

## C.27 Contractor Reporting Requirements

### REQUIREMENT: RFP Section 60.7.C.27

27. Contractor Reporting Requirements (Section 37.0 Contractor Reporting Requirement)

- a. As indicated in RFP Attachment C “Draft Medicaid Managed Care Contract and Appendices,” the Department would like to leverage the contracted MCOs existing technologies and reporting capabilities to develop a comprehensive reporting package through a collaborative process. Understanding that ultimately the Department will define the reporting package, describe the Contractor’s willingness to participate in such a collaboration, including a discussion of the following:
  - i. Proposed reports and report templates that will result in a comprehensive, Department-accepted reporting package.
  - ii. Proposed ideas for collaborating across MCOs to ensure consistent and comparable reporting using the same data definitions and specification can be achieved.
  - iii. Requirement of Subcontractors to participate and or comply with this process.
- b. Provide a detailed description of the Contractor’s capability to produce reports required under this Contract, including an overview of the Contractor’s reporting systems and capability to configure such systems to capture data according to reporting definitions and specifications as required by the Department.
- c. Describe the Contractor’s processes to review report accuracy and completeness prior to submission to the Department.
- d. Provide examples of the Contractor’s proposed:
  - i. Processes for conducting comparative data analyses, interpreting trends, and summarizing findings in a manner that is easily interpreted by the Department.
  - ii. Use of dashboard reporting to monitor, track, and evaluate performance metrics, including dashboard level data the Contractor proposes to submit to the Department. Provide a sample dashboard report.
  - iii. Use of findings from reports to make program improvements and to identify corrective action.
- e. Describe the Contractor’s processes for monitoring, tracking, and validating data from Subcontractors.
- f. Describe the Contractor’s proposed process for the receipt, generation, interpretation, and provision of ad hoc reports requested by the Department.

**Our reporting capabilities are driven by continuous innovation through highly scalable technologies informed by the thoughtful data analysis of experienced teams, resulting in the highest level of transparency, quality, and cost-effective care for Kentucky Medicaid Enrollees.**

The Department, MCOs, and providers can make the most informed, evidence-based decisions about the Kentucky Medicaid program and the health of Enrollees when *reporting is transparent, easily accessible, and accurately reflects the most up-to-date data and trends*. Molina commits to using our highly scalable and integrated data and analytics platform and advanced technologies to securely produce and deliver sophisticated, innovative analytics and reporting. By using best-in-class analytical tools as well as in-house data scientists to scrutinize available healthcare data, Molina can identify actionable insights that support stated goals.

Although the Department ultimately will define the reporting package, our significant technology and reporting capabilities will benefit the Commonwealth. Within the remainder of this section, we detail our compliance with Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 37, Contractor Reporting Requirements and Appendix D, Reporting Requirements and Reporting Deliverables.

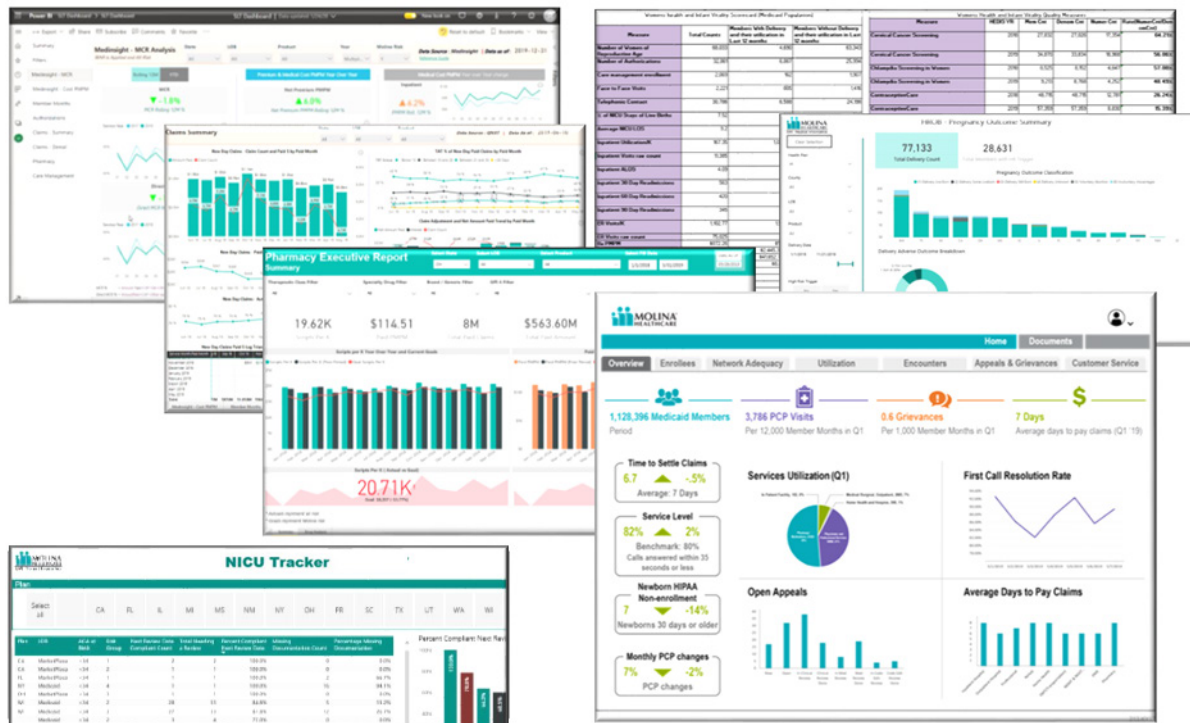
### A Committed Partner

- A modern, advanced, and integrated data and analytics platform with a proven, highly scalable data lake
- Thoughtful analysis and actionable insights from a seasoned Medicaid Managed Care analytics team
- An experienced, dedicated partner focused on Kentucky Medicaid program Enrollees

### a. EXISTING TECHNOLOGIES AND REPORTING CAPABILITIES

Molina will work with the Department to leverage our substantial existing technologies and reporting infrastructure to meet the Commonwealth’s reporting package needs, as detailed in Draft Contract, Appendix D, while maintaining compliance with 42 C.F.R. 438.604. We look forward to collaborating with the Department, other MCOs, provider groups, and stakeholders to develop a seamless data analytics and information exchange platform. Our comprehensive reporting from all aspects of operations,

highlighted in Exhibit C.27-1, ensures Molina decisions will be driven by *powerful data analytics to support positive health outcomes*.

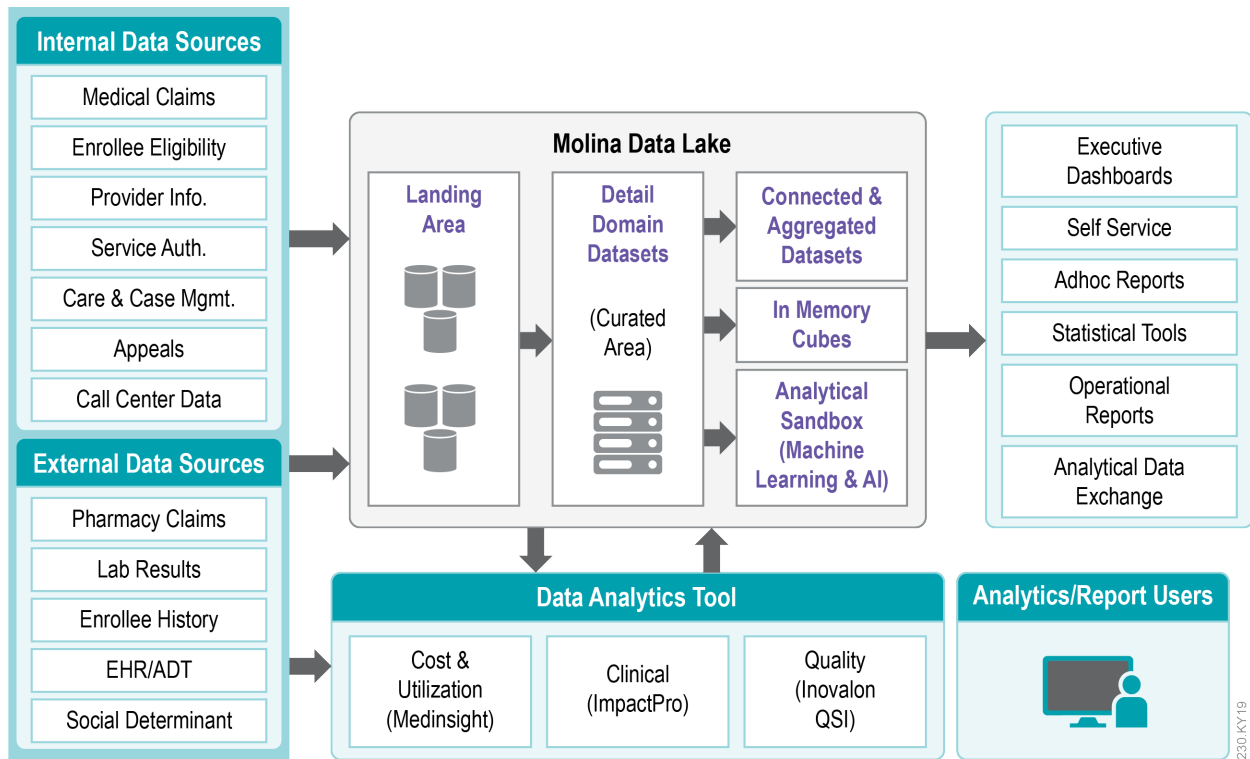


**Exhibit C.27-1. A Sampling of Our Comprehensive Reporting Resources**

**Modern, advanced, and integrated data and analytics platform.** Enterprise-wide, our reporting and analytics capabilities are grounded in our proven data integration platform: the Molina Data Lake. *The storage and processing capacity within the Molina Data Lake environment is highly scalable.* It comprises multiple nodes and clusters linked by big data technology and employs the industry-standard Hadoop distributed processing framework to offer unlimited storage potential. *Overall, Molina manages several hundred petabytes of data and houses more than 10 years of healthcare data.*

The Molina Data Lake uses *best-in-class data governance, security, and quality tools* coupled with a highly mature process to ensure that the available data is integrated, ready to use, and of the highest quality. In addition, the Molina Data Lake significantly reduces both development time and the opportunity for error by abstracting and combining data into the data layer itself, allowing for reuse and standardization across reports. This ensures that all data is accurately captured in one place for easy access and timely delivery of high-quality reports.

As detailed in Exhibit C.27-2, the Molina Data Lake will store various data, including claims and encounters, Enrollee information, service authorizations, primary care provider (PCP) information, Enrollee social/demographic, and lab results, all gathered and curated from internal and external sources. We use the curated data to produce various operational and compliance reports as well as actionable analytics. We will use several industry-leading tools to gain insight into Enrollee health, population risk identification and stratification, cost, and utilization. Enhanced data sets are also integrated with base data in the Molina Data Lake, and we use them to generate all dashboards, alerts, predictive and prescriptive analytics, and reports.



**Exhibit C.27-2. Molina Data Lake**

**Thoughtful analysis, actionable insights.** State-of-the-art technologies only take us so far. Our technology is backed and supported by the experience of our *analytics team*, which is ultimately responsible for data collection, integration, reporting, analysis, problem solving, and process improvement. In addition to their expertise in the areas of reporting and analytics, the team has a strong background in supporting Medicaid Managed Care with subject matter experts in all important aspects of healthcare reporting and analysis, including claims, authorizations, and quality. This team works to deliver insightful and actionable value-added analysis and key performance indicators (KPIs) that will empower the Department to advance population health and other initiatives. *For example, using our suite of advanced quality analytics tools, we have quickly identified intervention opportunities and optimized operational strategies to improve quality scores, such as HEDIS scores for Post-Partum Care and Comprehensive Diabetes Care.*

In addition to our in-house data science capabilities, we have licensed industry-leading analytic technologies to gain a deep understanding of cost of care, Enrollee health status, and evidence-based care gaps that provide transparency and assist in improving health outcomes to optimize cost and quality of care delivered. These tools are detailed further in Table C.27-1 below.

**Table C.27-1. Data Analysis Tools**

Tool	Capability
<b>Cost &amp; Utilization Analytics (Milliman MedInsight®)</b>	This product provides a deep analysis of cost and utilization data that enables us and the Commonwealth to identify cost trends and actions required to impact them. A Chronic Conditions Hierarchical Groups analyzer, where insured individuals are assigned to unique categories using clinically relevant hierarchy based on physician treatment decisions, provides powerful insights to assist users in identifying cost trend drivers for population management.

Tool	Capability
<b>Clinical Analytics (Optum Impact Pro®)</b>	Optum’s Impact Pro incorporates the analytical foundation of Optum Symmetry to predict future risk as well as evidence-based care gaps founded on both retrospective and prospective analysis of data. It will then stratify the risk to help care managers evaluate Enrollees’ current intervention program to discover opportunities to maximize intervention efficacy. Impact Pro will allow us to view Enrollee-centric individual profiles and forecast costs and medical service needs based on available data inputs, such as enrollment, medical claims, pharmacy claims, and lab results.
<b>Self Service Platform using Microsoft Power BI</b>	This tool enables users to connect to multiple data sources, simplify data preparation, drive ad hoc analysis, and interactively explore data through modern data visuals to quickly and easily deep dive into data. The Self-Service Platform also makes it easy for Molina’s analytics and business teams to rapidly provide insightful analysis and reporting to the department.
<b>Quality Analytics (Inovalon’s Quality Spectrum Insight [QSI®])</b>	QSI is an NCQA- and URAC-certified tool that offers advanced analytics and cloud-based data-driven intervention capabilities and provides precise accreditation measurement, value-based outcomes, and related reporting, while improving quality, utilization, and financial performance. With a flexible approach, we currently use QSI as an integrated quality measurement, reporting, and improvement solution in support of all of Molina’s affiliated health plans, helping improve care quality and coordination with providers.

