visits an ED so our care management team can follow-up with the Enrollee. Our care managers will assess Enrollee needs and collaborate with the Enrollee to assure his/her physical health, behavioral health, and social needs are being addressed. In addition, we will collaborate with partner hospitals to discuss embedding Molina care managers onsite to prevent barriers that preclude an Enrollee from achieving optimal health and positive lifestyle changes.

ED Executive Dashboard and Reports

We monitor and analyze ED use through monthly reports. Exhibit C.10-6 portrays an example of one of our ED reports from our Executive Dashboard.

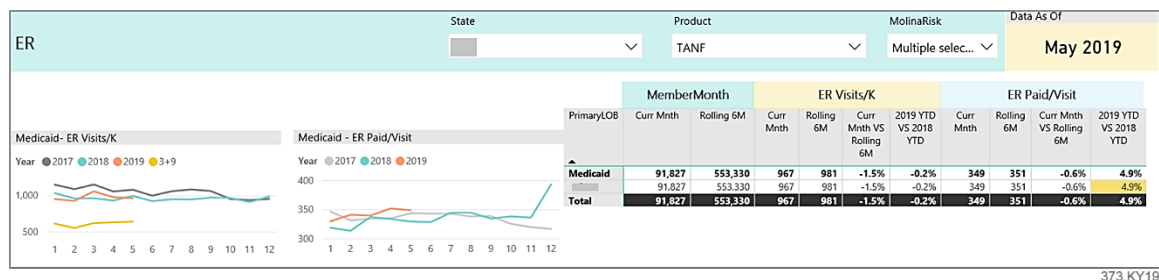


Exhibit C.10-6. SAMPLE ED Report from our Executive Dashboard

We identify ED super-utilizers, defined as Enrollees who visit the ED more than seven times a year, through these reports. Our reports display information about an Enrollee's PCP, the clinical category related to the ED visit, and the readmission facility visited, among other details. We share and discuss ED reports with Enrollees' PCP and quality interventions staff. Based on that discussion, we identify improvement opportunities and develop action plans. Some of the actions our affiliates have implemented that we will implement in Kentucky to reduce ED utilization include:

- ED appropriate utilization educational campaign with Molina's health educators
- Face-to-face and telephone outreach to high ED utilizers to assess their needs, identify alternatives, confirm they are aware of their assigned PCP, assist with a PCP change (if indicated), and encourage them to visit their PCP to improve preventive care

- Enrollee incentives such as gift card rewards for appropriate ED utilization and preventive care compliance
- 24-hour Nurse Advice Line and Behavioral Health Services Hotline, which Enrollees can use to reach a nurse and receive health advice that may otherwise have been sought in the ED
- Quality provider incentives tied to reducing ED visits and readmission rates
- Complex care discussion with PCPs and Molina staff
- Reinforcing extended hour services

Working with ED Super-Utilizers

A multidisciplinary team led by our care management director or assigned care manager addresses the needs of ED super-utilizers. We analyze a variety of potential causes of the Enrollee's outlier utilization and develop approaches and alternatives to address the Enrollee's needs as displayed in Exhibit C.10-7. We will present these to the Enrollee's PCP for integration into his or her care through:

- Detailed, transparent reporting provided through the provider Web portal
- Training and education provided at one of our regional Molina One-Stop Help Centers or through our Webinars
- Email/fax blasts
- Outreach provided by our provider engagement team

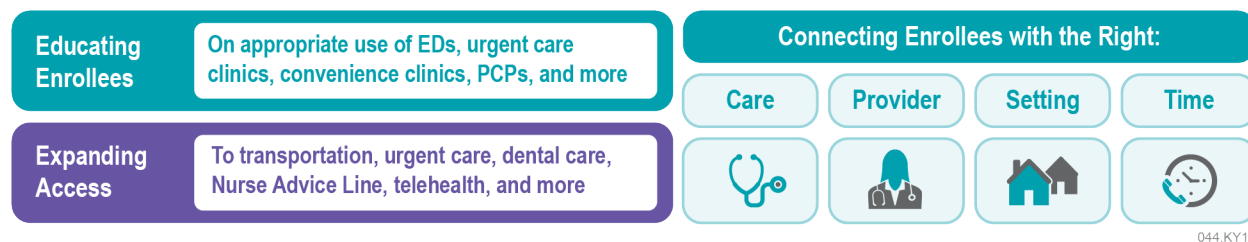


Exhibit C.10-7. Approach for Working with ED Super-Utilizers

We also follow-up with providers to analyze subsequent trends and make recommendations for improvements. Below, we highlight some of our successful methods for managing unnecessary ED utilization, avoidable hospitalization, and readmissions.

Emergency Department Support Unit (EDSU). Our California affiliate created an Emergency Department Support Unit (EDSU) as a member resource with the goal to decrease ED visits, hospital admissions and readmissions, and shorten hospital lengths of stay. The EDSU is a dedicated team, available 24/7, that collaborates with hospital EDs to help coordinate care and assure members' needs are met. The plan's member outreach team calls members two to three days after their ED visit to explain the need for follow-up care and assist with:

- Educating them on using urgent care and PCPs (including after-hours) to avoid the ED
- Connecting with or changing PCPs to better match members' needs (e.g., spoken language, proximity to member's home)
- Scheduling follow-up appointments and transportation
- Ensuring prescriptions are filled and DME is delivered
- Educating members on Molina's coverage and benefits

By placing members into the most appropriate care setting, the EDSU created a more cohesive healthcare support team for the member by linking and coordinating care with the PCP, pharmacy, and home health, as well as other needed services. Their increased efforts in pursuit of these members led to a 14% reduction from 2017 to 2018 in members who they were unable to contact.

Increased Enrollee Contact to Reduce ED Visits. Our Ohio affiliate implemented an ED Diversion program to decrease ED visits. The health plan partnered with the top 25 facilities that represented approximately 50% of the health plan's total ED utilization. The program's methodology included efforts to contact members within seven days of an ED visit and increase the overall member contact rate for the target population. The health plan used a holistic approach to address socioeconomic barriers, achieving positive outcomes for members. *During the first four weeks following member contact, there was a 4.7% reduction in ED utilization relative to members the plan was unable to contact.*

Lock-in Program to Prevent Inappropriate Utilization of Non-emergency Care and Prescriptions. Overutilization of ED for non-emergency care and to access controlled substance prescriptions is an indicator of a potential SUD. Following our affiliate models in other states, we will design a program to prevent inappropriate utilization of non-emergency care and prescriptions and guide those Enrollees through recovery and into better health.

Molina will identify Enrollees by examining pharmacy claims for controlled substance prescriptions. Each month, our lock-in team will generate utilization reports identifying Enrollees who demonstrate behaviors that may indicate a prescription drug misuse and/or service overutilization, prescription use behavior that is a danger to the Enrollee, or potential FWA.

In 2018, our Washington affiliate realized an estimated \$2.8 million in cost savings through a physician and pharmacy lock-in program. To track the program success, they measured utilization and estimated cost savings before and after lock-in. For each calendar year, members were attributed to the category that represented the stage of the lock-in program they were in: Year 1, Year 2, or Year 3 or more. Table C.10-1 shows our affiliate's 2018 results:

Table C.10-1. Lock-in Reductions in Utilization and Costs

Member Program Year	Utilization	Estimated Cost Savings
Year 1 from baseline (lock-in in 2018)	-46.9%	\$184,688
Year 2 from baseline (lock-in in 2017)	-22.6%	\$270,598
Year 3+ from baseline (lock-in in 2016 or earlier)	-11.3%	\$2,359,020
2018 total	-63.5%	\$2,814,306

Our Washington affiliate's lock-in program serves 332 Enrollees, for *an estimated cost savings of \$8,477 per Enrollee*. The lock-in program is part of the quarterly review process through our national Quality Improvement Committee. We will submit our proposed lock-in program for Kentucky Medicaid to the Department for advance approval. Any and all changes will also be approved by plan leadership and submitted to the Department for approval.

Partnerships with Community Mental Health Centers (CMHCs). A 2017 survey conducted by the Agency for Healthcare Research and Quality indicated an increase of 44.1% in ED visits nationally from 2006 to 2014 related to a behavioral health or SUD diagnosis. And, of those that resulted in a hospitalization, there was an increase from 3.4 to 4.5 visits per 1,000 individuals. We work to prevent ED visits, admissions, and readmissions for our most acute behavioral health Enrollees by partnering with CMHCs to assure Enrollees obtain appropriate CMHC contracted services.

We will leverage our relationship with Kentucky CMHCs to build an Intercept Pilot Program. Our UM clinical staff and transition of care coaches will work with CMHCs to develop a centralized process for scheduling appointments following a behavioral health or SUD inpatient discharge. These appointments are essential as there are significant transition of care needs which, when addressed, reduce the risk for readmission.

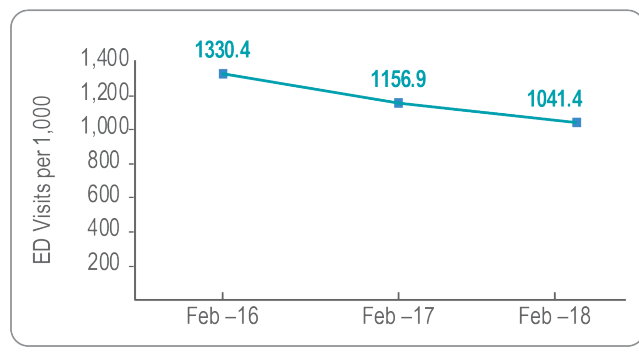
Whole-person Care Approach to Reduce ED Admissions. Our Washington affiliate executed a strategy to reduce ED and inpatient visits for diabetes-related conditions as a primary diagnosis by 50% and for diabetes-related conditions as a secondary diagnosis by 25%. Their care managers customized care plans, coordinated healthcare services with providers, and empowered members to make healthy lifestyle changes. Table C.10-2 displays favorable outcomes our affiliate experienced in 2018 when comparing their total averages to their demonstrated goal.