**An experienced, dedicated partner.** At Molina, facilitating exceptional care for Enrollees covered by government contracts like the Kentucky Medicaid program is our only business—not just a line of business. Molina has invested heavily in building our integrated data and analytics platform to directly support Medicaid stakeholders. We understand the critical need for transparency and collaboration and bring reporting and analytics best practices from 14 Medicaid plans to directly benefit the Commonwealth and deliver a best-in-class reporting experience. *For example, our provider Call Center dashboard integrates provider call data, appeals, claims, and denials, enabling us to quickly identify issues with providers, monitor issue resolution, and improve the quality of service we offer our providers.*

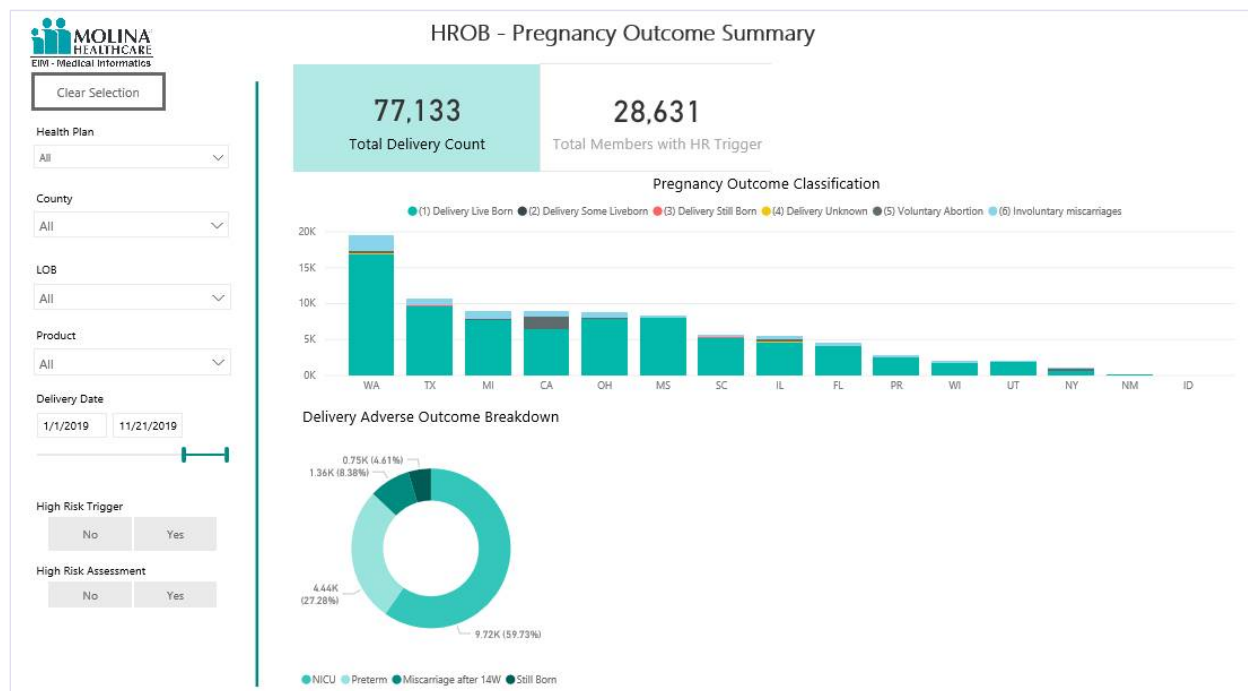
We will collaborate with the Department and fellow MCOs to help define a reporting package that makes the best use of our analytical capabilities to track, detail, and compare data within the Medicaid program. From ad hoc reporting to the reporting deliverables outlined within Draft Contract, Appendix D, we have the experience, analytics infrastructure, advanced technology, and trained, experienced staff to meet or exceed Department needs. Drawing upon our technologies and reporting capabilities, Molina has successfully collaborated with states nationwide on reporting packages and deliverables that help address important initiatives such as premature deliveries and low birth weights. For example, Molina’s affiliate health plans track pregnancy outcomes, as shown in Exhibit C.27-3.

We are also working to provide future-state capabilities such as real-time provider data sharing to drive increased transparency for our state partners.

#### Data from a True Care Coordinator

We share information about the services we provide with our Enrollees’ care providers. In the electronic medical records (EMR) arena, we have:

- Shared EMR records with 1,170 different organizations
- Sent 1.1 million and received 821,000 EMR records



**Exhibit C.27-3. SAMPLE Molina High Risk OB Pregnancy Outcomes Tracker**

**a.i. PROPOSED REPORTS AND REPORT TEMPLATES**

After reviewing the reporting package described in Draft Contract, Appendix D, we believe the Commonwealth has a well-considered reporting package already defined. We have experience reporting all the information defined in Draft Contract, Appendix D to other state Medicaid agencies. A selection of our experience includes the following.

**Initiative Targeting Pre-term and Low Birth Weight Deliveries.** Our affiliate health plan in Ohio has collaborated with Ohio Medicaid on reporting initiatives to better track the occurrence of pre-term and low birth weight deliveries. This important initiative is helping Ohio monitor and remain focused on reducing pre-term deliveries. We observe a similar report is already included in Draft Contract, Appendix D as “Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death.” We believe this is an important and worthwhile focus for the Department. We also suggest the Department include monitoring babies born with Neonatal Abstinence Syndrome (NAS).

Exhibit C.27-4 below shows our Comprehensive View of Women’s Health and Infant Vitality report, which tracks data points over a given period and enables the reviewer to drill down in level of detail.

In addition, our Live Birth and NICU Dashboard, Exhibit C.27-5, tracks birth outcomes over time so that progress can easily be monitored. Additional detail can be found on tabs within the report.

Womens health and Infant Vitality Scorecard (Medicaid Population)				Womens Health and Infant Vitality Quality Measures					
Measure	Total Counts	Members With Delivery and their utilization in Last 12 months	Members Without Delivery and their utilization in Last 12 months	Measure	HEDIS YR	Mem Cnt	Denom Cnt	Numer Cnt	Rate(NumerCnt/DenomCnt)
Number of Women of Reproductive Age	68,033	4,630	63,343	Cervical Cancer Screening	2018	27,832	27,026	17,354	64.21%
Number of Authorizations	32,861	6,867	25,994	Cervical Cancer Screening	2019	34,870	33,634	18,368	56.06%
Care management enrollment	2,069	162	1,907	Chlamydia Screening in Women	2018	8,525	8,152	4,647	57.00%
Face to Face Visits	2,221	805	1,416	Chlamydia Screening in Women	2019	9,213	8,768	4,252	48.49%
Telephonic Contact	30,786	6,588	24,198	ContraceptiveCare	2018	48,715	48,715	12,781	26.24%
% of NICU Stays of Live Births	7.52	N/A	N/A	ContraceptiveCare	2019	57,359	57,359	8,830	15.39%
Average NICU LOS	3.2	N/A	N/A	Postpartum	2018	4,544	4,549	2,602	57.20%
Inpatient Utilization/K	167.35	1,027.33	103.63	Postpartum	2019	3,905	3,905	1,952	49.99%
Inpatient Visits raw count	11,385	4,821	6,564	Prenatal	2018	4,544	4,549	3,466	76.19%
Inpatient ALOS	4.09	2.39	4.3	Prenatal	2019	3,905	3,905	3,089	79.10%
Inpatient 30 Day Readmissions	563	100	463	Progesterone	2018	3,883	3,883	65	1.67%
Inpatient 60 Day Readmissions	420	45	375	Progesterone	2019	1,875	1,875	52	2.77%
Inpatient 90 Day Readmissions	345	28	317	TobaccoCessation	2018	40,679	40,679	7,301	17.95%
ER Visits/K	1,102.77	1,519.19	1,071.94	TobaccoCessation	2019	42,803	42,803	8,645	20.20%
ER Visits raw count	75,025	7,125	67,900						
Rx PMPM	\$872.26	\$521.40	\$898.23						
Rx Cost	\$53,342,197.74	\$2,445,366.03	\$56,896,831.71						
Total Cost of Care	\$273,503,039.69	\$41,652,745.12	\$231,850,294.57						
Total Cost PMPM	\$4,020.15	\$8,881.18	\$3,660.24						
PCP Visit Within Prior 12 Months	60,735	3,630	57,045						
Low birth weight deliveries	4,050	N/A	N/A						
<1,500g	35	N/A	N/A						
1,500-1,999g	99	N/A	N/A						
2,000-2,499g	276	N/A	N/A						
2,500-3,999g	3,337	N/A	N/A						
4000g+	243	N/A	N/A						
MissingBirthweight		N/A	N/A						
Percentage of preterm births	10.2%	N/A	N/A						

Exhibit C.27-4. SAMPLE Women's Health and Infant Vitality Scorecard

LIVE BIRTH & NICU DASHBOARD						
SUMMARY METRICS						
Year	Delivery Count	NICU Count	Live-Born Count	Non-LiveBorn Count	Normal Delivery	Cesarean Delivery
2017	5,343	814	5,317	26	4,012	1,331
2018	6,970	1,291	6,947	23	5,174	1,794
2019	5,962	1,156	5,923	39	4,321	1,641
NICU Admits by Birthweight						
Claim Year	<1,500g	1,500-1,999g	2,000-2,499g	2,500-3,999g	4000g+	Grand Total
2017	80	116	316	294	8	814
2018	144	168	492	466	21	1,291
2019	129	154	421	422	30	1,156
Month over Month Summary						
Year Month	Delivery Count	NICU Count	Live-Born Count	Non-LiveBorn Count	Normal Delivery	Cesarean Delivery
2017-04	496	80	490	6	383	113
2017-05	587	71	586	1	433	154
2017-06	597	101	595	2	452	145
2017-07	634	95	631	3	483	151
2017-08	632	101	632	0	470	162
2017-09	640	80	637	3	479	161
2017-10	597	101	591	6	442	155
2017-11	575	96	571	4	424	151
2017-12	585	89	584	1	446	139
2018-01	608	115	606	2	473	135
2018-02	561	84	558	3	414	146
2018-03	601	82	598	2	457	144
2018-04	520	86	518	2	382	138
2018-05	589	114	588	3	443	146
2018-06	545	97	543	2	392	153

Exhibit C.27-5. SAMPLE Live Birth and NICU Dashboard



**Real-time Provider Data Sharing.** Molina Healthcare of Florida is currently working with the Florida Medicaid agency to develop real-time provider data sharing using XML. The intention is to update agency systems daily in response to any changes to Molina’s provider network. This information includes participation status changes as well as changes to available service locations and contact information. While this is still in the initial stages of development, we are excited by the potential of this effort to create a new level of data sharing and collaboration. Pending a successful implementation, there will likely be efforts to expand this to other data beyond just provider data. While this is not a report or report template per se, this capability can dramatically reduce the need for plans to generate and submit separate reports, as the data can be combined and reported out by the Department with up-to-date information that is uniform across plans.

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**Exhibit C.27-6. SAMPLE Real-time Data Sharing File**

Exhibit C.27-6 depicts an example of a file that could be exchanged through the real-time data sharing process being developed in Florida.

**Ensuring Consistent Reporting on all Complaint Fields.** In Texas, the state sought an initiative to help collect consistent complaints across all Texas MCOs. The state’s defined complaint categories and subcategories were proving to be ambiguous, which could lead to multiple interpretations and inconsistent data. Molina Healthcare of Texas worked with the Texas Association of Health Plans to identify opportunities to streamline and develop improved consistency across fields and categories to ultimately provide the state with an improved solution for dependable complaints data.

Exhibit C.27-7, shows how Texas complaints are bucketed into consistent categories and reported with detailed information. This allows Texas agencies to compare complaints accurately across MCOs.

 <b>TX MPRT (A&amp;G) Key Performance Indicator report</b>						
Classification	Case ID	Product Type	Complaint Delegate Name	Date Complaint was received	Complaint Reason	Type of Complaint Desc
Member Complaint		STAR+PLUS (State of Texas Access Reform Plus Long Term		1/17/2020	Access and Availability	HHSC
Member Complaint		MOLINA MARKETPLACE		1/17/2020	Billing/Financial	COMPLAINT
Member Complaint		MOLINA MARKETPLACE PROGRAM		1/16/2020	Billing/Financial	TDI
Member Complaint		STAR (State of Texas Access Reform)		1/22/2020	Billing/Financial	COMPLAINT

**Exhibit C.27-7. SAMPLE Texas Key Performance Indicator Report**

**Example of Reporting Enhancements.** Molina Healthcare of Illinois has collaborated with Milliman to develop an effective Encounter Data Comparison Report for Illinois’ Medicaid agencies. Although other states have reports that accomplish a similar goal and this report is also listed in Draft Contract, Appendix D, we believe their report represents one of the best versions we have observed. It clearly shows existing encounter issues that may be causing discrepancies between encounter data and reported financials.

Exhibit C.27-8 shows the scored summary section of our Illinois Encounter Data Comparison Report. Along with the other nine sections of the report, this section helps our affiliate health plan in Illinois determine encounter data completeness and ensure reliable information for rate setting.

Unadjusted EUM Scores				
Service Category	HFS Accepted Encounters Service Cost PMPM	Medicaid Spend Data Service Cost PMPM	EUM Score	HFS Threshold
Inpatient Hospital			94.6%	85.0%
Outpatient Hospital			90.2%	85.0%
Retail Pharmacy			100.0%	85.0%
Transportation			91.0%	85.0%
Dental			95.9%	85.0%
Encounter Rate Clinic			96.9%	85.0%
Professional (including DME/Prosthetics and Vision)			95.5%	85.0%
SUPR			53.1%	85.0%
LTC + Hospice			93.2%	85.0%
Waiver			68.5%	85.0%
Home Health			66.4%	85.0%
<b>SUM OF COVERED SERVICES (EXCL HH &amp; Waiver)</b>			<b>94.7%</b>	<b>96.0%</b>
<b>SUM OF ALL SERVICES</b>			<b>94.4%</b>	<b>96.0%</b>

Adjusted EUM Scores				
Service Category	HFS Accepted Encounters Service Cost PMPM	Medicaid Spend Data Service Cost PMPM	EUM Score	HFS Threshold
Inpatient Hospital			94.6%	85.0%
Outpatient Hospital			90.2%	85.0%
Retail Pharmacy			100.0%	85.0%
Transportation			91.0%	85.0%
Dental			95.9%	85.0%
Encounter Rate Clinic			96.9%	85.0%
Professional (including DME/Prosthetics and Vision)			95.5%	85.0%
SUPR			53.1%	85.0%
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Waiver			68.5%	85.0%
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<b>SUM OF ALL SERVICES</b>			<b>94.4%</b>	<b>96.0%</b>

**Exhibit C.27-8. SAMPLE from Our Illinois Encounter Data Comparison Report**

With enterprise-wide experience working with Medicaid agencies across 14 states, we are in an excellent position to help the Department adopt/adapt best-in-class reports into the accepted reporting package. We look forward to collaborating with the Department to enhance an already strong reporting package.



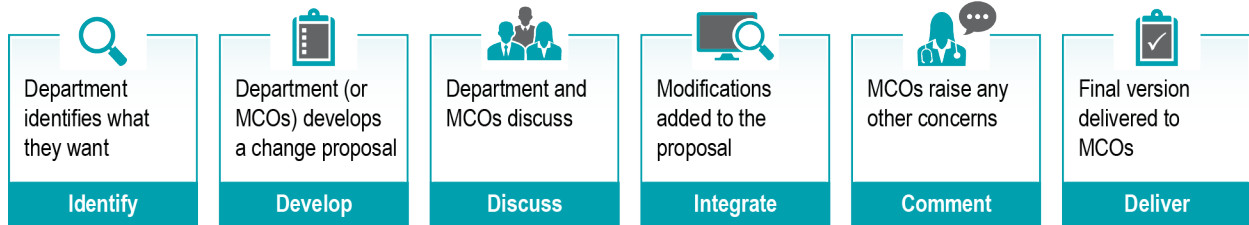
## a.ii. PROPOSED IDEAS FOR COLLABORATING ACROSS MCOS

Molina frequently collaborates with MCOs on the creation of reports and interventions in support of the states we serve. We work with our state partners in the manner they prefer and that often involves collaborating with other stakeholders such as our fellow MCOs to achieve consistent and comparable reporting. Below, we propose two ideas for Kentucky Medicaid based on our collaboration and experience in other states:

- MCO Roundtables.** In this instance, representatives from contracted MCOs gather and hold regular meetings to discuss with the Department, and amongst themselves, high-level issues related to reporting. Such roundtables can be useful in devising solutions for matters such as the need for new reporting requirements due to influence from parties outside of the Department and MCOs, including large provider groups and associations, lawmakers, etc. Other topics that could be covered include addressing data trends of specific concern to the Department; finding common ground to better manage reports that are difficult to consolidate and to compare data across MCOs; and confronting universally applicable data issues that can make reports difficult to complete or interpret. These discussions will then be used to drive additional meetings and conversations about solutions.
- Department Driven Dialogue.** For collaborating on possible changes to existing reports and new reports, we propose a more top-down approach, driven by the Department. This procedure works best for highly specific, actionable items, such as data, information, or outcomes needs that may already have been identified in an MCO Roundtable or that would not fit into the cadence of the MCO Roundtables described above. The process would resemble that shown in Exhibit C.27-9.

**Collaboration Speeds Flow of Hospital Data**

At an MCO roundtable meeting, our affiliate health plan in Florida raised a concern that hospitals were not reporting data to MCOs promptly. The lag time made it difficult for health plans to support PCPs in post-hospitalization and post-emergency department visit follow-ups. Heeding this concern, the state and MCOs partnered with a vendor to consolidate hospital data submitted at the time of discharge, admission, or emergency department visit. MCO members now receive hospital data regularly throughout the day so it can be shared with PCP groups, empowering PCPs with real-time data to help them improve member health outcomes.



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**Exhibit C.27-9. Department Driven Dialogue Process Flow**

For example, one state Medicaid agency took advantage of an opportunity for department driven dialogue when it was having a difficult time comparing financial results across MCOs due to differences in how the MCOs interpreted each cost category. The agency proposed a detailed specification for each cost categorization. Each health plan then submitted feedback and suggested clarifications and enhancements, which were evaluated and incorporated into the final specification. In the end, after a few rounds of feedback, the agency arrived at a universal definition that was comparable across all health plans because it was a product of strong collaboration.

While these are our proposed ideas for collaboration on consistent and comparable reporting, Molina is supportive of any process that achieves this important goal.

### a.iii. SUBCONTRACTOR REQUIREMENTS

Emphasizing open communication, collaboration, and proactive problem-solving, Molina’s Kentucky Medicaid subcontractor oversight program will be guided by robust policies and procedures leveraged by all our affiliate health plans. Supported by our dedicated delegation oversight staff and a proactive provider engagement approach, these established processes drive close, ongoing collaboration between the health plan and our subcontractors. Our proven approach supports effective monitoring and continuous evaluation of all aspects of subcontractor performance to ensure compliance with all reporting and other contract requirements while delivering high-quality products and services.

Subcontractors will be required to participate in accordance with agreed-upon reporting policies and procedures. At minimum, we require subcontractors to abide by all new data requirements that result from this process. We will also engage subcontractors in relevant areas to gather and contribute their feedback to be shared with the Commonwealth and other MCOs. If changes to reporting policies occur, subcontracts will be required to abide by all new data requirements.

We notify subcontractors of changes to reporting expectations at least 60 calendar days in advance, unless a shorter implementation timeframe is required by the Division. The 60-day lead-time allows subcontractors to test new reporting and have questions answered to ensure that accurate data can be provided by the effective date. If in the unlikely event we determine subcontractors are not compliant, we outreach via our dedicated national account manager, delegation oversight team, or network teams to determine the issue. When appropriate, we implement corrective action plans (CAPs), up to and including financial penalties for non-compliance with reporting requirements.

Quality is a focus for all areas of our operations, and this applies to subcontractor oversight as well. Our multi-layered subcontractor oversight process is based on NCQA standards for delegation oversight. We maintain oversight of our subcontractors through the terms of our contracts and provide ongoing oversight activities through our oversight committee structure.

#### Subcontractor Oversight Activities

As noted in Proposal Section C.1, Subcontracts, we monitor subcontractor performance through a series of pre- and post-contractual assessments, routine performance monitoring, and audits. Reviews focus on areas such as ability to meet delegation requirements; required reporting and system interfaces; financial operation and amounts paid for covered services; contract compliance; and logged complaints. Oversight activities are described in Table C.27-2.

**Table C.27-2. Oversight Activities**

Activity	Outcome
<b>Contract Development</b>	This process includes the careful drafting and negotiation (proof of concept through scope of work) of all applicable master services, business associates, nondisclosures, independent contractors, and other necessary agreements.
<b>Pre-Assessment Audits</b>	Pre-assessment audits occur before delegation effective dates. A pre-assessment audit evaluates a potential subcontractor’s ability to meet all contractual agreements and program requirements, CMS, federal, Kentucky requirements, and NCQA standards, as applicable. We review policies, procedures, and applicable files and interview staff during the audits. Even though our proposed subcontractors currently provide services to our Enrollees, we will conduct Kentucky Medicaid specific pre-assessment audit to confirm their ability to provide services under the next contract.
<b>Continual Monitoring and Oversight</b>	Monitoring and oversight of performance reports begins with delegation effective dates. Reports are submitted for each function delegated on a monthly and quarterly basis. Compliance with contractual performance expectations are reviewed and summary reports are created. Summary reports of performance are taken to the Delegation Oversight Committee (DOC) and reviewed for compliance. When appropriate, implementation of CAP is approved, up to and including issuing any financial penalties.

Activity	Outcome
<b>Audits</b>	We also conduct audits for each delegated function every year or more frequently as requested by the DOC or the Department, or as required by Kentucky Medicaid or federal agencies. Annual audits follow a format similar to pre-assessment audits, as does the determination of a need for corrective action. DOC reviews annual audit results and decides on a course of action, up to termination if necessary.
<b>Meetings with Subcontractors</b>	We schedule monthly touch base meetings and quarterly Joint Operations Committee meetings with our subcontractors to review overall utilization and performance standards, such as reporting requirements, Enrollee complaints, and discussion around any contractual or operational concerns with the subcontractor. Meeting participants include numerous functional areas from Molina and attendees from the subcontractor.
<b>CAPs/ Enforcement</b>	Our policies and procedures include guidelines for enforcement of non-performance and corrective actions used to improve performance, which may include: corrective action plans, sanctions, penalties (if the subcontract contains performance guarantees), revocation of delegated functions, or imposition of other sanctions if performance is inadequate.
<b>Penalties</b>	Our subcontracts also provide for financial penalties for subcontractor non-compliance. Subcontractors may be assessed a penalty or be required to pay any sanctions leveraged against Molina, if the sanction was related to a delegated function of the subcontractor.
<b>Contract Termination</b>	While ending our relationship with a subcontractor is an option, we prefer to avoid this measure at all costs. We try to work with under-performing local subcontractors and encourage them to improve their operations instead of terminating their contract.

Our approach to driving required subcontractor reporting compliance will also leverage the success of our newest Medicaid affiliate health plan in Mississippi and its successful subcontractor relations approach and activities, which include:

- Encouraging subcontractor participation in monthly/quarterly meetings with the Department, as applicable, based on agenda topics
- Engaging subcontractors as part of external audits or quality reviews to address first-hand all aspects of their health plan relationship and services provided
- Conducting regular audits to validate subcontractor performance, including reporting compliance
- Fostering ongoing relations with our subcontractors through regular meetings and other open communications
- Employing a dedicated local delegation oversight manager within the health plan to oversee all aspects of subcontractor performance

This example from Mississippi is just another way we will bring our best practices from our 14 affiliated Medicaid health plans to benefit Kentucky.

## b. CAPABILITIES TO PRODUCE REQUIRED REPORTS

Upon our detailed review of the reporting package descriptions included in Draft Contract, Appendix D, Molina is confident in our ability to produce all the required reports due to our extensive experience producing similar reports for Medicaid agencies nationwide.

**Overview of reporting systems.** Integrated reporting systems and functionality enables us to produce reliable and compliant reports that meet the Department’s specifications and requirements. As detailed in Exhibit C.27-10, MIS Report Generation Components, our MIS report generation components fully support all quality and compliance-related program reporting. Molina produces reports for all operational and functional areas following program requirements specified in the RFP and Draft Contract. To ensure the accurate, complete, and timely submission, all reports are developed to the Department’s specifications (e.g., instructions and formats) and submitted in compliance with submission methods and timeline indicated.

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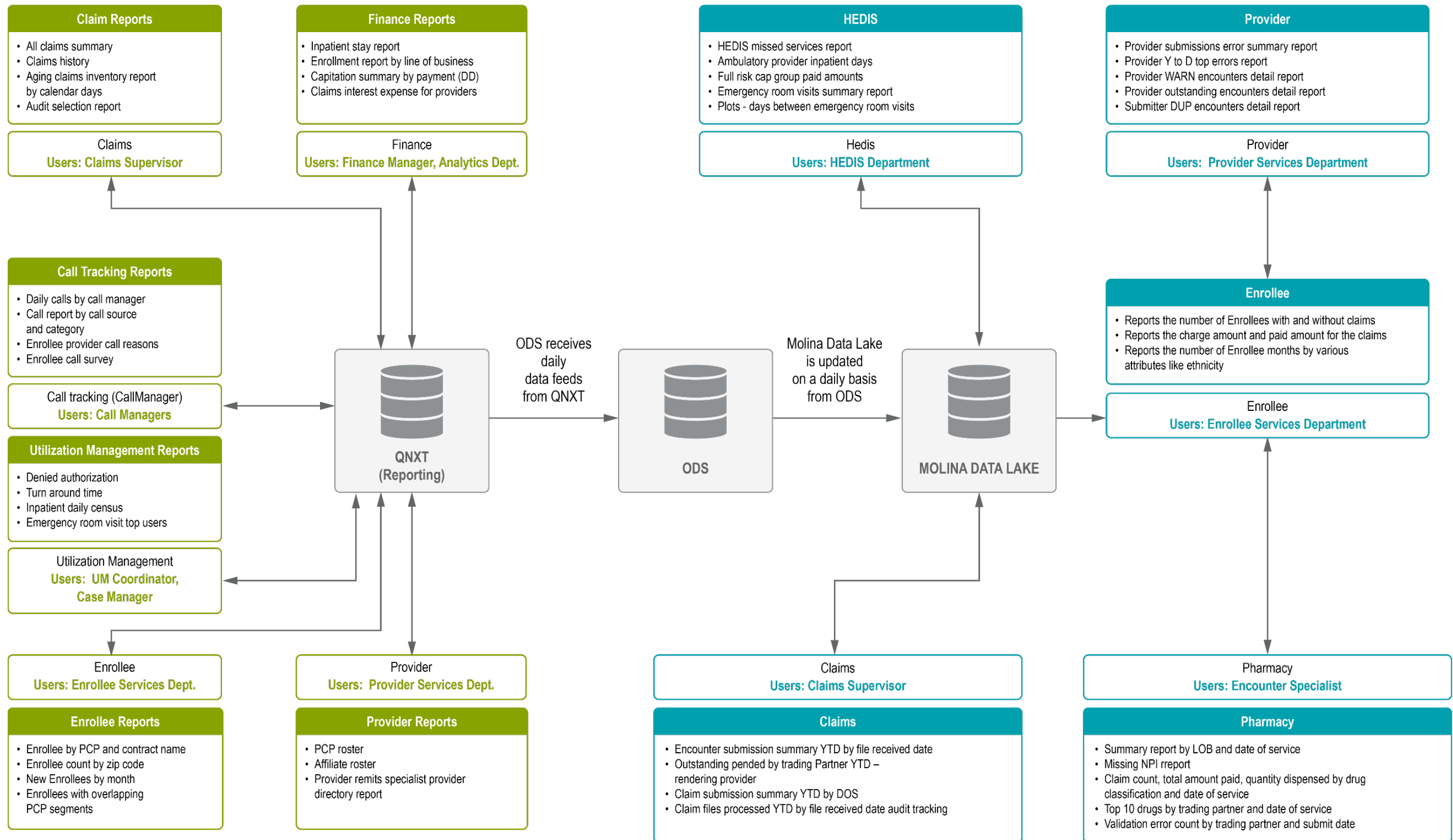