Table C.10-2. ED and Inpatient Reductions

Month	New Cases	ED Reductions Diabetes-Related Primary Diagnosis	Inpatient Reductions Diabetes-Related Primary Diagnosis	ED Reductions Diabetes-Related Secondary Diagnosis
January	33	86%	66%	52%
February	22	86%	68%	48%
March	30	70%	70%	53%
April	31	81%	46%	51%
May	26	79%	39%	44%
June	29	78%	46%	43%
July	23	80%	47%	42%
August	30	78%	27%	49%
September	20	74%	46%	32%
October	24	77%	36%	33%
November	25	77%	34%	36%
December	25	67%	23%	-6%
<i>Goal</i>	<i>300</i>	<i>50%</i>	<i>50%</i>	<i>25%</i>
Total/Averages	318	78%	46%	40%

Partnerships with Patient Centered Medical Homes (PCMH). In Kentucky, we will support a Medical Home Model where we actively mentor willing network providers to become PCMHs operating under value-based care reimbursement arrangements. We will pay an additional incentive for provider partners that obtain PCMH certification through NCQA, The Joint Commission, or URAC. We see a significant opportunity to use our PCMH plan with Federally Qualified Health Centers (FQHCs) and other primary care groups in Kentucky to improve quality of care for Enrollees, lower costs, optimize Enrollee and provider experiences, and assure appropriate utilization.

These models will financially incentivize our providers to maintain timely access to care for Enrollees, enable us to use our analytic capabilities to identify Enrollees who continue to access ED services inappropriately, and partner with PCPs to bring Enrollees into compliance with appropriate treatment patterns. Additional strategies we will use include Enrollee education about using the 24/7 Nurse Advice Line, our network of urgent care clinics, and telehealth. Using this approach, one of our affiliate health plans successfully



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Exhibit C.10-8. Successful Reduction of ED Admissions through PCMHs

reduced ED admissions by 22% between February 2016 and February 2018, as illustrated in Exhibit C.10-8.

Reducing Hospital Readmissions through Transitions of Care

Our transition of care program focuses on Enrollees with the greatest risk for utilization and poor health outcomes to address social determinants that lead to readmission. Interventions include assessment of health status, including mental health and substance use issues and needs; medication management; follow-up care; coordination of post discharge services; evaluation of housing/shelter to facilitate services if appropriate; and nutritional management. ***Through transition of care initiatives one of our affiliates deployed in Texas, readmissions are trending downward from 11% to 7% in just one year.***

We intervene as early as possible in the admission/transition to improve continuity of care and discharge planning—ideally with face-to-face contact in the hospital. We invite Enrollees and their care management teams to multidisciplinary meetings while still inpatient to launch the transition of care process and identify Enrollees’ needs. Participation by our medical director, clinical pharmacist, and behavioral health clinicians, as appropriate, support better care and outcomes. Transition of care coaches make their first acuity-based, post-discharge contact with Enrollees face-to-face or by phone within two business days of discharge. We target the second and third post-discharge contacts for 7 days after the first home contact and 14 days after the second contact.

Additionally, ***transition of care coaches collaborate with hospitalists and those involved in discharge plans to facilitate continuous care.*** With Enrollee/responsible party permission, the care management team is involved throughout the transition to support follow-up care, home health, and other services and supports. Our transition of care processes focus on challenges by addressing and tracking exacerbation of chronic conditions post-hospitalization, fragmentation of care, medication errors post-discharge, Enrollee and caregiver confusion and distress, and social determinants.

We will bring these best practices and lessons learned to assist the Commonwealth with decreasing ED utilization to improve overall Kentucky population health and achieve program success.

Example 1: Urine Drug Screening

Our affiliate in Michigan noticed a negative trend in definitive testing, specifically G codes G0480 – G0483. The health plan reported an overall cost increase from \$2.4 million in 2017 to \$5.9 million in 2018 (a 14% increase), mainly from a handful of providers. There were no prior authorization requirements for urine drug screening requests at that time. The data validated the negative trend and verified that overutilization was prevalent across the enterprise.

Initiatives Undertaken. The health plan undertook the following initiatives:

- Reviewed additional data, such as claims, by a multidisciplinary team on a weekly to bi-weekly basis.
- Provided additional analytical support by collecting an in-depth analysis of claims per code and per provider. The team determined the mean and assigned two standard deviations above average utilization for every episode of care as excessive overutilization.
- Submitted the final recommendation to the Prior Authorization Governance Committee (PAGC). There were no changes to presumptive testing, as the data for presumptive testing, unlike definitive testing, did not show overutilization.
- Recommended G code edits to review outlier requests. The overall strategy was not to penalize the providers who followed evidence-based practices.

Results of Initiatives. ***From 2017–2019, our affiliate saw a downward trend. In 2017, urine drug screenings claims totaled \$20.9 million. As of October 2019, urine drug screenings claims totaled \$15.9 million—a decrease of more than 24%.***

Example 2: Opioid Use Disorder Program

Our affiliate in Ohio provides another example of Molina's successful methods to monitor appropriate healthcare utilization through its Opioid Use Disorder Program, which coordinates care for members in need of outpatient treatment. As in Kentucky, opioid abuse is a major concern for states across the country as it often leads to multiple co-occurring medical conditions resulting from IV drug use, such as endocarditis, pericarditis, and osteomyelitis. Medical facilities that treat individuals with IV drug use are often ill equipped to handle SUD treatment needs, so addiction often goes untreated.

Initiatives Undertaken. Molina Healthcare of Ohio is partnering with a network of skilled facilities and a comprehensive opioid treatment program provider to facilitate integrated treatment for members as soon as they are admitted with an indication of active IV drug use. As members are admitted to inpatient and skilled facilities, the health plan's Helping Other People through Empowerment (HOPE) team is enlisted to support the members through their recovery, in collaboration with the transition of care and Community Health Worker teams who visit members in the facilities.

The health plan's target population includes members 18 years and older, members referred by the UM team at admission, and members identified as having current IV drug use.

Since November 2018, the HOPE team has received 263 referrals of active IV drug users where 111 were reached successfully and 16 of the members received visits in the facility.

Results of Initiatives. *The HOPE team is following 43 members through a transition period and 15 members have agreed to longer term intervention*, as depicted on Exhibit C.10-9.

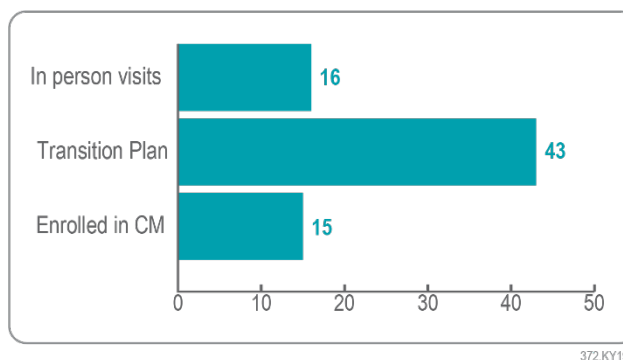


Exhibit C.10-9. Impact of Successful Contact Referrals

Example 3: Underutilization of Preventive Services

A prime example of underutilization of preventive services where Enrollees would benefit from specialized interventions occurred in our Florida affiliate health plan where Well Child Visits during the first 15 months of life were below the baseline rate being the 25th National NCQA benchmark.

Initiatives Undertaken. Targeted interventions included member outreach by contacting members to assist with scheduling visits and transportation, a member incentive for completing all six well visits, community outreach home visits, provider engagement, and educational materials.

Results of Initiatives. *Over the course of three years, Well Child Visit performance improved by 55%.*

Example 4: HPV Partnerships

Our South Carolina affiliate partnered with the American Cancer Society, Eau Claire Cooperative Health Centers, and several other MCOs to discuss how to improve HPV immunization rates. The pilot project focused on Eau Claire Cooperative Health Centers to drive practice improvement efforts to increase immunization compliance rates for adolescents.

Initiatives Undertaken. Molina Healthcare of South Carolina partnered with American Cancer Society to develop co-branded Immunizations for Adolescents (IMA) reminder postcards. Our affiliate mailed 6,803 IMA reminder postcards to 11- and 12-year-old members and provided follow up calls to assist them in scheduling appointment and transportation needs. Molina's associate vice president of quality served on the South Carolina Primary Health Care Association's conference HPV panel to share areas of opportunity to improve adolescent immunizations rates. Each provider group in attendance received a detailed IMA report for their practices results.

Results of Initiatives. *Out of 989 calls made, 223 were successful. In aggregate, 1,337 of 7,381 gaps in care have been closed for these measures (18.13%).*

a.iii. FREQUENCY IN RE-EVALUATING UM APPROACHES

Daily Discussion

Molina UM staff understand the importance of daily, continuous review and evaluation of UM data and criteria to ensure we provide Enrollees the right services, in the right settings, and at the right time. Because of this, UM staff conduct daily discussions with health plan leadership regarding, for example, inpatient trend reviews to re-evaluate our approaches continuously.