Exhibit C.27-10. MIS Report Generation Components

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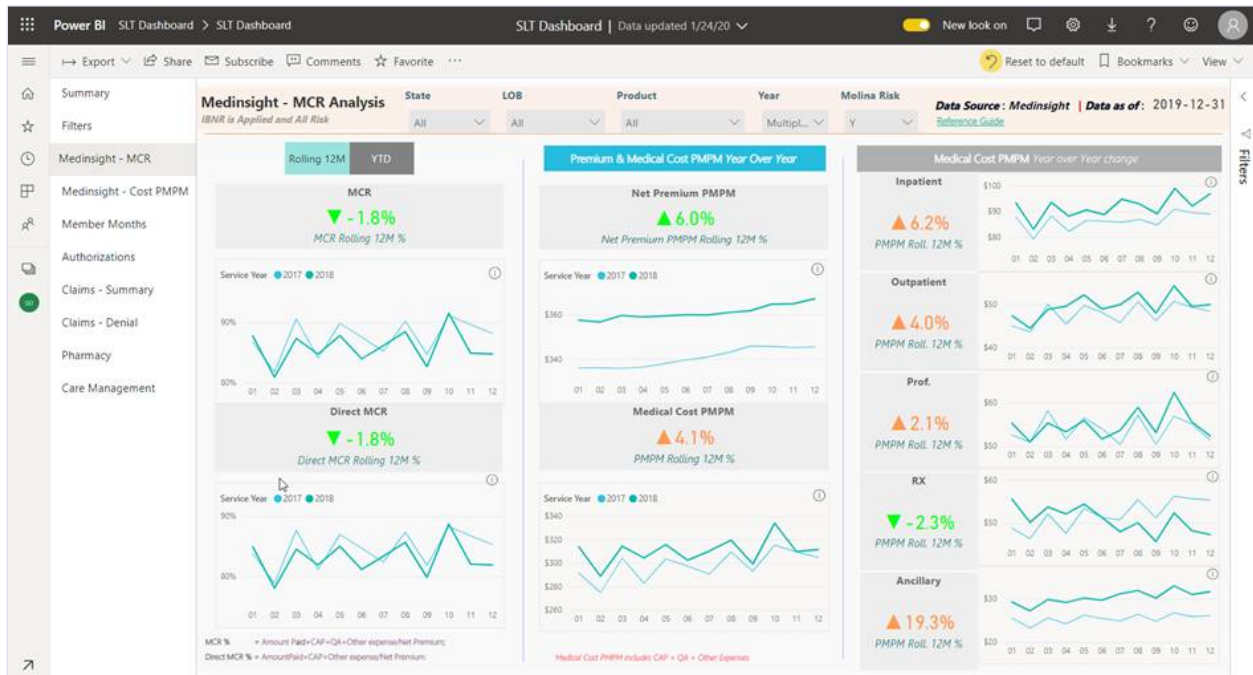
**Capability to Configure Systems to Capture Data.** Our systems and software generate standard and ad hoc reports in various formats from low, medium, and high-volume data sets. Some reports include internally produced data; others have data received from subcontractors or external entities (e.g., lab, pharmacy, past medical history).

Regardless of the data being reported, all data is pulled from a single location, the Molina Data Lake. For some MCOs producing state required reports is usually difficult for two reasons.

- Some MCOs maintain multiple disparate data sources that must be merged together to produce Department-requested reports. The Provider Credentialing and Contracting Status Report is a good example of this. Credentialing and contracting are typically two separate functions with data being input into two separate locations.
- Similar data is often shown across multiple reports but need to tie together. For instance, the MLR and Total Cost of Care (TCOC) Per Member Per Month (PPPM) reports will have related data even though they display it differently.

The Molina Data Lake solves both issues by abstracting and combining these data definitions into the data layer itself. Definitions for concepts like “inpatient claim” or “ancillary service” are defined once and then reused across reports. This standardization of data definitions and business logic benefits our reporting by both reducing development time and ensuring consistency in reporting. Additionally, disparate data is joined together in a single place. For example, medical cost and premium information are tied to the Enrollee information in the data lake. As data joining is not required, development time is further reduced and errors from joining between multiple data elements are eliminated.

Exhibits C.27-11 through C.27-13, below, show examples of our report capabilities.



**Exhibit C.27-11. SAMPLE Senior Leadership Team Dashboard Report**

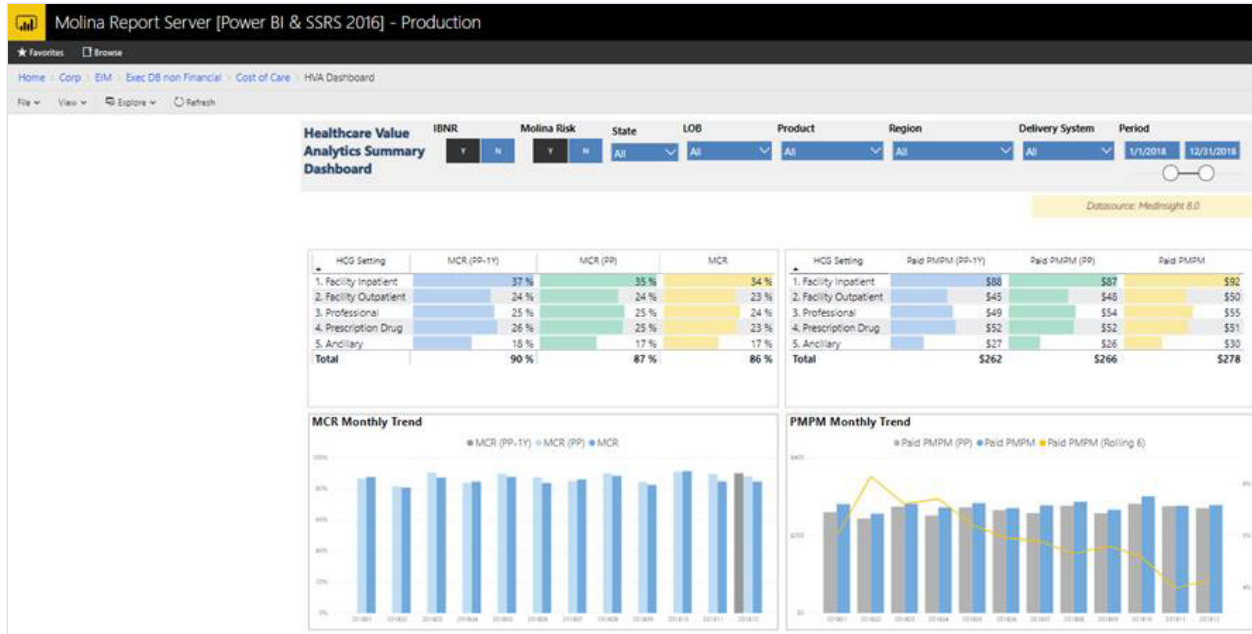


Exhibit C.27-12. SAMPLE MLR Report

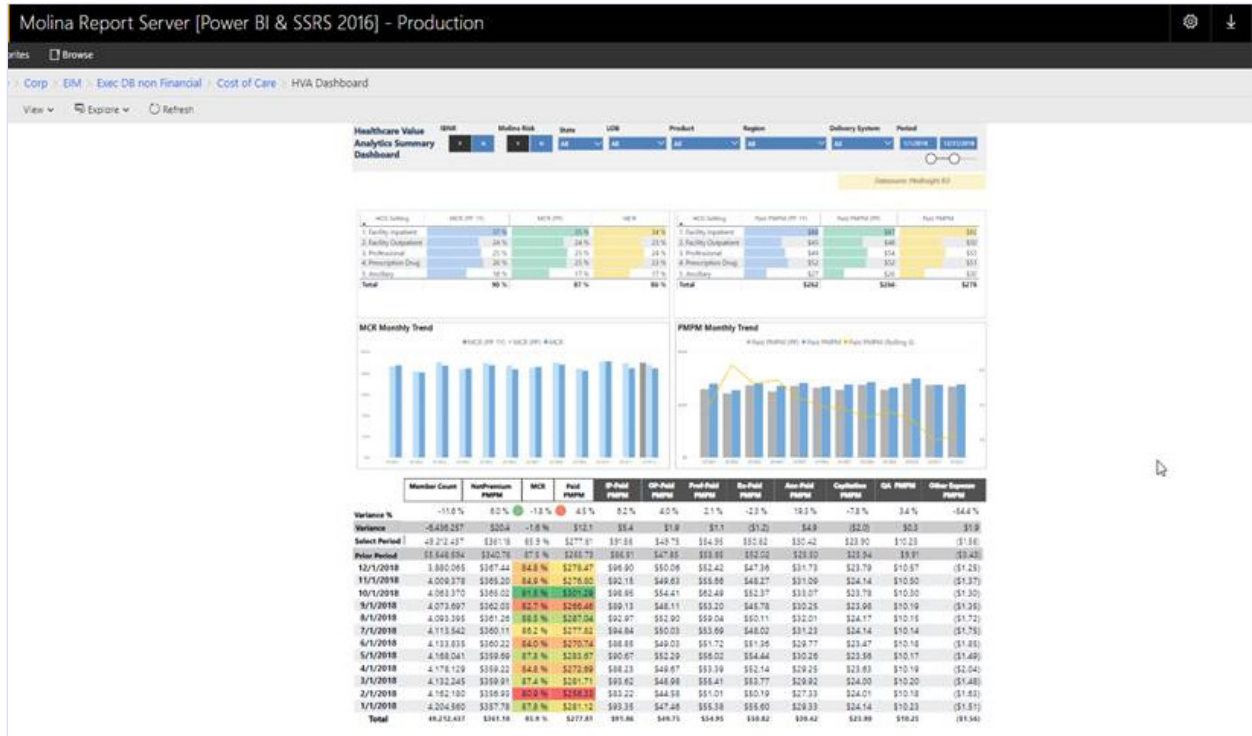


Exhibit C.27-13. SAMPLE Healthcare Value Analytics Dashboard TCOC Report

## C. REVIEW OF REPORT ACCURACY AND COMPLETENESS

Report accuracy and completeness is reviewed collaboratively by Government Contracts, Enterprise Information Management (EIM), Healthcare Analytics, and the relevant operational area, as shown in Exhibit C.27-14. Each department brings with it a different focus and area of expertise to ensure reasonableness, trending, conformity, and correctness.

**Reasonableness.** The subject matter expert from the relevant operational area evaluates the report for reasonableness against their working knowledge of the subject matter. If a pharmacy report is showing a decline in high-cost drug spend, but the pharmacy director knows that authorizations for these drugs has been increasing, then the report will be rejected so that further investigation can be taken. This process ensures that *reporting is reflective of the reality witnessed by our operational teams.*

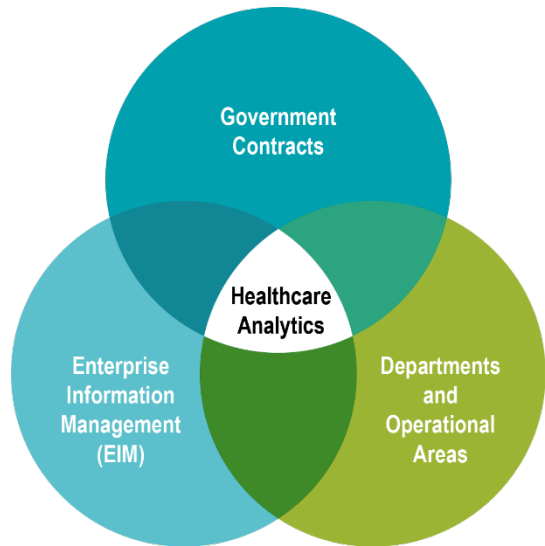
**Trending.** Our Healthcare Analytics team evaluates the report based on trending comparisons between previous versions of the same report as well as other related reports. For example, if a report shows that HIV drug utilization is increasing, but another report shows that Enrollees identified as HIV positive are decreasing, the Healthcare Analytics team will reject the report for further investigation. This ensures that reporting is consistent across multiple versions of the same report as well as across different sets of reports.

**Conformity.** The Government Contracts team compares the final report against Commonwealth specifications to ensure that all the required information is present and in the correct format. If the specification states that dates are to be represented as MM/DD/YYYY, but the dates are being output as YYYYMMDD, the report will be rejected so that the EIM team can correct the format in the reporting logic. This ensures that the report provides the exact information the Department requires in a format they can use.

**Correctness.** All new code and coding changes are reviewed for correctness by the EIM team. This is typically done with the SME from the relevant operational area. If a report showing PCP spend is modified to show the spend segmented by Enrollee region, all required code changes will be reviewed. If it is found that the segmentation is being done by the provider region instead, the report will be rejected so that the coding can be corrected by the EIM team. This ensures that the report is capturing the intended information and not just information that may appear to be correct.