Monthly Reviews

In addition to daily discussions, our Kentucky medical director and Healthcare Services leaders will evaluate utilization data monthly using medical utilization reports from major areas of healthcare services (e.g., inpatient admissions and days of care; outpatient visits, including ED visits; surgical procedures or diagnostic tests; and over- and underutilization). They will review utilization reports to:

- Re-evaluate UM approaches for needed adjustments, including existing prior authorization requirement for appropriateness
- Compare reports on key performance indicators for inpatient and outpatient services authorized and requested from the current month to the previous month and year-to-date averages
- Forecast future claims activity
- Identify trends and variances from national norms and prior performance periods

Report data includes separate results by admission type, including length of stay, and by specialty services, such as behavioral health admissions, allowing our UM team to identify drivers for various trends. This is especially critical in markets where most contract arrangements pay a flat rate for the diagnosis related grouping or, like Kentucky, use all patient refined diagnosis-related group for most admissions. Trended results by type of admission allow the UM team to focus on critical admission types where the length of stay translates directly to the cost of the admission.

Diagnostic level reports use clinical classification software to group admissions for specific conditions to identify trends at the condition level. We use drill-down data to identify specific diagnoses clusters driving negative Enrollee results. Using inpatient and outpatient reports, we monitor for unusual changes between specific periods of time and flag them to re-evaluate that need for prior authorization review.

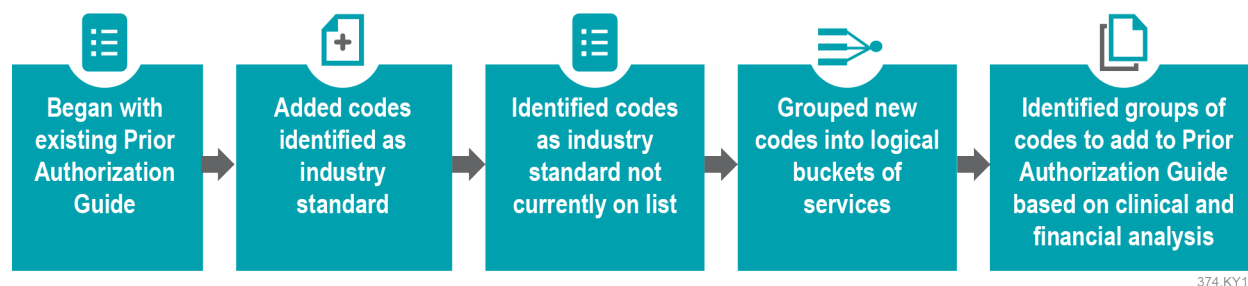
Annual Healthcare Services and Quality Improvement Committee Evaluation

When our UM team identifies a trend for review, discussion, and re-evaluation, they report it to our Healthcare Services Committee. This committee meets quarterly to review and act on the findings and recommend interventions. In addition to annually reviewing utilization trends, they conduct a formal prior authorization and coding review to evaluate national procedure code set modifications from the previous year. Procedures that have been eliminated from the national code sets are reviewed and removed from the prior authorization list, and new codes are evaluated for effectiveness, potential for abuse, and expected utilization.

From that analysis, with help from our affiliate health plans nationwide, our Healthcare Services Committee will make initial recommendations to the Kentucky Quality Improvement Committee and medical director for placing specific codes under prior authorization. Following their review, they will submit a summary of their recommended initiatives to Molina's national Quality Improvement Committee and medical directors. If Molina's national Quality Improvement Committee and medical directors agree that modifications are needed, the Healthcare Services Committee will reconvene to review and/or modify those recommendations and submit them to the Kentucky Quality Improvement Committee for final approval.

Once we implement a change, we use subsequent quarterly meetings to monitor the ongoing effectiveness of our prior authorization recommendations. If our prior authorization requirements create unnecessary barriers to Enrollee care or are not effective in managing utilization, the Healthcare Services Committee makes additional recommendations regarding prior authorization requirements.

An Example of the Process in our Affiliate Health Plan: In 2018, one of our affiliate plans conducted an analysis that identified codes for an opportunity to require prior authorization as part of industry standard (which had no prior authorization requirement at that time). They identified groups of codes to add for prior authorization based on clinical and financial analysis. After review of the paid claims utilization data, the Healthcare Services Committee determined that the utilization had increased after removing authorization requirements. In addition to evaluating trends by provider and geography, the Healthcare Services Committee recommended reinstating authorization requirements for specific services where costs and utilization increased. Exhibit C.10-10 provides the analysis approach used for the 2019 Prior Authorization Guide update.



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Exhibit C.10-10. 2019 Prior Authorization Guide Update Analysis Approach

b. MOLINA'S UTILIZATION MANAGEMENT (UM) PROGRAM

We designed our UM program to ensure that Enrollees receive appropriate, medically necessary services and high-quality care in the least restrictive and most cost-effective setting consistent with the requirements detailed in Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 20, Utilization Management, as defined in KRS 304.17A- 600, 42 C.F.R. 456, 42 C.F.R. 431, and 42 C.F.R. 438, and in compliance with NCQA standards. We integrate physical health, behavioral health, and social support services within our UM program to meet the individualized needs of Enrollees and respond to changes in the Enrollee's condition. Our Enrollee-centric care environment supports better health outcomes and reduces the need for institutional care.

Under the direction of our Kentucky medical director, Dr. Jason Dees, and behavioral health director, Dr. LaTonia Sweet, our documented UM program will detail the program structure to ensure a high quality, clinically appropriate, highly efficient, and cost-effective delivery system using defined review criteria, information sources, and processes. To best serve Enrollees, we coordinate, direct, and monitor quality and cost-effectiveness of healthcare resource utilization. We implement comprehensive processes to monitor and control the utilization of healthcare resources to continually evaluate the cost and quality of medical services delivered by providers.

University of Kentucky, Board-certified Physician

Dr. LaTonia Sweet is a lifelong Kentuckian who received her MD from the University of Kentucky. Dr. Sweet is Board Certified in Psychiatry and Addiction Medicine.

Our data-driven UM program encompasses the entire spectrum of an Enrollee's care from prior authorization of complex and/or costly procedures through retrospective review, incorporating care management, care coordination, and quality improvement. Our analytics platform uses an array of data sources, including claims, Enrollee assessments, pharmacy, Enrollee demographics, and public health

data to stratify our Enrollee populations. Our clinical teams of registered nurses, behavioral health professionals, and physicians use evidence-based clinical guidelines and leverage their professional experience for care management determinations and interventions.

We require prior authorization for certain services, procedures, surgeries, devices, supplies, drugs, and other high-cost or high-risk treatments. Our list of prior authorization requirements will be available in our Kentucky Provider Manual and on our website. Coverage is not authorized until the request has been reviewed and approved by our UM department. Our review/approval processes are constructed to ensure that we do not create a delay in receiving urgently needed care, including expedited reviews for time-sensitive care. We do not require prior authorization for emergent physical or behavioral health services.

We maintain a written UM program description that includes:

- Scope of the program
- Processes and information sources used to determine service coverage
- Clear definition of authority and accountability for all UM activities
- List of services requiring PCP referral and prior authorization and how we process requests for initial and continuing services
- Written policies and procedures to evaluate medical necessity, the criteria used, information sources, timeframes, and the process used to review, approve, or deny the provision of services, as needed, including those specific to the EPSDT program
- Policies and procedures to evaluate discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery
- Written policies and procedures for monitoring clinically appropriateness and continuity of care
- Written policies to ensure the coordination of services:
 - Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays
 - With the services the Enrollee receives from any other MCO
 - With the services the Enrollee receives in fee-for-service
 - With the services the Enrollee receives from community and social support providers
- Written policies and procedures that explain how Molina will incorporate prior authorization data into our overall Quality Improvement Plan
- Education plan for UM staff in the application of related policies and use of designated criteria in making UM decisions
- Written policies and procedures for complying with the Mental Health Parity and Addiction Equity Act (MHPAEA)
- Mechanisms to identify or detect underutilization and overutilization of services
- Description of evaluation approach of Enrollee satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of our satisfaction surveys, including how we will use results

We will submit our UM Program description to the Department for approval within 30 days of signing the Contract, annually, and at any time when making material revisions, including any revisions resulting from our annual evaluation of our UM program.

UM PROGRAM ACCOUNTABILITY

Our medical director and vice president of Healthcare Services will jointly chair our Kentucky Healthcare Services Committee and have ultimate accountability for the UM program development. The Kentucky Health Plan Board of Directors will have ultimate authority and responsibility for implementation of the UM program. The Board will delegate responsibility for oversight of the UM program to the Quality Improvement Committee and implementation to Kentucky health plan leadership.

DELEGATION OF UM ACTIVITIES

Our parent company and parent company's UM services vendor will provide UM services along with seven specialty modalities for Kentucky's Medicaid program, including advanced imaging, cardiac imaging, ultrasound, sleep, genetic lab, medical oncology, and radiation therapy. MHI supports UM nationally for all Molina health plans. However, consistent with our approach for local control and vendor management, we will provide stringent oversight to ensure our service level agreements yield appropriate services.

MEASURING UM PROGRAM SUCCESS

We will measure UM program success using the following metrics:

- Reduction in 30-, 60-, and 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
- All medical costs of identified Enrollees (actual and per Enrollee per month)

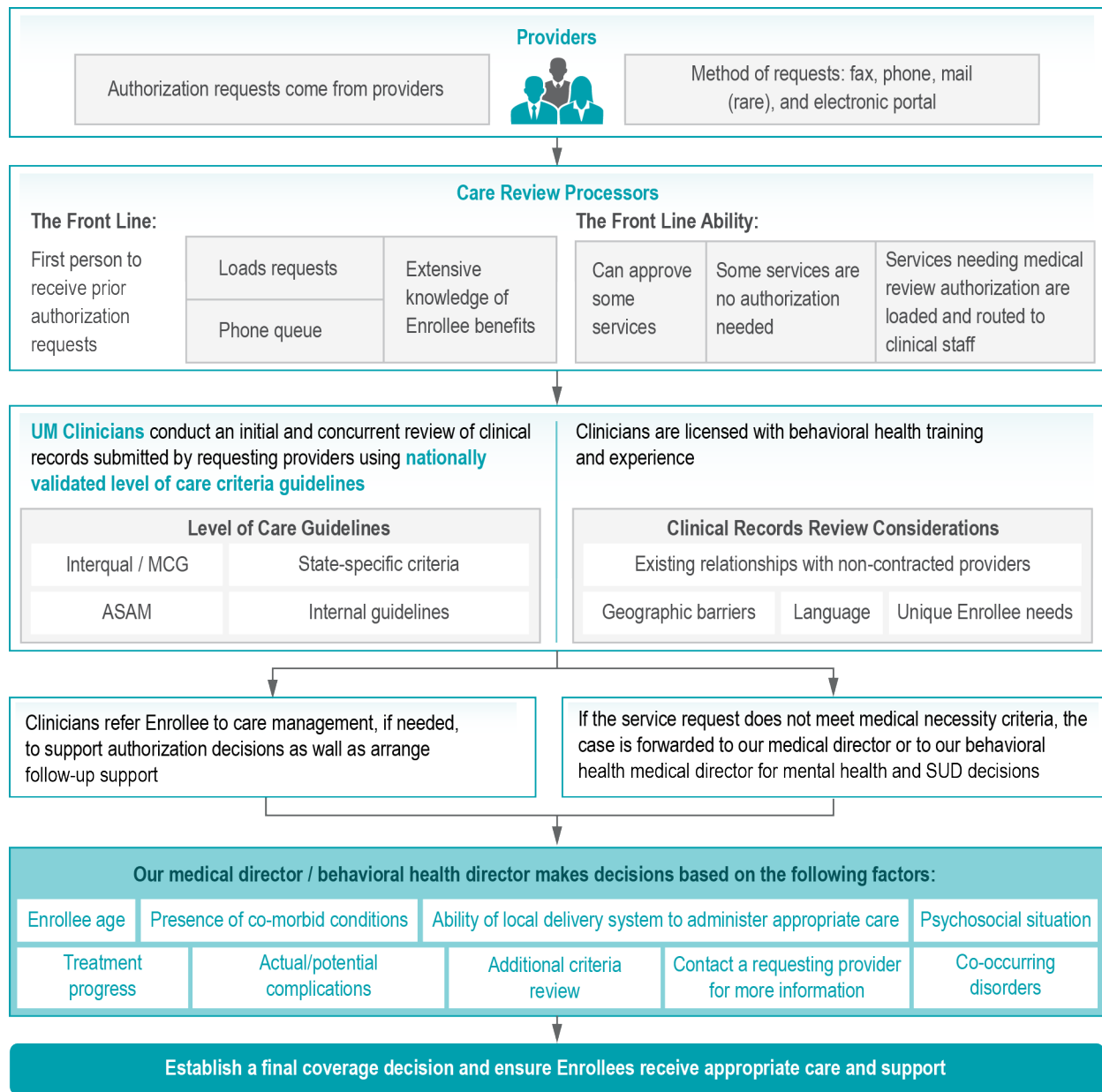
The information we receive from tracking these metrics will inform our program, initiatives, and approach as we work to refine methods to ensure greater quality and outcomes while achieving cost-effectiveness and return on investment.

b.i. APPROACH TO ALIGN THE UM PROGRAM WITH THE DEPARTMENT'S REQUIRED CLINICAL COVERAGE POLICIES

Once drafted, our Molina government contracts team will review the details of our written Kentucky UM program description against the Contract, ensuring we have overall compliance with the Department's required clinical coverage policies. After reviewing and approving the UM program description from a compliance perspective, local Kentucky UM leadership will again review the document against the Contract as a final quality assurance step before developing Kentucky-specific UM staff training.

We will require that all UM staff and those responsible for UM decisions perform the following before Contract go-live (or in the case of staff hired after go-live, before we allow them to work independently): (1) read Molina's Contract with the Department; (2) complete Kentucky UM training on Molina's corporate learning platform; (3) complete the Kentucky UM training with a passing test score; and (4) demonstrate knowledge and understanding of the UM program description and how to use evidence-based decision support tools.

Authorization Review. Under the direction of our Kentucky medical director, our UM clinicians and other licensed professionals will apply evidence-based guidelines and gather the clinical information and medical records (e.g., clinical notes, consultation reports, imaging studies, lab reports, hospital reports, and letters of medical necessity) required to determine medical necessity and approve requested service authorizations. This will be accomplished through admission reviews, concurrent hospital reviews, and outpatient service requests. UM clinicians will refer cases to our medical director that require physician intervention or do not meet clinical criteria. The medical director will review the case and make final determination based on a review of medical records and other analyses of appropriate clinical criteria, and conversation with the provider, as necessary. Exhibit C.10-11 provides an explanation of our administrative and clinical review process.



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Exhibit C.10-11. Administrative and Clinical Review Process

b.ii. PROPOSED EVIDENCE-BASED DECISION SUPPORT TOOLS

Molina will make decisions about medical necessity and the appropriateness of services requiring authorization using nationally recognized and standardized clinical review criteria compliant with Department requirements. Practicing physicians will help develop criteria in their areas of expertise, and our Healthcare Services Committee will review and formally adopt guidelines annually. Our criteria will be available for the Department and the public, upon request, on our website. We will include the guidelines in our Provider Manual and will be available at any time upon request by providers, ensuring transparency of our guidelines and procedures.

Upon receipt of request for authorization, we will take into consideration local Kentucky factors such as demography, epidemiology, and the provider network. Our UM program and policy will address the application of how we assess the local delivery system. We consider the following evidence-based

decision support tools as approved and acceptable resources for clinical criteria. The order in which we list them below is considered the acceptable hierarchy for use:

- **Physical and Behavioral Health.**
 - Applicable federal mandates and CMS guidelines: National Coverage Determinations, Local Coverage Determinations
 - State regulations and Commonwealth-specific criteria guideline sets
 - Delegated third-party clinical criteria guidelines reviewed and approved for UM use in compliance with Molina policies
 - Corporate guidance documents and policies, including Molina Clinical Policy, Molina Clinical Review
 - Licensed external decision-making criteria, including InterQual® Criteria, MCG, American College of Radiology, American Society of Addiction Medicine (ASAM)
 - National Comprehensive Cancer Network
 - Level of evidence 2A or above may be considered for approval
 - Hayes Technology Assessment
 - Hayes Rating of B or better for the treatment/device may be considered for approval
 - Hayes Rating of C or below does not have proven benefit or sufficient evidence and would not be approved
 - UpToDate®
 - Technology assessments established by nationally accepted governmental agencies, physician specialty societies, associations, or academies and published in peer reviewed medical literature
 - Well controlled studies published and referenced in medical or scientific literature with relevant clinical evidence supporting the assertion that the requested modality would provide benefit to the member and a clinical advantage over its competitors; two independent studies are preferred
 - Specialty consultations by a third-party reviewer or an Independent Review Organization
- **Pharmacy.**
 - Commonwealth regulations and guidelines
 - Molina corporate guidance documents (e.g., Molina Clinical Policy, Molina Clinical Review, Pharmacy Prior Authorization Criteria + Drug to Criteria Crosswalk)
 - Externally purchased criteria (e.g., American college of Radiology Link, National Comprehensive Cancer Network, MCG, Hayes Technology Assessments, InterQual)
 - UpToDate
 - Assessments from nationally accepted governmental agencies; physician specialty societies/associations/academies; published in peer review medical literature; well controlled or prospective cohort/comparison studies published and referenced in medical or scientific literature with relevant clinical evidence supporting the assertion that the requested modality would provide benefit to the member and a clinical advantage over its competitors—two independent studies are preferred
 - Specialty consultations by a third-party reviewer (e.g., American College of Radiology)

When criteria do not appropriately address individual Enrollee's needs or unique circumstances (e.g., age specific issues), the physician reviewer may use their clinical judgment to approve or deny services if there is relevant evidence to support their assertion.

Clinical Practice Guidelines. We adopt and disseminate CPGs to providers to reduce inter-provider variation in diagnosis and treatment, and we measure adherence annually. All guidelines are based on scientific evidence and review of medical literature and/or appropriate established authority. We review CPGs annually and update them as new recommendations are published. Our current CPGs include:

- Asthma
- Attention Deficit-Hyperactivity Disorder
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Diabetes
- Depression
- Detox and Substance Abuse Treatment
- Heart Failure
- Hypertension
- Obesity
- Opioid Management
- Sickle Cell Disease

Preventive Health Guidelines. We provide coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force, American Academy of Pediatrics, and Centers for Disease Control and Prevention, and in accordance with CMS guidelines. Preventive tests and exams include, but are not limited to:

- Adult Immunizations
- Adult Preventive Services (e.g., prostate cancer screening, colorectal cancer screening, cholesterol screening, and breast cancer screening)
- Child and Adolescent Immunizations
- Pediatric Preventive Healthcare, including well child and adolescent well visits, counseling and anticipatory guidance
- Routine Prenatal and Postnatal Care

Review and Adoption of Clinical Practice and Preventive Health Guidelines. We regularly monitor evidence-based consensus statements and guidelines from nationally recognized healthcare organizations and published peer-reviewed medical journals to confirm our guidelines include the most current industry information. With the development of each guideline, we also develop methods for monitoring its implementation. Our CPG process is a cycle of ongoing monitoring, as outcomes re-measured and specific programs are enhanced with each cycle. Our national Quality Improvement Committee, under the oversight of the national medical director and co-chaired by a Molina medical director and Vice President of Quality and with participation from physicians and other health professionals, meets quarterly and more frequently as clinical evidence is updated. Once a guideline is approved for implementation, we conduct a critical review of all proposed evaluation metrics. To verify the validity and reliability of the data, these reviews use specific criteria, such as external national benchmarks, performance measures, and goals. Any opportunities detected with an intervention, or significant variance from performance standards, are reported for further review and action.

b.iii. INNOVATIONS AND AUTOMATION TO IMPROVE EFFICIENCY

Because government programs are our only business, we take pride in our approach to finding progressive ways to build strong provider relations and reduce provider administrative burden under the UM Program. Our approach drives proactive provider engagement, education, collaboration, and transparency; maximizes provider satisfaction and retention; and minimizes provider abrasion.