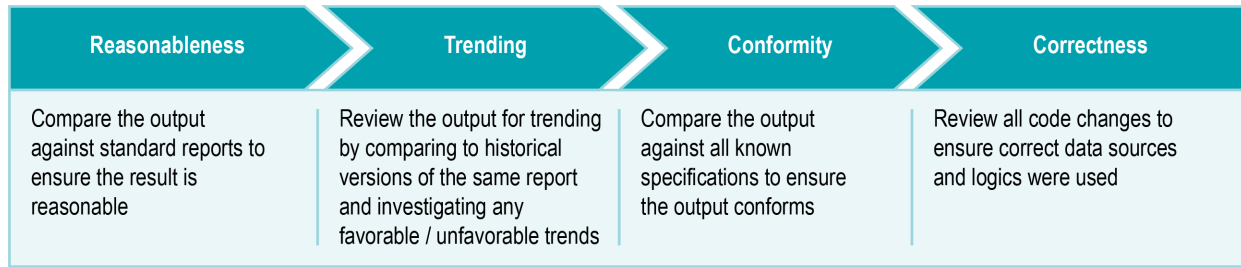
When a report is rejected, it always goes back to both EIM and the SME in the operational area. They then decide the next course of action to either explain the issue if the report is in fact still correct or modify the underlying code if the report requires modification.

As illustrated below in Exhibit C.27-15, these four quality assurance tasks work together to ensure that all reporting is accurate and complete. The report is sent to the lead subject matter expert, who approves the report along with a signed attestation. The Government Contracts team delivers the report to the Department.



148.KY19

Exhibit C.27-14. Collaborative Review Process

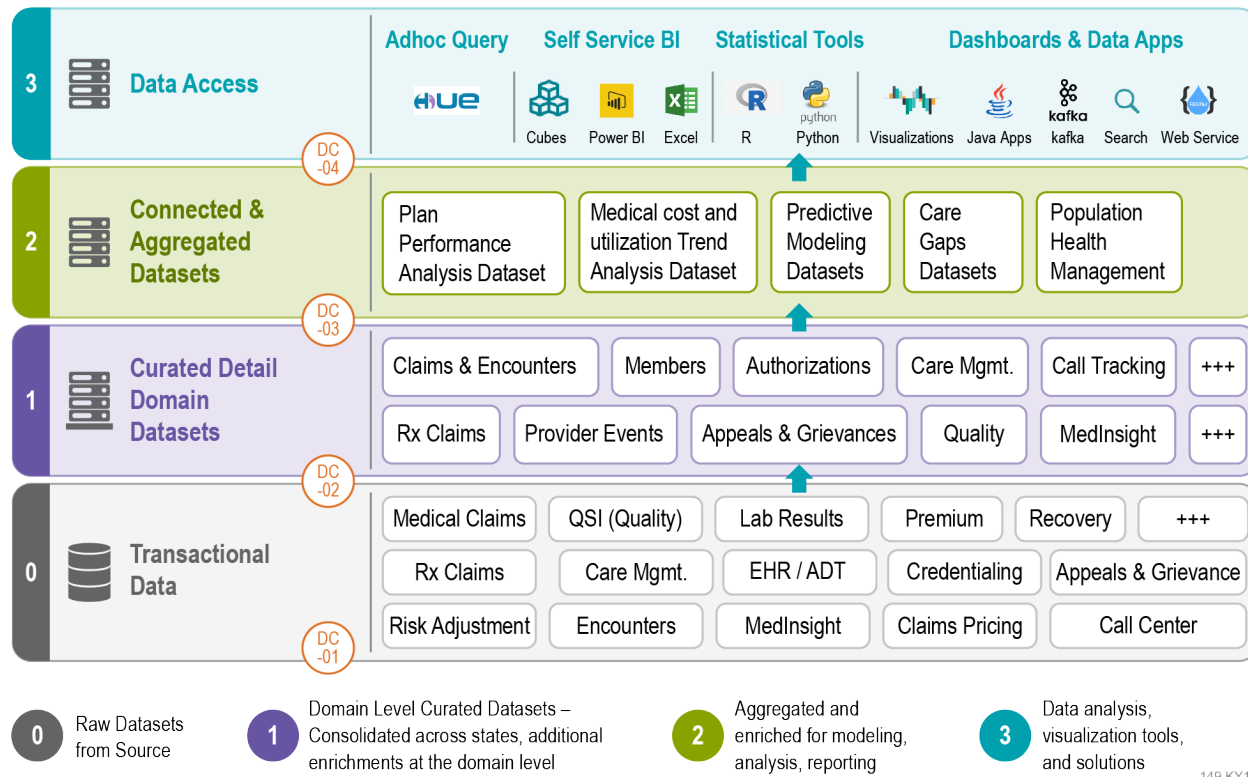


147.KY19

**Exhibit C.27-15. QA Process to Ensure Reporting is Accurate and Complete**

### Data Monitoring, Tracking, and Validation

Molina has established robust processes to assure the highest quality of data is available to the end users. Data quality checks and validation scripts are implemented at various stages of the data transformation pipeline. Exhibit C.27-16 below describes at a high-level the different layers of data transformations and enrichments that take place within the Molina Data Lake and the various points at which data validation and monitoring is executed (orange circles). Note: The references to various systems, and applications are illustrative and do not represent an exhaustive list.



149.KY19

**Exhibit C.27-16. Data Transformations and Enrichments within the Molina Data Lake**

### Data Validation Points

Molina uses industry-leading Informatica data governance and data quality tools to measure data quality, track data lineage and establish data stewardship. These sets of robust tools enable Molina to monitor, enhance and deliver high data quality.

While the data is accumulated and curated, Molina performs several data validation, monitoring, and data certification processes to ensure that the data used for reporting and analytics are of highest quality. The orange circles in the exhibit represent the points at which data validation and certification scripts are executed through robust tools and processes.

- DC-01 means the source to the raw data layer (Level 0). Molina’s certification processes capture the snapshot of the data from the source platform and compares the quality against the data loaded in the CDP. Any variance above a business-defined threshold is red-flagged and alerted to the data operations team for corrective action. This test is executed using semi-automated scripts during the testing and development phases and then fully automated using the Big Data Quality (BDQ) tool upon implementation in production.
- DC-02 certifies that the business definitions and rules applied at level 1 data are correctly applied, and that the resulting data set reconciles back to the source data in terms of consistency, completion, and accuracy. This is executed using pre-defined scripts within the Big Data Quality tool.
- DC-03 certifies that data is aggregated or moved correctly from the level 1 to the level 2 semantic layers. This is also automated using the Big Data Quality tool.
- DC-04 is the last mile check to assure that the data in the underlying platform is displaying accurately on the consumption layer. In most cases, data in the presentation tool itself like Power BI, and SQL server reporting services is compared to the sources using a rigorous data validation and QA process.

We also employ a Data Quality dashboard, shown in Exhibit C.27-17, below, which is the primary data monitoring tool used by Molina’s Enterprise Information Management (EIM) team. ***This tool helps us monitor the data completeness, data timeliness and data accuracy of the data in the Molina Data Lake.*** The EIM team uses this tool daily to proactively monitor data quality for internal and external reporting. Our Analytics and Reporting team also uses this tool for root cause analysis and continuous data quality improvements.



**Exhibit C.27-17. Data Quality Dashboard**



## d. EXAMPLES OF MOLINA'S PROPOSED PROCESSES AND USE OF DASHBOARDS AND REPORT FINDINGS

Below, we provide examples of how Molina conducts analysis, uses reports to evaluate performance metrics, and uses our findings to identify improvement and corrective actions for Kentucky Medicaid.

### d.i. PROCESSES FOR CONDUCTING DATA ANALYSES, INTERPRETING TRENDS AND SUMMARIZING FINDINGS

**Conducting Data Analyses.** Our *Analytics team* meets monthly to discuss analyzed utilization and related cost trends to define courses of actions toward improvements in operational processes, quality of service, and overall financial performance. The analytics team also participates in a weekly corporate-wide Analytics Work Group to discuss analytics with a focus on continuous improvement, identified utilization and cost trend issues, and peer reviews of key analyses and processes.

**Interpreting Trends.** Working with our Analytics team, our centralized *Medical Economics function* is led by a Vice President of Medical Economics. This team represents a multi-disciplinary capability that relies on Clinical, Actuarial, Business Operations, Finance and Quantitative analysis capabilities. It is embodied in a physical manifestation of a Healthcare Cost Trading Floor; a physical location to house and convene groups to analyze, debate, and conclude on the information created. It acts as an enterprise-wide, institutional medical economics capability to support, influence, and drive all business decisions and relies on informed views of medical cost baseline, cost trend, and granular attribution to root causes of changes therein.

Using best-in-class population health and medical cost classification dimensional cubes, the Medical Economics team routinely monitors medical utilization and cost trends and identifies discrete service categories in which emerging trends are unfavorable to expectations or recent history. When such instances are identified for Kentucky Medicaid, the team will draw on its experience to formulate multiple hypotheses regarding possible root causes and then conducts analyses to either prove or disprove each hypothesis. Once the underlying driver(s) of the variances are defined, the findings are socialized with local health plan senior leadership, at which point the collective group devises interventions intended to react to the root causes and mitigate the trend.

Exhibit C.27-18 shows a Medical Economics Dashboard report that displays three- six- and 12-month trends in unit cost and other information for each of Molina's lines of business across multiple care categories (e.g., acute inpatient, maternity, skilled nursing facility, outpatient, and emergency department).



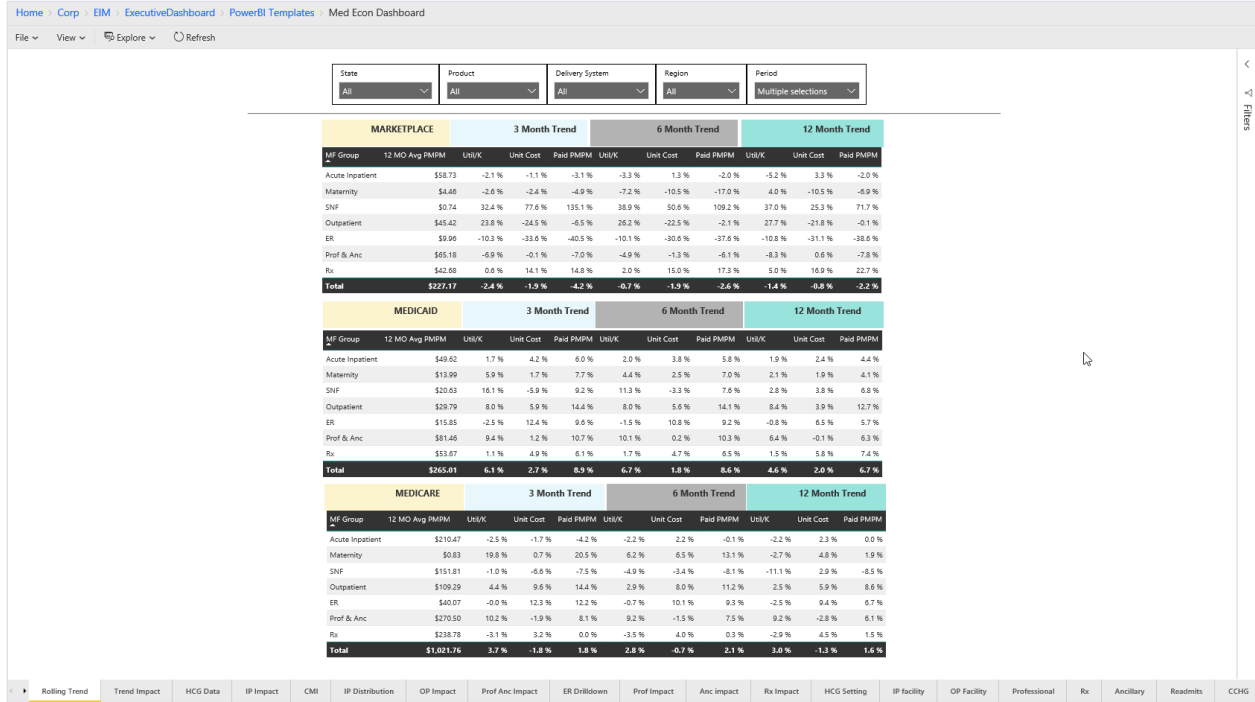


Exhibit C.27-18. Medical Economics Dashboard I

Additionally, Exhibit C.27-19 shows a second Medical Economics Dashboard view providing inpatient facility cost analysis. The dashboard incorporates multiple charts depicting color-coded 12-month trends for each tracked data item in four consecutive years.

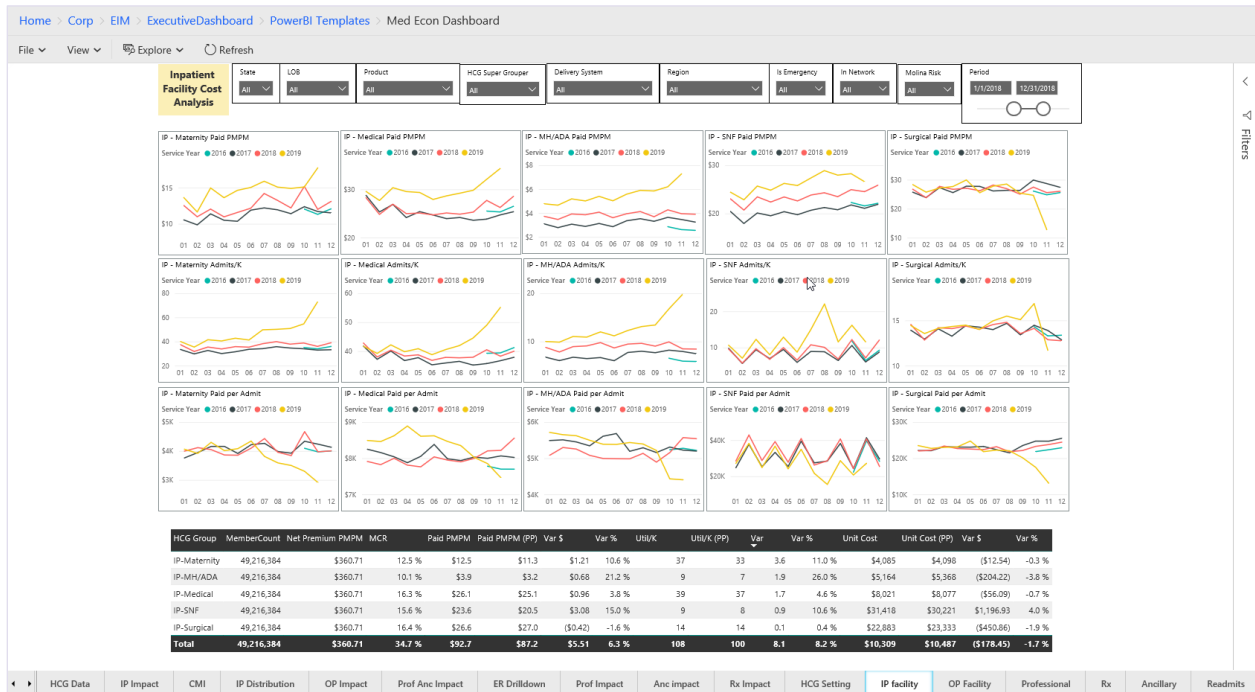


Exhibit C.27-19. Medical Economics Dashboard II

**Summarizing Findings.** As our staff review each Kentucky Medicaid report, requested items, and applicable questions and fields, they approach it as more than a simple compliance exercise. Recognizing that data in a given report may not be sufficient for researching trends and patterns, they also consider alternative or supplemental information, which might require accessing underlying data within a report through appropriate tools to conduct further analysis. We also perform extensive data analytics beyond required Kentucky Medicaid reporting requirements.