Prior Authorizations

Removing Prior Authorization Requirements. During our focus groups, we heard frustrations from providers about cumbersome prior authorization requirements. As a manner of practice in Kentucky, Molina will systematically review our approach to prior authorization codes to discern the utilization, approval rates, and impact on both quality and cost. We will regularly perform an extensive review of all codes that require prior authorization to identify those that we can ***build into our value-based programs to relax, or even eliminate the requirements of prior authorization to remove barriers to Enrollee care and to improve provider relationships.***

We will implement our 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 for providers. After implementation with these select Preferred Providers, we will hold quarterly joint operating committee meetings with providers to review utilization, quality, and cost metrics to determine if adjustments to the program are warranted.

Expediting the Prior Authorization Process. For expedited authorization requests (i.e., a standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function), we will make determinations as quickly as the Enrollee's health requires and ***no later than 24 hours after we receive the initial request for service.***

For Enrollees diagnosed with an SUD, we will always treat authorization requests as expedited.

Authorizing Services from a Non-Participating Provider. Where service needs cannot be met by our contracted provider network, UM staff will authorize services to out-of-network providers following our out-of-network provider policy and according to Kentucky regulatory guidelines. The process for out-of-network providers to receive authorization for services follows a similar process to that for our network providers. Providers can contact our UM hotline or submit the service authorization request via fax or mail.

Except for the initial 90 days of an Enrollee's membership with Molina where we will honor all existing authorizations, an out-of-network practitioner/provider authorization is generally approved for up to three visits and/or an episode of care based on the clinical condition being treated and/or the course of treatment being recommended. Additional visits and/or services requested beyond the initially approved services to an out-of-network provider must include the medical necessity and the Enrollee's progress and/or response to the current plan of care.

Pharmacy Prior Authorizations

Molina's pharmacy prior authorization submission process is provider-friendly, offering multiple methods to allow for the most appropriate process for each therapy: electronic prior authorizations, smart prior authorizations, and traditional reviews. Electronic prior authorizations can be submitted electronically through a secure portal using various vendors (e.g., CoverMyMeds, SureScript, ePrescribe, and EPIC) and are sent on to Molina for any further review. ***The innovative SmartPA® tool uses medical claims data and Enrollee information to automatically prequalify an Enrollee through automatic coding rather than a hard stop to the claim.*** This not only facilitates speedy processing, it reinforces evidence-based, quality treatment for our Enrollees. Should the data elements fail to meet the pre-specified criteria, a traditional review will be triggered.

Behavioral Health Excellence Program

Molina's Behavioral Health Excellence Program improves quality, increases collaboration between facilities and Molina, and increases Enrollee and facility satisfaction by guiding and rewarding inpatient psychiatric care facilities for delivering services efficiently and effectively. Molina will collect performance data from inpatient psychiatric care facilities using claims utilization and HEDIS data. We will use comparative national benchmarks, such as HEDIS and NCQA's Quality Compass, to spot trends and patterns in the program outcomes so that we can collectively address them with facilities monthly to drive continuous quality improvement.

Our Behavioral Health Director, Dr. Sweet, will work with staff from our Kentucky quality improvement, UM, and care management teams to support facilities in improving their performance. We will recognize and reward top-performing facilities through facility rankings which will drive Enrollees to highly rated facilities.

Performance measurement includes targets for re-admissions (measured at 30 and 90 days) and follow-rates post discharge (measured at 7 and 30 days). Based on each eligible facility's performance, we will rank each facility as:

- **Top-Tier Facility.** Meets and exceeds all four readmission and follow-up metrics
- **High-Quality Facility.** Meets one of two readmission and one of two follow-up metrics
- **Satisfactory.** Meets one of four readmission or follow-up metrics
- **Not Meeting Expectations.** Does not meet the threshold for readmission or follow-up metrics

We provide the most recent results for our Illinois affiliate in Exhibit C.10-12.

Success in Illinois: BH Excellence Program Provider Examples



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Exhibit C.10-12. Molina Healthcare of Illinois' Recent Behavioral Health Excellence Program Results

Expedited Appeals

Upon receipt of a request for an expedited appeal, a Molina registered nurse conducts a clinical review of the request to determine if criteria for an expedited review are met and reviews the case with Molina's medical director for additional clinical input. If the request meets criteria for expedited review, we will review the appeal and make a determination within 72 hours of our receipt of the appeal (unless an extension is made in accordance with requirements).

Provider Self Services

For a fully automated provider experience, we maintain a secure 24/7 provider portal that allows access to Enrollee care and service plans, including Enrollee profiles that detail inpatient/outpatient visits, prescriptions, service authorizations, and utilization history. Providers can obtain real-time approvals, check claims receipt and status, generate a listing of Enrollee panels, and view HEDIS services reports.

Once registered, providers can assess the following functions:

- Enrollee eligibility inquiry
- Provider search
- Authorization and claims status inquiry and submission
- Claims appeals, corrections and batch submissions
- Contacts: address, phone numbers, fax numbers, and emails
- HEDIS alerts and reporting
- View/update profile
- Download forms
- Connect to the pharmacy company website, PBM, and access the preferred drug list
- Account management tools and third-party secure access
- Enrollee listing
- Access to Provider Manuals, notices, FAQs links, and newsletters

b.iv. METHODS AND APPROACH TO BALANCE TIMELY ACCESS TO CARE

We promote Enrollees' timely access to care by using a multi-faceted approach that includes: (1) authorization decisions based upon Enrollees' individual physical, behavioral, and communication needs (e.g., language interpretation, aids for low vision, and TTY/TDD and relay services for those who are deaf or hard of hearing) and (2) removal of prior authorization requirements for certain provider delivered services and self-referred care.

We consider Enrollee demographics and eligibility information, age, co-morbidities, relevant clinical information, psychosocial situation, home environment, and characteristics of the local delivery system available to the Enrollee when making authorization decisions. For example, we consider local hospitals' ability to provide all recommended services, available home care in the service area to support the Enrollee after discharge, and any other available home and community resources in these decisions.

Continuity of Care Considerations




Molina will implement a pre-service process as an integral part of our continuity of care strategy, and our policies will make special provision for Enrollees transitioning from another MCO or fee-for-service Medicaid. This will include coverage of services approved by the former MCO, authorization of services that did not require authorization by fee-for-service Medicaid, and coverage of out-of-network OB/GYN care for Enrollees. Our proven transition approach will provide a framework that ensures the innovative tools and support needed to focus on what matters most—the Enrollee. We will honor authorizations for Enrollees transitioning from another MCO for up to six months unless there is a change in condition or a reassessment of care needs performed. This six-month grace period will allow additional time for out-of-network providers to join our network and, in the case of a provider electing not to contract with Molina, an opportunity for Enrollees to select a new network provider.

To help with timely transitions, we will use a concurrent review process to proactively determine continued medical necessity and appropriateness of ongoing inpatient, transitional, and home healthcare services. This also will help identify Enrollees for referral to specialty programs (e.g., disease management) and allows for discharge planning and coordinated transitions of care when ready.

UM clinicians will assess each Enrollee's clinical status, progress, and care they have received to determine whether it warrants a continued inpatient stay. They will document their findings in our clinical management system, including whether services are authorized and when the next concurrent review should occur. Our Kentucky-licensed medical director will communicate any denials or limitations of service in writing. Such letters will include the specific utilization review criteria or benefits provisions used in the determination and provide appeals process information.

Discharge planning for all inpatient stays will be another integral step in helping prevent unnecessary readmissions and quality recovery from inpatient services. Starting from the time the Enrollee is admitted, our clinicians will coordinate with the Enrollee, facility, Enrollee's PCP, and our care management team to assure the Enrollee's needs are met through appropriate discharge planning. The clinicians will continue to monitor any discharge needs through the admission, including identifying barriers that may result in readmissions (an inpatient admission within 14 calendar days of discharge for the same diagnosis), identifying services and supplies to be needed after discharge, and if there is appropriate caregiver support if applicable. We will embed transition of care clinicians in select Kentucky facilities to promote successful transitions of Enrollee care. In addition, twice weekly hospital case reviews will provide an opportunity for the UM manager, clinicians, and the medical director and/or the behavioral health director to discuss Enrollees' progress, the continued appropriateness of inpatient care, and discharge planning.

Our decision process for all coverage determinations complies with Commonwealth and NCQA standards for timeliness. Exhibit C.10-13 illustrates our authorization decision timeframes.