To track workload, priority, and progress, we schedule and monitor report production and analytics requests appropriately through a centralized ticketing platform. To ensure we address Kentucky Medicaid contract and business operational requirements, our business requirement review committee (BRRC) meets monthly or, if needed, on an ad hoc basis to review and discuss requirements and assess data sources and criteria that might need to be applied to specific reports. The BRRC is a cross-functional peer review group that evaluates business requirement documents and benefit-interpretation guidelines that govern core system configuration, Molina processes, and departmental policies and procedures. BRRC members ensure that report programming goes smoothly, minimizing the possibility for conflicts and errors.

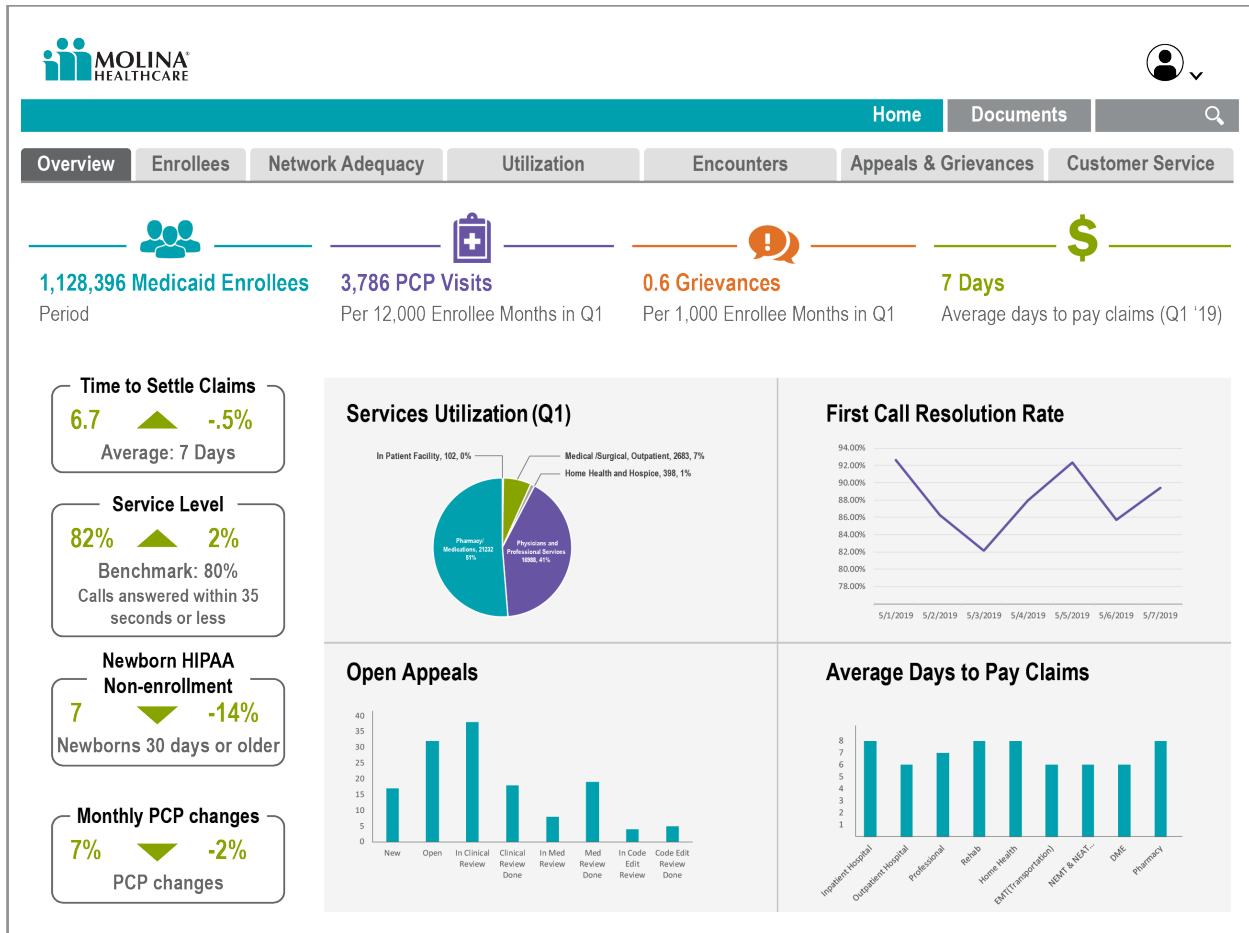
All reports to be submitted to the Department are provided to Government Contracts staff who are responsible for final review and signoff that the report includes the information being requested from the Department and that it is in a format that is easily interpreted by the Department.

#### **d.ii. USE OF DASHBOARD REPORTING**

Molina makes extensive use of dashboard reporting to monitor, track, and evaluate performance metrics. The following are representative examples of some of the key dashboards we will provide the Department to help track program effectiveness and performance.

#### **Reporting Dashboard for Kentucky**

As part of our commitment to transparency and partnership with Kentucky Medicaid, we developed an online Kentucky-focused reporting dashboard, shown below in Exhibit C.27-20, which will enable Department staff to access snapshots of key data around the clock. This dashboard will also include access to monthly reports as required by the Commonwealth. The goal is to make key areas of state reporting more readily available and easily accessible.



213 KY19

### Exhibit C.27-20. SAMPLE Proposed Kentucky Reporting Dashboard

Below we have provided an overview of a selection of the numerous internal reports that can be incorporated into the *Kentucky Medicaid Reporting Dashboard*. We will collaborate with the Department to ensure the Kentucky Medicaid Reporting Dashboard contains the data needed to track, detail, and compare the impact of Kentucky’s Medicaid managed care program across MCOs.

#### Senior Leadership Team (SLT) Dashboard

Our Senior Leadership Team (SLT) dashboard provides a sample of an executive-level view into overall trends and performance across a variety of business domains. Data is integrated from claims, authorizations, pharmacy, enrollment, and care management to enable a singular and holistic view of the plan.

As shown in the Claims Summary view of the SLT Dashboard, Exhibit C.27-21, Molina manages a core group of Claims KPIs to assure that contractual and compliance standards are met in the payment of claims to providers. Claims Turnaround Time (TAT%), Inventory Aging, and Auto Adjudication rates are closely monitored to ensure that providers are paid on a timely basis.

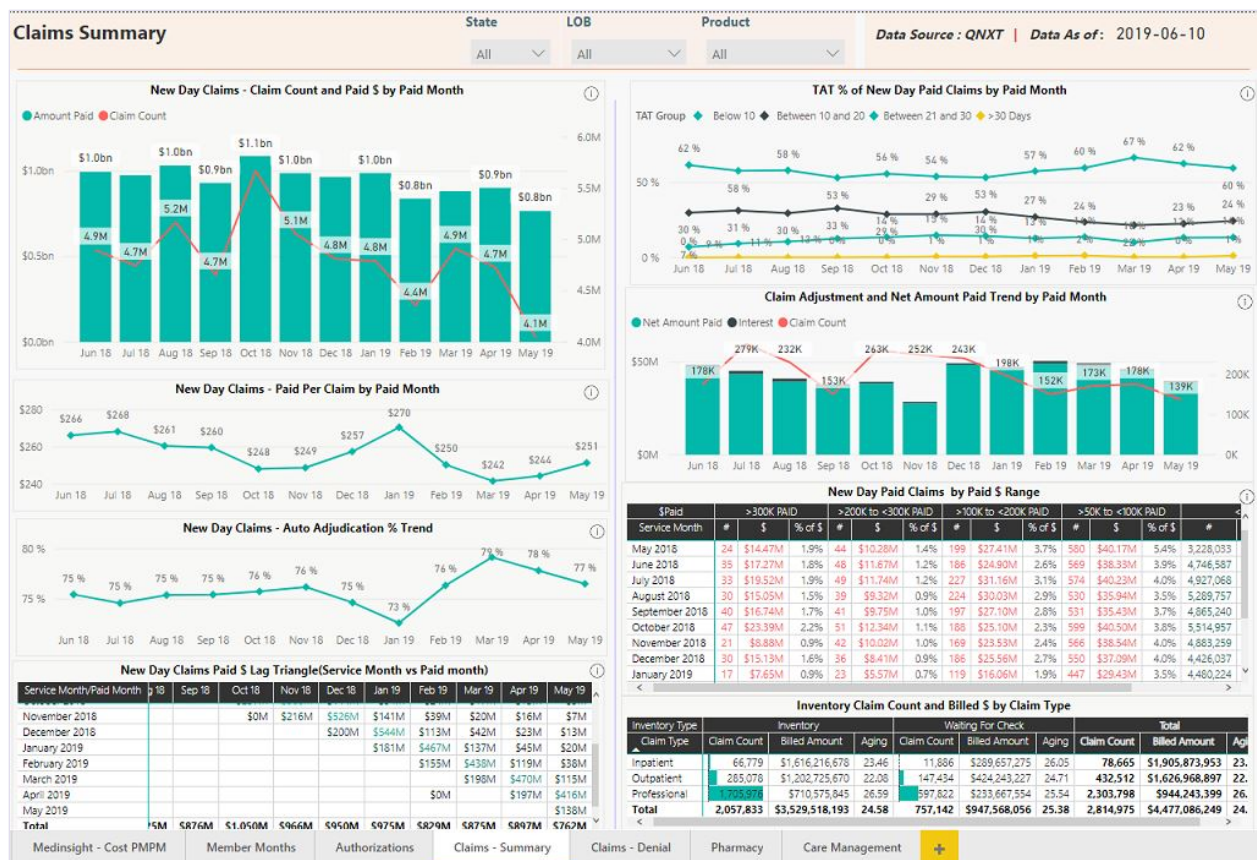


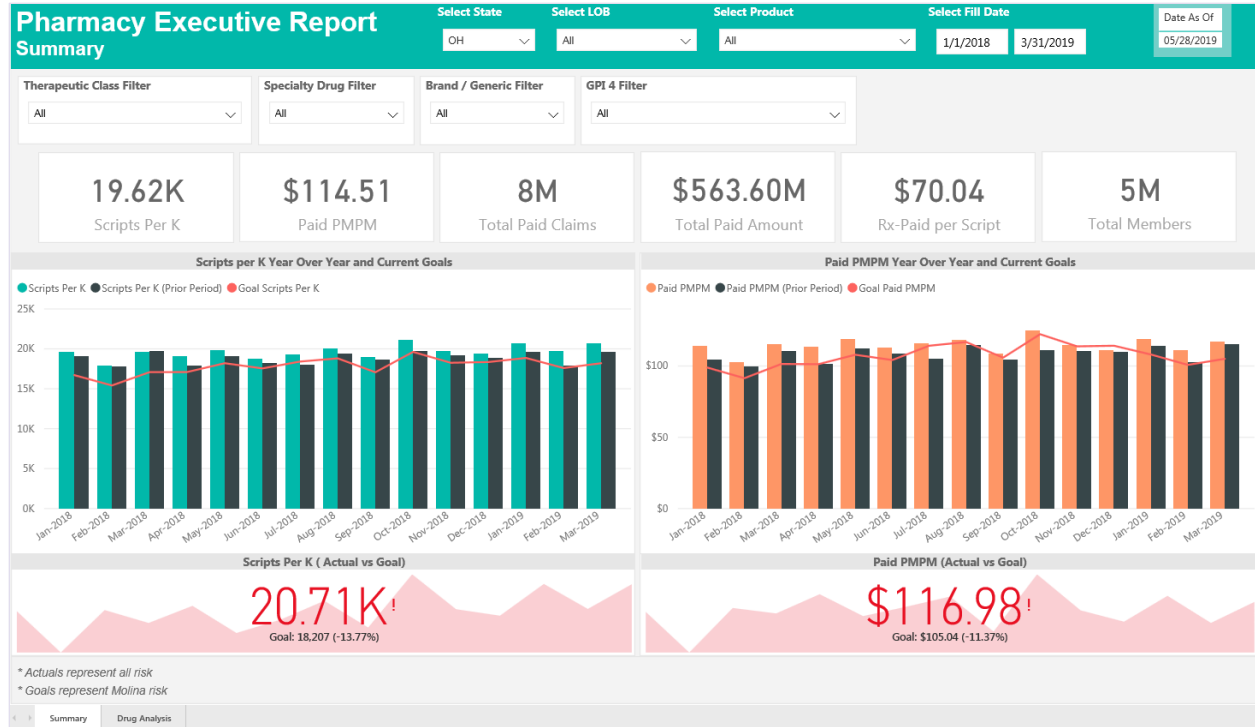
Exhibit C.27-21. SAMPLE Claims Summary Dashboard

### Pharmacy Executive Report

Our Pharmacy Executive Report, shown as a Sample in Exhibit C.27-22, allows users to view and download pharmacy utilization data to proactively manage RX utilization trends. Brand versus generic analysis, comparison of actuals to goal, and drug analysis by therapeutic class are all available to facilitate understanding of key drivers of RX cost trends.

With the Pharmacy Executive Report, pharmacy directors in Kentucky can understand drug trends within the Commonwealth to help establish where there may be unfavorable trends with the Enrollees based on therapeutic class and drill downs into the specific drugs. Our Pharmacy team wants to properly manage cost and utilization for our Enrollees and this dashboard allows them to see high-level trends and where attention needs to be focused.

In addition to providing pharmacy cost and utilization information, the Pharmacy Executive Report enables Molina to proactively manage pharmacy authorizations by monitoring prescription authorization approvals and Turnaround Times (TATs) to assure that compliance targets given by the Commonwealth are met and that patients receive timely service.

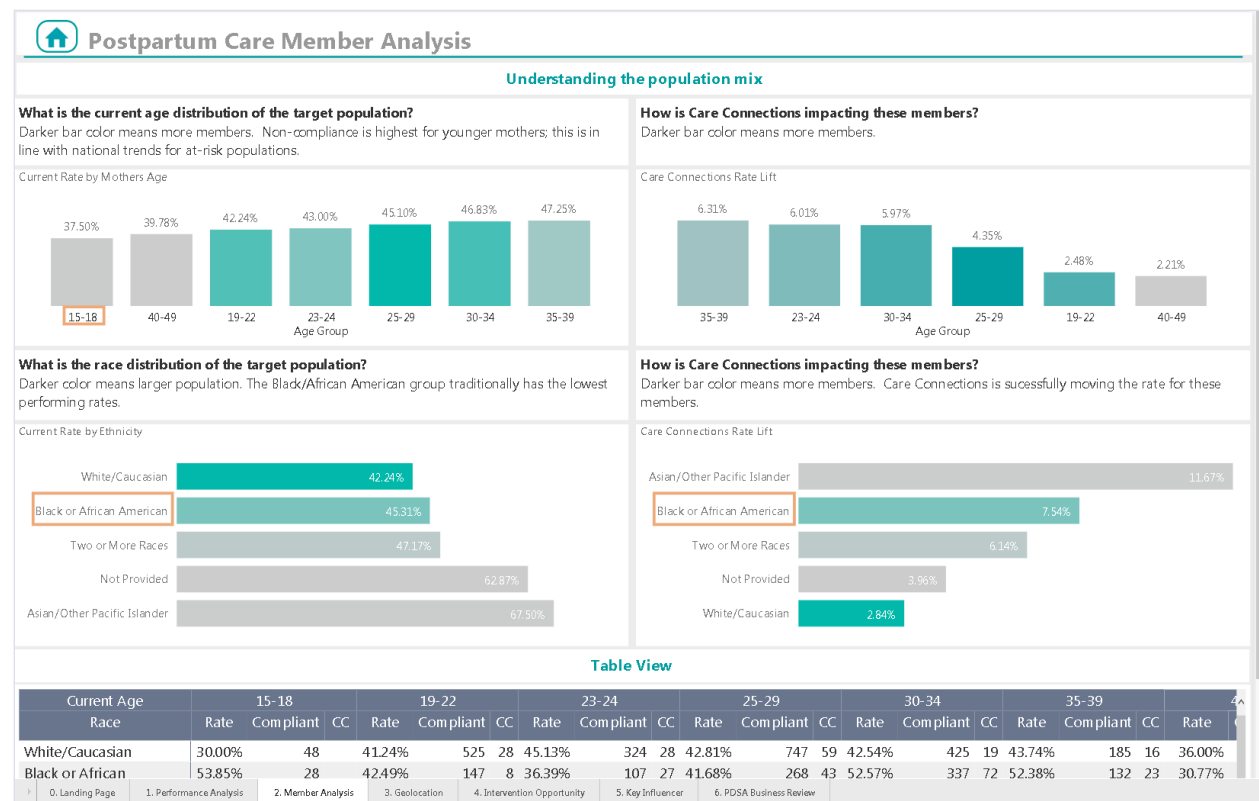


**Exhibit C.27-22. SAMPLE Pharmacy Dashboard**

### Quality Postpartum Care (PPC) Dashboard

The Postpartum Care Dashboard (PPC Dashboard), shown as a sample in Exhibit C.27-23, provides health plan management with data-driven insights and analytical support to aid them in understanding HEDIS PPC measure performance. The tool incorporates multiple data analysis views, including trend, Enrollee, and geolocation analysis to highlight progress and intervention opportunities. These findings are supported by AI driven visuals that statistically analyze the data to provide insights and a road map of recommendations.

The PPC Dashboard enables Molina to target PPC interventions where they will have the most impact for specific Enrollee populations in Kentucky. In addition, our Postpartum Care Dashboard identifies the key factors in measuring non-compliance to effectively address those issues and to improve PPC measure compliance.



**Exhibit C.27-23. SAMPLE Postpartum Care Dashboard**

## Care Management Dashboards

In addition to the many internal reports that can be incorporated into the *Kentucky Medicaid Reporting Dashboard*, our efforts with our Care Connections care management dashboards are also worth highlighting. Exhibits C.27-24 and C.27-25 depict two Enrollee-focused dashboards showing such information as care histories, goals, social determinants, and care gaps. There is even functionality to display the Enrollee’s risk of hospital admission or ED visit. Exhibit C.27-26, on the other hand, shows our Care Everywhere statistics dashboard, which displays information about how we track, use, and share Enrollee records.



Find Patients - Generic Criteria [1501859] as of Mon 1/27/2020 2:19 PM

Patient Name	MRN	DOB	Age, Sex	PCP	Care Manager	Hosp or ED Adm Risk (%)	Hosp Adm or ED Trend	Last IP Discharge	Last ED Discharge
	203192		26 y.o. Male	Physician Family Medicine, MD		-20	-6	None	None
	201308		39 y.o. Male	Physician Family Medicine, MD		-16	-6	None	None

**Allergies**

- Penicillins  
No severity specified - Hives, Swelling

**Problems**

- Nervous: Noted
- Tobacco dependency: 61 years ago
- Essential hypertension: 19 years ago
- Atrial fibrillation (CMS/HCC): 10 years ago
- Gastroesophageal reflux disease: 14 years ago
- Endocrine/Metabolic: Hypothyroidism

**Social Determinants of Health**

**Goals**

- Record your weight once a week: On track Today
- Blood Pressure < 130/80: 148/92 6yr ago

**Care Gaps**

- Overdue: MMR Vaccines (1 of 1 - Standard series) MAR 15 1994. Last completed: Never done

**Care Team**

- Physician Family Medicine, MD: Started 6 years ago
- Physician One Cardiology, MD: Started 6 years ago

**Recent Visits**

- JAN 17 2020: Admission (Current) - EMH Cardiac Catheterization - Lhs Invasive Cardiologist Cupid, MD
- JAN 17 2020: Procedure - EMH CARDIAC CATH LABS - Cardiothoracic Surgery, Lhs Physician, MD
- JAN 17 2020: Surgery - EMH OR - Cupid, Lhs Invasive Cardiologist, MD

Exhibit C.27-24. SAMPLE Care Management Dashboard Focused on Patient History

Find Patients - Generic Criteria [1501767] as of Mon 1/27/2020 12:59 PM

Patient Name	MRN	DOB	Age, Sex	PCP	Care Manager	Hosp or ED Adm Risk (%)	Hosp Adm or ED Trend	Last IP Discharge	Last ED Discharge
	204405		21 y.o. Male	Physician Family Medicine, MD		36			
	204409		21 y.o. Male	Physician Family Medicine, MD		33			

**Allergies**

- Sulfa Antibiotics  
High - Anaphylaxis

**Problems**

- Nervous: Noted
- Migraine headache: 2 months ago
- Infectious/Inflammatory: HIV (human immunodeficiency virus infection) (CMS/HCC) 2 months ago

**Social Determinants of Health**

**Care Gaps**

- Overdue: Meningococcal Vaccine (1 - Risk start before 7 months 4-dose series) JAN 18 1999. Last completed: Never done
- Overdue: Varicella Vaccines (1 of 2 - 2-dose childhood series) NOV 18 1999. Last completed: Never done
- Overdue: Pneumococcal Vaccine: Pediatrics (0 to 5 Years) and At-Risk Patients (6 to 64 Years) (1 of 2 - 0 to 5 Y) NOV 18 2004. Last completed: Never done

**Risk of Admission or ED Visit**

**36%** This score indicates an adult patient's 1-year risk, as a percentage, of a hospital admission or ED visit.

Current PCP: Physician Family Medicine, MD

- Hospital Admissions: 0
- ED Visits: 1
- Has Medicaid: No
- Has Medicare: No
- In relationship: No
- Has Anemia: No
- Has asthma: No
- Has atrial fibrillation: No
- Has CVD: No
- Has chronic kidney disease: No
- Has Chronic Obstructive Pulmonary Disease: No
- Has Congestive Heart Failure: No
- Has Connective Tissue Disorder: Yes
- Has Depression: No
- Has Diabetes: No
- Has liver disease: No
- Has Peripheral Vascular Disease: No

**Care Team**

- Case Manager: General Practice: Started 1 month ago

**Appointments**

- JAN 27 2020 02:00 PM - Follow Up Appointment: EMC Pain Medicine - Physician Pain Medicine, MD
- JAN 27 2020 02:00 PM - Post-op: EMC Neurology - Physician Neurology, MD
- JAN 27 2020 02:00 PM - Consultation: EMC Infectious Disease - Physician Infectious Disease, MD
- JAN 27 2020 02:00 PM - Procedure: EMC Gastroenterology - Physician Gastroenterology, MD
- JAN 27 2020 02:00 PM - Well Child: EMC Family Medicine - Family Medicine, Physician, MD

**Recent Visits**

- JAN 27 2020 Office Visit: EMC Family Medicine - Train Physician Champion, MD
- JAN 19 Office Visit

Exhibit C.27-25. SAMPLE Care Management Dashboard Showing Enrollee Risk of Admission

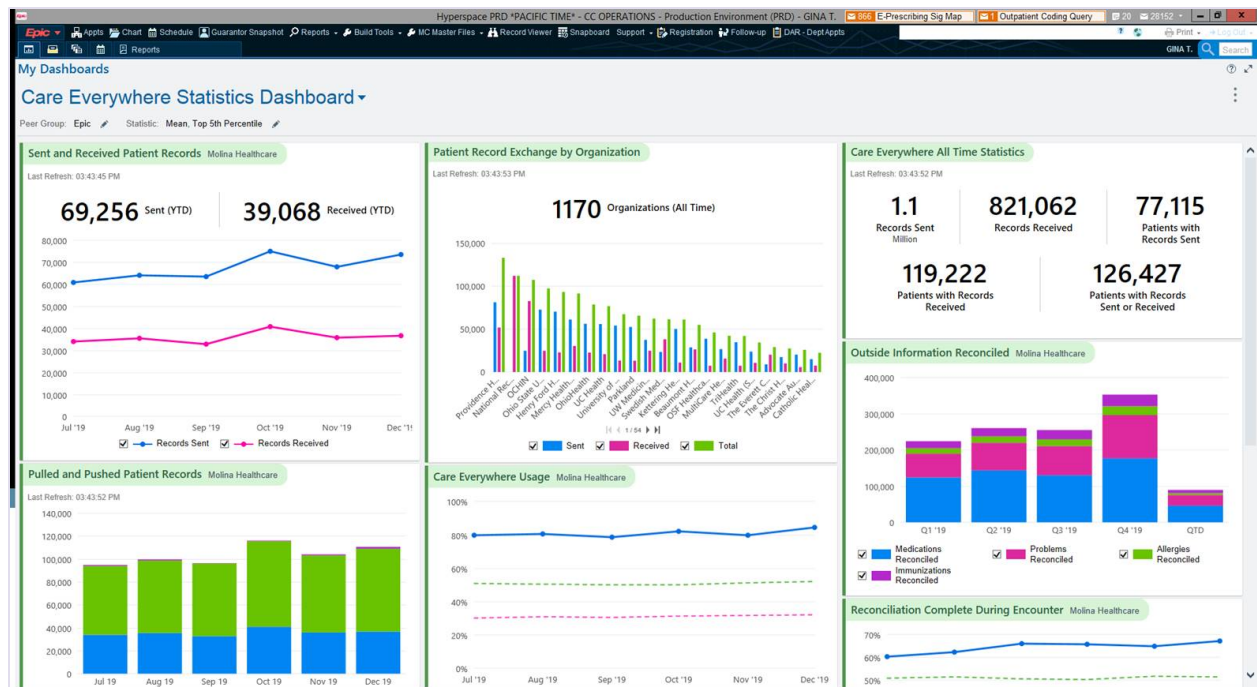


Exhibit C.27-26. SAMPLE Care Everywhere Statistics Dashboard

### d.iii. USE OF FINDINGS FOR IMPROVEMENTS AND TO IDENTIFY CORRECTIVE ACTIONS

Molina continuously reviews performance in all aspects of its operations, actively seeking opportunities to improve quality of care, profitability, and compliance. Data from generated reports and dashboards form the basis for identifying operational issues that warrant corrective action.

Discoveries of new opportunities and deficiencies in the data are immediately noted and reviewed in further detail during our various monthly committee meetings including Senior Leadership meeting, Quality Improvement Committee, and Monthly Operational Reviews (MOR).