Authorization Request Type	Authorization Timeframe	
Standard Prior Authorization Request		2 business days OR 14 business days*
<p><i>*Timeframe for a standard authorization request may be extended up to fourteen (14) Days if the Provider or Enrollee requests an extension, or if the Contractor justifies, in writing, to the Department a need for additional information and how the extension is in the Enrollee's best interest. Further, for cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, complete an expedited authorization decision within twenty-four (24) hours and provide notice as expeditiously as the Enrollee's health condition requires.</i></p>		
Expedited/Urgent Authorization Request		24 Hours
<p><i>*SUD Diagnosis will be considered an Expedited/Urgent Authorization Request</i></p>		
Post-Service (Retrospective) Review Request		14 calendar days OR 28 calendar days*
<p><i>*Timeframe for a post-service (retrospective) review requests may extend up to an additional fourteen (14) Days if the Enrollee or the Provider requests an extension or the Contractor justifies in writing to the Department a need for additional information and how the extension is in the Enrollee's interest</i></p>		

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Exhibit C.10-13. Prior Authorization Timeframes

In cases requiring retrospective review, clinicians request medical records and conduct a medical necessity and appropriateness review based on criteria (e.g., McKesson InterQual Criteria, Hearst MCG), state and federal regulations, and UM policies. For example, unplanned services that normally require prior authorization might be delivered in an emergency and are then retrospectively reviewed for appropriateness.

Self-Referred Services

Many key services integral to our Enrollees' health do not require authorization, and Enrollees may access them without prior approval. Authorization is not required for the following services: behavioral health outpatient care, emergency and post-stabilization services (including crisis stabilization), urgent care, basic obstetrics and prenatal care, family planning services, preventive services, urgent support for home and community care, and communicable disease services (including sexually transmitted infections and HIV testing).

Services that do require prior authorization in Kentucky will be listed on our public website.

b.v. APPROACH TO INTEGRATE MEDICAL AND BEHAVIORAL HEALTH SERVICES

At Molina, our in-house, fully integrated physical and behavioral health program assures full integration with physical health, mental health, SUD, and social determinants of health to coordinate robust, high-quality covered benefits and services to drive positive health outcomes for Kentucky Medicaid Enrollees. Every functional area (e.g., UM, pharmacy, and quality) includes a dedicated behavioral health professional who assures the full integration and comprehensive support of Enrollee behavioral health needs while receiving full support and collaboration of our clinical and healthcare operations. Through this seamless integration, we offer fully integrated care management across the continuum of care.

To support our integrated team, our integrated platform for care management, UM, pharmacy, medication therapy management, and care access and monitoring enables workflows across risk, care, and quality management. In a single view, clinicians and authorized representatives can view each Enrollee's current

and historical records of services, including services performed by ancillary vendors, such as vision and dental providers.

The platform aggregates and organizes data from disparate sources into a single integrated platform and ensures compliance with NCQA standards and regulatory requirements.

Integrated Care Management

Our suite of health information technologies enables our care managers and other clinicians to effectively manage Enrollees' holistic physical health, behavioral health, and social determinants of health needs, regardless of the complexity of their medical care or social needs. Compliant with NCQA standards and those of other regulatory agencies, our suite of technologies offers a rich range of capabilities, providing users with an integrated view of Enrollee information, provider information, claims authorizations, Enrollee contact information, pharmacy data, and lab data—all organized in an Enrollee-centered way to facilitate improved health delivery.

The Care Evolution-Member360 portal provides a consolidated view of historical Enrollee data within a single, web-based solution. Our workflow management platform supports the management of the referral/utilization control processes and procedures, seamlessly integrating with our other systems so our staff can identify and monitor PCP referral patterns. It also provides access to coordination of services information (e.g., actions of peer review and service utilization per visit). Users can view provider alerts to identify unsatisfactory providers quickly, leading to more appropriate and cost-effective provider selection. In addition, our workflow management platform provides integrated views showing information from commonly used systems such as Care Select, CMS Manuals, CMS Medicare Home Website, MHI Behavioral Health data sources, and more.

Utilization Data and Quality Improvement

Our integrated and cross-functional health information system enables the quality improvement team and other teams throughout Molina to collect, integrate, analyze, and report data necessary to implement and evaluate UM program activities. This health information system will provide the data needed to support program goals and principles that align with Kentucky's key priorities.

For example, Molina's core administrative system, QNXT, valuable data can be harvested, including population demographics and physical and behavioral health utilization data from across the entire continuum of care (e.g., outpatient physician and specialist offices, diagnostic testing centers, EDs, home-based care, laboratories, pharmacies, and inpatient settings).

The utilization data housed in these systems are foundational to our UM efforts. We use them to monitor and evaluate the demographics and specific needs of Enrollee populations and to manage the effectiveness of clinical programs and activities. For example, our clinical and operational leaders review key indicators on the Executive Dashboard daily to evaluate program effectiveness and to monitor areas for potential improvement. The dashboard view (see Exhibit C.10-14 below for an example) shares inpatient utilization for Molina's affiliate health plans, including number of days and admissions, and rates per 1,000 Enrollees. Dashboards like this allow our leaders to drill down to the institutional level to evaluate variances and determine appropriate actions.

Inpatient Utilization By Provider - Based on Complete Authorizations from QNX

Completion Factor (IBNR) Bed Type Days Distribution Is Network Period

Estimated Complete ACUTE R... BH 00 01 02 Y May 2018 - May 2019 MONTHS

Raw Hospice ICU/CCU 03 04-05 06-10 N SEP OCT NOV DEC JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

State LTAC MED/SU... 11-15 16-30 31-90 Unknown

CA FL ID IL MI MS NM NY OH PR SC TX

Primary Lob Discharge Facility

	Days			Admits			Days Per K			Admits Per K			ALOS		
	Days	Days (PP)	Variance (%)	Admits	Admits (PP)	Variance (%)	Days Per K	Days Per K (PP)	Variance (%)	Admits Per K	Admits Per K (PP)	Variance (%)	ALOS	ALOS (PP)	Variance (%)
GrandTotal	1,633,761	1,677,247	-2.6%	293,017	306,598	-4.4%	508.0	489.4	3.8%	91.1	89.5	1.8%	5.6	5.5	1.9%
MarketPlace	22,022	30,667	-28.2%	4,522	5,923	-23.7%	6.8	8.9	-23.5%	1.4	1.7	-18.6%	4.9	5.2	-5.9%
Medicaid	23,939	20,444	16.0%	4,160	3,434	21.1%	7.4	6.0	23.6%	1.3	1.0	29.1%	5.8	6.0	-4.3%
Medicare	11,960	12,513	-4.4%	3,185	3,174	0.3%	3.7	3.7	1.9%	1.0	0.9	6.9%	3.8	3.9	-4.7%
(blank)	16,858	17,365	-2.9%	3,114	3,306	-5.8%	5.2	5.1	3.4%	1.0	1.0	0.4%	5.4	5.3	3.1%
Product	14,433	14,341	0.6%	3,098	3,166	-2.1%	4.5	4.2	7.2%	1.0	0.9	4.3%	4.7	4.5	2.8%
ABD BH	14,193	13,817	2.7%	2,847	2,722	4.6%	4.4	4.0	9.5%	0.9	0.8	11.5%	5.0	5.1	-1.8%
ABD Kids	15,985	15,690	1.9%	2,700	2,613	3.3%	5.0	4.6	8.6%	0.8	0.8	10.1%	5.9	6.0	-1.4%
ABD LTC Non-Dual	12,328	16,238	-24.1%	2,610	3,570	-26.9%	3.8	4.7	-19.1%	0.8	1.0	-22.1%	4.7	4.5	3.8%
ABD Non-Dual	11,172	15,018	-25.6%	2,541	3,362	-24.4%	3.5	4.4	-20.7%	0.8	1.0	-19.5%	4.4	4.5	-1.6%
Region	12,020	11,158	7.7%	2,446	2,285	7.1%	3.7	3.3	14.8%	0.8	0.7	14.1%	4.9	4.9	0.0%
CA - IMP	15,250	14,618	4.3%	2,301	2,264	1.6%	4.7	4.3	11.2%	0.7	0.7	8.3%	6.6	6.5	2.7%
CA - LA	15,461	19,252	-19.7%	2,290	2,619	-12.6%	4.8	5.6	-14.4%	0.7	0.8	-6.8%	6.8	7.4	-8.1%
CA - RIV	10,124	15,881	-36.3%	2,196	3,229	-32.0%	3.1	4.6	-32.1%	0.7	0.9	-27.5%	4.6	4.9	-6.3%
CA - SAC	19,347	19,395	-0.2%	2,169	2,095	3.5%	6.0	5.7	6.3%	0.7	0.6	10.3%	8.9	9.3	-3.6%
	8,508	9,703	-12.3%	2,152	2,326	-7.5%	2.6	2.8	-6.6%	0.7	0.7	-1.4%	4.0	4.2	-5.2%
	10,957	11,572	-5.3%	2,132	2,029	5.1%	3.4	3.4	0.9%	0.7	0.6	11.9%	5.1	5.7	-9.9%
	9,564	9,735	-1.8%	1,916	1,927	-0.6%	3.0	2.8	4.7%	0.6	0.6	5.9%	5.0	5.1	-1.2%
	7,532	8,246	-8.7%	1,792	1,981	-9.5%	2.3	2.4	-2.7%	0.6	0.6	-3.6%	4.2	4.2	1.0%
	10,054	11,876	-15.3%	1,768	2,007	-11.9%	3.1	3.5	-9.8%	0.5	0.6	-6.1%	5.7	5.9	-3.9%
	9,482	10,318	-8.1%	1,753	2,084	-15.9%	2.9	3.0	-2.1%	0.5	0.6	-10.3%	5.4	5.0	8.2%
	7,620	5,752	32.5%	1,710	1,377	24.2%	2.4	1.7	41.2%	0.5	0.4	32.4%	4.5	4.2	6.2%

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Exhibit C.6-14. Sample Executive Dashboard showing Inpatient Utilization Across Molina's Affiliate Health Plans HEDIS Data Collection and Reporting

b.vi. APPROACH TO ENSURE OUR UM PROGRAM IS COMPLIANT WITH MENTAL HEALTH PARITY

Molina has a two-pronged approach to ensure we are adequately and carefully considering the needs of Enrollees regarding MHPAEA and thus a solid strategy to ensure we are appropriately addressing parity in the state of Kentucky.

- Internal Program Strategy on Mental Health Parity.** Our national Behavioral Health department assesses mental health parity routinely and maintains an updated mental health parity toolkit with all the necessary resources to ensure compliance across all our affiliate health plans. Molina takes a *standardized integrated approach to parity by not treating behavioral health in a silo and coupling parity with all benefits that have prior authorization or annual limit requirements*. As evidenced by the following:
 - Addressing parity *every time* there are behavioral health benefit exception requests which are received bi-weekly and monthly
 - Using our enterprise-wide Prior Authorization Committee as a forum to identify potential risks related to parity compliance
 - Developing integrated multi-disciplinary team rounds inclusive of both physical health and behavioral teams
 - Monitoring external parity legal suits and the associated implications and trends by performing an internal gap analysis to further ensure Molina's compliance with MHPAEA and identify opportunities for growth
 - Providing consultation services to our health plan departments to address state regulatory questions surrounding parity and assist with assessing parity compliance in their state
- National Behavioral Health's** work has resulted in the following outputs:
 - Mental Health Parity Crosswalk** that identifies the four service areas impacted by MHPAEA and provides an at-a-glance view to ensure behavioral health benefits are not more restrictive than the comparable medical/surgical benefit

- b. **Mental Health Parity training** provided to our behavioral health directors to ensure they understand the law and implications for unfairly limiting Enrollees access to necessary mental health and/or SUD care
- c. **Mental Health Parity Checklist.** A tool created to assist each of our health plans with conducting an internal assessment of their compliance with MHPAEA and identify areas of opportunity to strengthen compliance with MHPAEA
- d. **Consultation with our National Compliance team** to ensure that the standard approach to assessing and monitoring parity is appropriate and comprehensive

This approach will help to ensure that our Kentucky leadership is appropriately trained in mental health parity compliance and regularly uses the Mental Health Parity Internal Compliance Checklist.

We also conduct annual reviews of benefit structures to assure compliance with the MHPAEA. Molina healthcare mental health and substance use benefits meets all parity requirements and guidance that include coverage of treatment services at every available level of care as with our medical services. This includes, but is not limited to, inpatient (psychiatric and detoxification), residential services, partial hospitalization, intensive outpatient, psychosocial rehabilitation, home and community-based services, psychotherapy, and psychological testing. When a level of care is not available in an identified area, we work with local providers to support a strategy to create telehealth or alternative means to assist our Enrollees.

Molina's internal analysis by the behavioral health team includes a review of inpatient, outpatient, emergency, and prescription drugs for mental health and SUD benefits in all classifications in which medical/surgical benefits were provided. Our medical/surgical benefits and mental health and SUD benefits provide for similar coverage for out-of-network providers. Additional quantitative treatment limitations and non-quantitative treatment limitations were reviewed. Molina's mental health and SUD benefits do not impose quantitative limits such as visit limits and day limits unless mandated by the state. Molina's mental health and SUD non-quantitative limits, such as medical management, step therapy and pre-authorization standards, are comparable and are applied no more stringently than medical surgical/benefits in the same classification.

Ensuring Quality Care Standards through Utilization Management

Nationally Recognized Care Guidelines. Molina will follow applicable federal and Commonwealth of Kentucky mandates and coverage guidelines. In addition, Molina uses best-in-class third party-based criteria industry standard guidelines (e.g., McKesson InterQual Criteria, Hearst MCG), for UM to conduct principle medical necessity reviews when making decisions on behavioral health services. These sources serve as our principle review criteria for making decisions about medical necessity and appropriate use of behavioral health services. All clinical staff members have access to the guidelines in an online, Web-based format, with clinical content, level of care, and care planning criteria.

Additionally, all Molina clinical reviewers have access to and will use the ASAM Criteria for SUD service determinations; these nationally recognized criteria help determine the appropriate level of care for Enrollees with SUDs. When specific criteria are not available, the medical director (a board-certified psychiatrist), uses Molina Medical Clinical Policy and Molina Clinical Review Guidelines. The Medical Clinical Policy and Molina Clinical Review undergoes an extensive review process for new treatment modalities that do not have nationally recognized guidelines. If we do not have a medical clinical policy, we follow algorithms and guidelines from recognized professional societies, and authoritative review

Nationally Recognized Care Guidelines



articles and textbooks. If medical necessity criteria are not available or are not specifically addressed for a specific behavioral health service or for a specific population, we will discuss the issue with the Commonwealth.

Molina's clinical review behavioral health team is composed of Licensed Professional Clinical Counselors, Licensed Clinical Social Workers, and registered nurses who review clinical information submitted for authorization of behavioral health services. Our behavioral health clinicians conduct medical necessity reviews for services such as inpatient care, residential treatment, and selected outpatient services. ***We will make determinations based on a Kentucky Medicaid Enrollee's individualized needs, physical and behavioral health conditions, and availability of psychosocial resources.***

Multidisciplinary Team Rounds. Our UM staff regularly review inpatient Enrollee cases during twice-weekly, internal multidisciplinary rounds, which enables them to obtain the feedback necessary to make optimal decisions regarding the Enrollee's complex needs. The multidisciplinary team rounds consist of the behavioral health and physical health directors, care managers, pharmacy, and paraprofessionals (e.g., SUD navigators, and peer support specialists, or housing specialists). This enables a comprehensive review from multiple perspectives to have a meaningful discussion and plan for how to best assist our Enrollees in receiving appropriate care. Our goal is to always provide appropriate care to our Enrollees in the least restrictive environment.

Peer-to-Peer Consults. Molina's behavioral health director will conduct ongoing peer-to-peer consults with facility providers to ensure full understanding of the Enrollee's complex circumstances is taken in account in clinical decision-making. Additionally, Molina behavioral health (and medical) directors have access internally to Forensic, Child, & Geriatric Psychiatry; Addiction Medicine; and Neonatology, Cardiology, and other medical specialties within our organization. For example, if a Molina physical health director reviews a complex SUD case, the Molina addiction specialist will be consulted on the Enrollee's behalf.

Transition and Discharge Planning. Our behavioral health director will also partner with our facilities to coordinate discharge planning options with our Molina transition of care coordinators, including accessible alternative levels of care suited for the Enrollee when it is determined medically necessary and clinically appropriate to ensure a safe discharge. Molina's behavioral health teams collaborate with local psychiatric facilities for Enrollees with severe mental illness and Enrollees with eating disorders.

Through strong relationships with network providers, we offer clinical and administrative support for both Enrollees and facilities via liaisons in care management, UM, and provider services.

Molina will be one call away for providers or facilities requiring quick and effective solutions when questions of benefit coverage or parity present.

b.vii. ENSURING ACCOUNTABILITY FOR DEVELOPING, IMPLEMENTING, AND MONITORING COMPLIANCE WITH UTILIZATION POLICIES AND PROCEDURES

Ensuring consistent application of the clinical criteria used by our UM teams to make initial authorization determinations is crucial to ensuring the integrity of our entire UM program. Our clinical determinations must be consistent with accepted, evidence-based clinical guidelines and current standards of care to assure the best care for our members and the overall integrity of program. All UM staff follow NCQA and internal UM policies and procedures, such as those for turnaround times and decision notifications.

Our UM activities are governed by our Healthcare Services Committee and, ultimately by our Quality Improvement Committee and medical director. These committees monitor the consistency of how our review teams apply clinical criteria through formal inter-rater reliability and internal quality control processes and also through ongoing training provided by our clinical leadership team. All clinical review professionals receive an in-depth orientation on the prior authorization determination process as well as regularly scheduled trainings, including classes, webcasts, and individual mentoring. Orientation lasts approximately three to four weeks and includes UM basic concepts, role specifics, and systems training.

Competency and skill validation are accomplished by demonstration and parallel practice, knowledge checks, post-tests with feedback, and practice cases. Partnering with a mentor or Subject Matter Expert is vital to a successful training. It is during this time the new employee will be provided more hands Kentucky-specific training, including a Kentucky Medicaid overview and prevalent health conditions in Kentucky. The clinical review professionals also must pass tests on new review criteria. Periodic staff audits validate coverage decisions, and UM leaders review documentation for accuracy and consistency.

Consistent Application of Criteria

In addition to scheduled monthly reviews, we perform ad hoc audits to identify trends and ensure consistent application by individual clinical reviewers. Table C.10-3 describes our main quality control methods.

Table C.10-3. Consistent Application of Criteria by Individual Clinical Reviewers

Method	Description
Internal Quality Control	<p>Within their initial 90 days of employment, Healthcare Services staff members are included in the monthly internal quality control review. Monthly, we select cases for review from each of our clinical reviewers. Audits are conducted to evaluate staff performance and understanding of UM policy and procedure using an interactive auditing tool. The tool focuses on the following UM principles:</p> <ul style="list-style-type: none"> • UM standard documentation process • UM consistency of decision making • UM turnaround times • UM letter requirements <p>Results from these audits are utilized to identify gaps in training for individual reviewers.</p>
Inter-Rater Reliability	<p>Annually, within the first quarter of every year, the inter-rater reliability is conducted using what we call the 8/30 audit methodology. Thirty files are selected at random from the monthly staff audits for review for each Healthcare Services department functional areas. These functional areas include prior authorization nurses, inpatient review clinicians, medical directors, behavioral health professionals, pharmacists, and others who make medical necessity decisions.</p> <p>For example, 8 of the 30 files are reviewed for compliance using the appropriate criteria. If all eight of the files reviewed are in compliance with all of the appropriate criteria, then the audit is complete. If one or more of the initial eight are out of compliance for the appropriate criteria use, then 22 additional files are reviewed. If the first eight of the files reviewed follow all criteria, then the score is 100%. If a total of 30 files are reviewed due to the first eight being non-compliant, then the goal score should be 90% or 27 out of 30 files were correct.</p> <p>Any score less than 90% for staff requires a corrective action plan. Our affiliate health plans in Ohio, Texas, Utah, and Washington each achieved an aggregate score of 100% for the annual inter-rater reliability this past year.</p>
Monthly Audits	<p>In addition to inter-rater reliability, we perform monthly audits on all UM reviewers. For medical directors and behavioral health directors (including contractors), we audit two cases, pulled randomly, per medical director and two cases per behavioral health director per month using the medical director audit tool. Audits are based on technical aspects of the decision language (e.g., grade level, state mandated guidelines, appropriate criteria used) as well as providing a summary and rationale for their decision. We consider a passing score to be 90%.</p> <p>In the fourth quarter of 2019, behavioral health directors scored 97% across the enterprise.</p>

b.viii. PROCESSES AND RESOURCES USED TO DEVELOP AND REVIEW UTILIZATION REVIEW (UR) CRITERIA

Molina develops our UR criteria using a thorough process that includes:

- Review of UM trends
- Review of current policies
- Review of competitor guidelines

- Review of best practice guidelines from nationally recognized professional organizations like the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American Psychiatric Association, Centers for Disease Control and Prevention, InterQual, MCG, Substance and Mental Health Services Administration, and URAC
- Review of current clinical research
- Input from licensed, board-certified providers from a variety of specialties and academic settings

Whenever possible, we determine benchmarks and indicators using external data. Our Kentucky medical director will engage practicing Kentucky physicians from across the Commonwealth to help develop UM criteria specific to their area of expertise. Once developed, our Quality Improvement Committee and Healthcare Services Committee review the recommended criteria for implementation.

In addition to reviewing UM criteria, they conduct an annual, formal review of all UR criteria in use. During their review, committee members will make initial recommendations to the Kentucky Quality Improvement Committee and medical director regarding the need for additions or modifications. Following their review, they will submit their recommendations to Molina's national Quality Improvement Committee and medical directors. If Molina's national Quality Improvement Committee and medical directors agree that additions or modifications are needed, the Healthcare Services Committee will reconvene to review and/or modify those recommendations and submit them to the Kentucky Quality Improvement Committee for final approval.

b.ix. PRIOR AUTHORIZATION PROCESSES FOR NON-PARTICIPATING PROVIDERS OR EXPEDITED PRIOR AUTHORIZATION

Our robust authorization process ensures all prior authorization determinations occur timely and consistently as the Enrollee's medical condition requires, regardless whether the Enrollee requires services from a non-participating provider or if the request is urgent or expedited. We describe our prior authorization process for Enrollees requiring services from non-participating providers or expedited prior authorization in Exhibit C.10-15.

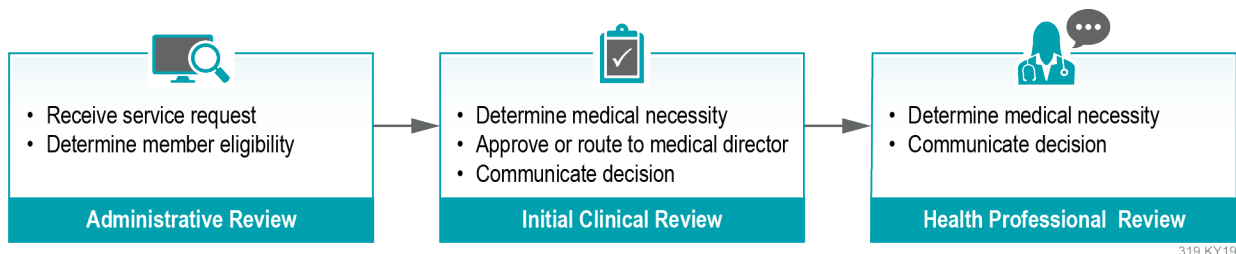


Exhibit C.10-15. Non-Participating Providers or Expedited Prior Authorization Process

We will always advocate for whole-person, individualized care for Enrollees and recognize Enrollees may need services from non-participating providers. Thus, when a qualified specialist or healthcare provider is not available with our contracted network, we will coordinate the medically necessary services with an appropriately licensed and credentialed out-of-network specialist.

For example, a child member in our Wisconsin affiliate health plan was suffering from a very rare inherited disease (hemophagocytic lymphohistiocytosis). The treatment she needed was only available at an out-of-state facility. The member's care manager worked with the health plan's UM and provider services teams to authorize a stem cell transplant for the member at the University of Cincinnati Children's Hospital—the leaders in treating children with this disease. ***Because of their quick coordination advocating for this member, the child is alive and doing well today.***

Assuring Services Are Not Arbitrarily or Inappropriately Denied or Reduced in Amount, Duration, or Scope

Assuring services are not arbitrarily or inappropriately denied or reduced in amount, duration, or scope is crucial to the integrity of our entire UM program. As such, we will:

- Assure requested services are covered benefits.
- Use evidence-based clinical criteria to approve or recommend care at the most appropriate and least intensive level of care.
- Assure licensed clinicians conduct clinical reviews for cases requiring assessment of clinical information and/or the application of all medical necessity criteria.
- Assure a physician, pharmacist, or appropriate behavioral health practitioner (i.e., doctoral-level clinical psychologist or certified addiction medicine specialist) reviews all cases that do not meet criteria based on medical necessity, depending on the type of service and clinical appropriateness.
- Conduct weekly and ongoing UM review to verify that the appropriate decision-maker was used for all decisions.
- Complete internal quality control and inter-rater reliability to assure appropriate decision making and correct application of clinical criteria.

We will provide coverage for our new Kentucky Medicaid Enrollees already receiving physical and/or behavioral health services from out-of-network providers. Existing Enrollees who require out-of-network services or equipment due to medical necessity will be provided coverage under continuity of care. We will provide coverage for second opinions, at the request of the Enrollee and/or the qualified health professional within the network, or we will arrange for the Enrollee to obtain a second opinion outside of the network at no cost to the Enrollee.

For expedited authorization requests, we will make determinations as promptly as the Enrollee's health requires and no later than 24 hours after we receive the initial request for service. For Enrollees diagnosed with a SUD, authorization requests are treated as expedited.

b.x. USING OUR UTILIZATION MANAGEMENT COMMITTEE TO SUPPORT UTILIZATION MANAGEMENT ACTIVITIES

Our Kentucky-based Healthcare Services Committee will integrate both care management and UM to monitor and analyze utilization data for potential over- and underutilization. The Healthcare Services Committee will formally review and approve all UM standards, including authorization criteria, clinical guidelines, and programs to assure our accountability for developing, implementing, and monitoring compliance with UM policies and procedures. They will also review grievances and appeals, including expedited appeals and state fair hearings related to UM to recommend any change in policy.

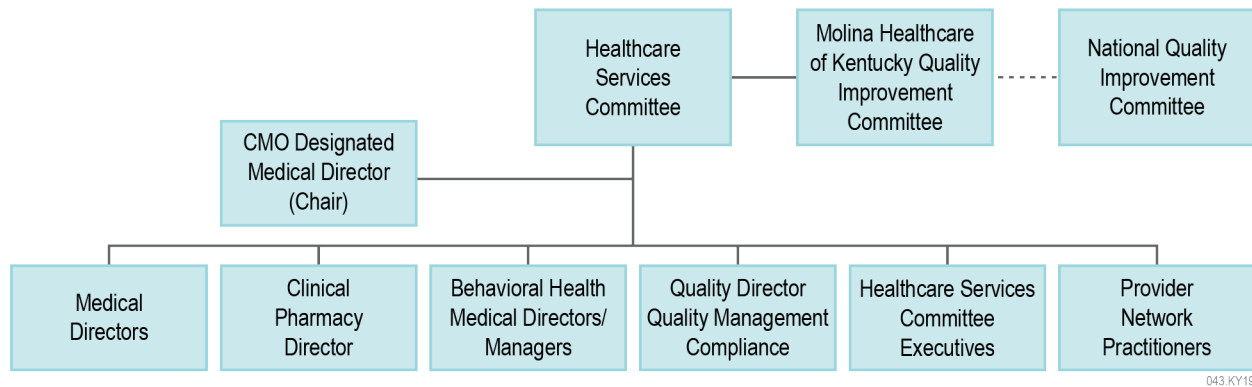
The Healthcare Services Committee will review data reported on outcomes and trend studies to recommend additional studies and/or changes in data collection; conduct under/over utilization monitoring by select diagnosis and practice type; evaluate Enrollee and provider satisfaction using their input; make recommendations to improve relationships with Enrollee and community providers; monitor inter-rater reliability for each clinical review group annually; monitor compliance with regulatory agencies and accreditation bodies; and review utilization information from delegated vendors, if applicable.

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

Our Kentucky Quality Improvement Committee, chaired by our medical director, will reflect a diverse array of expertise, including our CEO and the leaders from the Quality Improvement, Healthcare

Services, Behavioral Health, Network, Provider Services, Compliance, and Community Engagement teams. Any recommended modifications to our UM processes or criteria will be submitted to the Quality Improvement Committee for review and approval.

A formal description of our UM Program will be articulated in our Kentucky Utilization Management Plan. This plan will be reviewed and approved by the Healthcare Services Committee and the Quality Improvement Committee annually and be submitted to the Commonwealth of Kentucky for review and approval before program go-live. Exhibit C.10-16 reflects the composition of the Healthcare Services Committee.



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Exhibit C.10-16. Kentucky Healthcare Services Committee

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