- **Senior Leadership Meeting.** Our senior leadership team holds monthly review meetings where the team looks at KPIs and reviews ongoing performance improvement plans and CAPs.
- **Quality Improvement Committee.** Our Quality team and Operational departments participate in monthly Quality Improvement Committee meetings. This Quality team is focused on improving quality of care and health outcomes through regular review and of analysis and HEDIS result data.
- **Monthly Operations Review.** All issues related to financial integrity are discussed during a Monthly Operating Review meeting after thorough analysis is provided by the Healthcare Analytics and Finance teams.

Deficiencies and improvement opportunities are addressed with performance improvement plans (PIPs) or CAPs.

- PIPs that are identified are assigned to the business owners responsible for the initiatives. They are developed collaboratively to ensure all aspects of the improvement opportunity are addressed appropriately. Improvement plans are monitored regularly to ensure responsible parties stay on track and ensure that any barriers are appropriately addressed.

- Issues that require CAPs are handled between our compliance department and the business owners responsible for the issue and/or the corrective action. An initial meeting is held where the compliance department aids the business owner in the creation of the CAP. Regular meetings are held until the CAP has been satisfied and a final meeting is held to determine satisfactory resolution of the issue so the CAP can be signed off on and closed.

All information identified for internal PIPs and CAPs relevant to the Department’s goals can be shared freely between the MCO and the Department. This ensures transparency and collaboration as all parties work to improve the care of Enrollees and make wise and informed use of the funds provided by the Kentucky Medicaid program.

In Table C.27-3, below, we share several examples demonstrating how we put data analysis findings to work to improve programs and identify corrective actions.

**Table C.27-3. How We Use Report Findings to Improve Programs**

Opportunity	Examples
<b>Member Engagement</b>	Molina uses report data to drive community programming and engagement efforts, employing enrollment dashboards to understand Enrollee demographics as well as enrollment and disenrollment trends at the county level and at the provider level. We also look to integrate information such as reasons for enrollment/disenrollment. Our affiliate health plan in Washington used this approach to identify providers for joint programming with members while our affiliate health plan in Ohio applied report findings to define differences in community programming needs between Cuyahoga and Franklin counties.
<b>Provider Engagement</b>	Reports drawn from provider information enable us to proactively identify provider improvement opportunities. Dashboard reports track information including provider calls, claims processing, and appeals and grievances at a provider level. Our findings enable us to tailor provider outreach, so we can help providers address challenges and improve performance.
<b>Quality of Care</b>	Dashboard reports help us identify quality of care gaps at member- and provider-specific levels, enabling us to perform outreach campaigns and to adjust member and provider incentive approaches. Our affiliate health plans use a control group to measure the effectiveness of member incentive programs. Additionally, the development of a predictive benchmark projection methodology contributes to the ability to set targets in advance and track HEDIS measures relative to the projection. <b><i>As a result, 82% of our affiliate Medicaid health plans increased their HEDIS scores for Comprehensive Diabetes Care—Retinal Eye Exam between 2017 and 2018. Another example: 85% improved their HEDIS scores for Use of Opioids High Dosage (UOD) between calendar years 2017 and 2018.</i></b>
<b>Cost Effectiveness:</b>	Our data tools help us better understand the drivers of medical cost trends. We monitor both unit cost and utilization dynamics with a specific focus on those areas of cost most relevant to the Medicaid population (e.g., maternity and newborn, behavioral health, and emergency department use). We then apply our findings to develop programs targeting specific challenges, so we can bend the cost curve.  We also use dashboards to monitor payment integrity activities and to review situations where there might be fraud, waste, and/or abuse; findings from active monitoring and review help us refine network contracts and minimize inappropriate provider billing.
<b>Operating Productivity and Performance</b>	Tracking staff productivity and operating effectiveness enables us to understand—and improve—prior authorization turnaround times. Quarterly review of prior authorization data helps us refine prior authorization lists, enabling us to balance efficiency and medical cost management. Molina also tracks the effectiveness and efficiency of claims processes and Call Center activity. Our findings help us remain compliant and improve individual staff activity, which drives overall productivity and performance improvements.

## **e. MONITORING, TRACKING AND VALIDATING DATA FROM SUBCONTRACTORS**

Our Analytics team works with our Government Contracts staff and related operational departments to analyze, review, define, and properly document requirements, data sources, required criteria and programming logic for accuracy and adherence to the Department's specifications before—and following the completion of—Enterprise Information Management (EIM) programming. Business owners, Government Contracts staff, and our Analytics team capture all regulatory requirements in business requirement documents to ensure continuity in report development. Moreover, based on the Department's feedback and/or upon new regulatory requirements, Molina reviews and updates our business requirement documents accordingly.

We ensure subcontractor compliance through a variety of monitoring and auditing efforts. These include review of monthly and quarterly reports summarizing delegated responsibilities, monthly and quarterly meetings with subcontractor staff and health plan participants, annual delegation audits, and regular review of complaints and grievances to ensure timely resolution to Enrollee issues. If areas of non-compliance with contractual performance expectations are identified, we implement corrective action measures, up to and including financial penalties.

### **MONITORING DATA FROM SUBCONTRACTORS**

We have delegation oversight staff and dedicated national account managers for each subcontractor who monitor weekly reports before contract go-live, and monthly and quarterly performance reports submitted by subcontractors. Monitoring includes reminder emails before report due dates, compliance with report due dates, and once received completeness and accuracy of the information reported. If any area of concern is identified, the national account manager or delegation oversight staff will outreach to the subcontractor to confirm if the issue is related to a reporting issue or an actual performance issue, and then work collaboratively with all impacted teams on a resolution before the due date to provide the information to the Department.

If performance reports identify an area of compliance concern, issues can be addressed through rapid response meetings, monthly touch point meetings with Molina account manager and subcontractor staff or quarterly Joint Operations Committee meetings with the Molina account manager, delegation oversight, network and contracting staff, as well as subcontractor participants. If it is determined the issue is related to a delegated function, corrective action will be pursued through heightened delegation oversight processes.

Our proactive process evaluates and ensures provider/subcontractor compliance with data submission requirements, including encounter data. Contracts with subcontractors contain specific data and reporting requirements and performance targets specifying timeliness, accuracy, and data quality metrics, including all related Department reporting requirements. We will perform quality and completeness checks throughout the claims/encounter submission process to validate appropriate volumes of received and submitted encounters. Monthly reports will identify, track, and benchmark metrics (e.g., encounter submission rates) that will enable us to identify underperforming or non-compliant entities.

As part of our quality and completeness checks, we will accept and verify submissions through our secure Web portal. Providers, provider groups, and our subcontractors submit claims/encounters through secured socket layer (SSL), and submissions will be automatically logged and tracked. Submissions, including errors, can be viewed to enable resubmissions as needed. Further, claims/encounters are received daily from clearinghouses that format electronic data into standard 837 formats. The claim is routed through a pre-processor and then through our claims gateway. An image of the claim is also generated and can be retrieved through a claim viewer. We will also work with providers and an electronic data interchange clearinghouse to identify barriers in moving to electronic functionality and regularly evaluate systems to determine areas for improvement.

### Monitoring Subcontractor Reporting from Avesis Dental

One example of our successful approach to monitoring subcontractor reporting relates to our dental subcontractor, Avesis. Molina did not receive accurate universal denial reports from Avesis during a recent annual claims and utilization management audit. These reports are critical to determine the selection of files we will review during the audit to determine the appropriateness of both claims and utilization management denials. Avesis' utilization denial report submitted to Molina contained approved authorizations. The claims denial report that was submitted contained adjusted claims. In both cases, these reports should have contained only denials. Upon notice of the deficiency, Avesis submitted two more reports with the same errors. We proactively worked with Avesis to correct the issue until an accurate report was produced. To help mitigate this issue in the future, we requested Avesis add a "status" column on the report to assist in their own review to produce accurate reports. We also had Avesis complete attestations to confirm the accuracy of the reported data.

Further, because of this experience and our desire to identify opportunities to strengthen subcontractor monitoring and oversight, we have adopted and implemented the CMS Audit protocol for all Medicaid providers and vendors. The protocol results in a failed file audit after three failed attempts by a vendor to produce accurate reporting from which file selection is made. Follow-up file reviews will be completed 60 calendar days from the date of the last failed universe submission, allowing groups adequate time to correct their universe issues. We have met with Avesis compliance leadership to discuss this new protocol, with both parties agreeing to adoption, as we continue to work in partnership to achieve compliance.

### TRACKING DATA FROM SUBCONTRACTORS

We apply a variety of ongoing measurement and analysis tools to monitor the quality of delegated functions. We continuously evaluate the effectiveness of subcontractor performance and look for areas of improvement through the work performed by the teams described previously. As a result, we institute rapid-cycle process improvements based on the feedback and data received. This information comes from quality control monitoring conducted by our Delegation Oversight department to make appropriate recommendations to the DOC, Quality Improvement Committee, and senior leadership, which then develops a course of action and applicable interventions.

We meet with our subcontractors several times a month via touch point calls, monthly implementation and post go-live calls, and, when appropriate, delegation oversight discussions. These calls include representation from subcontractors and the impacted health plan departments. In the event compliance concerns are identified, the list of attendees is expanded to include network and/or senior leadership from both Molina and our subcontractor.

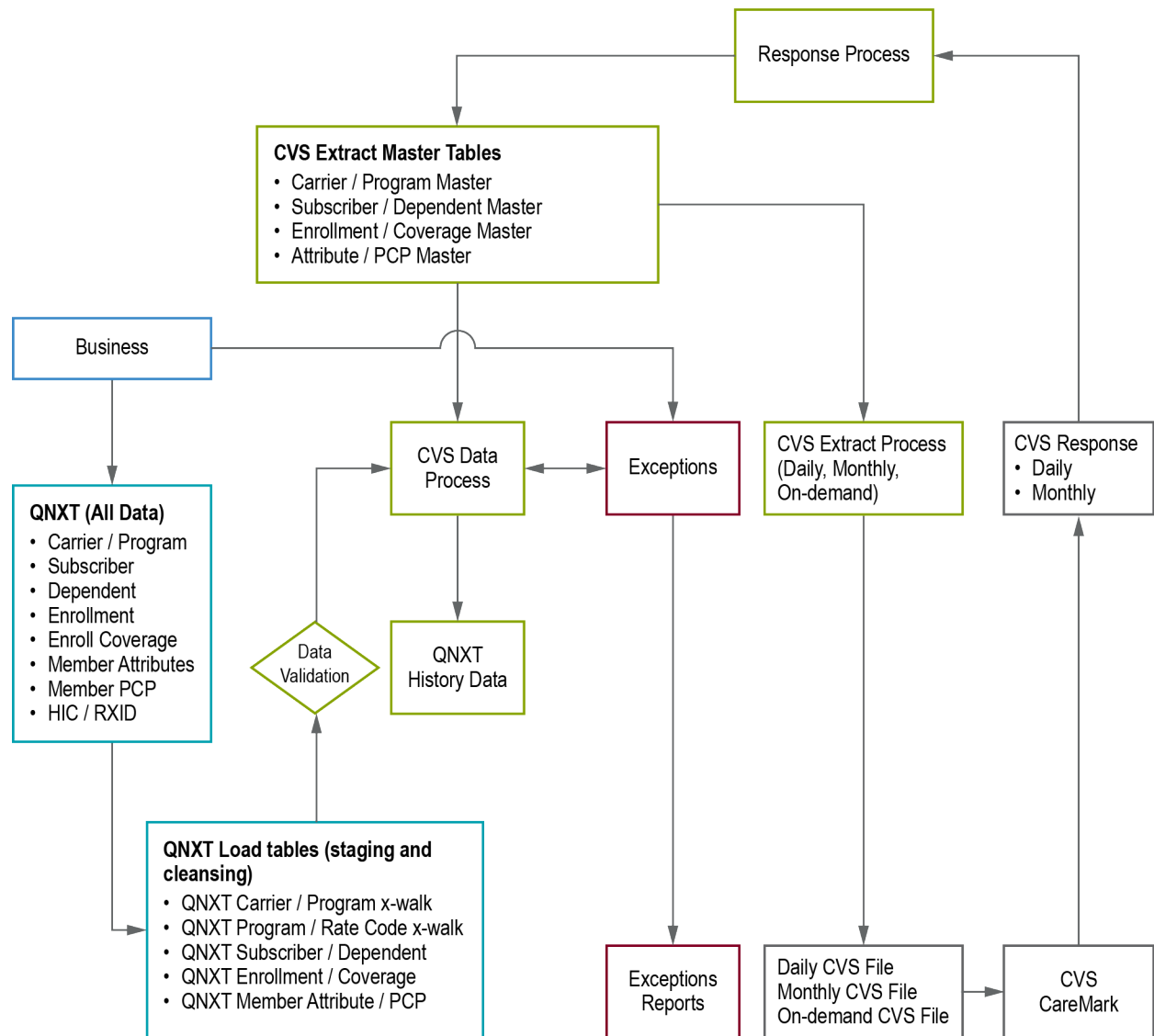
### VALIDATING DATA FROM SUBCONTRACTORS

As part of our oversight process, we audit subcontractors to ensure they are submitting all encounters. We will require each subcontractor to submit its complete claims dataset for specific dates of services. We will then complete a data integrity check by comparing the data to the encounters we have for the subcontractor. Further, we recently rolled out a new custom-developed, Web-based application that automates most of the functions/requirements. The tool helps monitor the subcontractor submission, identifies the resubmissions of the previously denied encounters, checks encounter completeness, and monitors file failure. Our process generates complete and accurate encounter data and facilitates the timely submission of encounters consistent with required formats.

Exhibit C.27-27 offers our CVS data validation process as an example. The process includes monitoring and tracking of all daily and monthly files received. The process is integrated within our QNXT claims engine, which validates master data internally against incoming master data from CVS. The output of the validation process generates an exception report, which is then reconciled daily by the encounter inbound process team.



## CVS Data Validation Process



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**Exhibit C.27-27. CVS Data Validation Process**

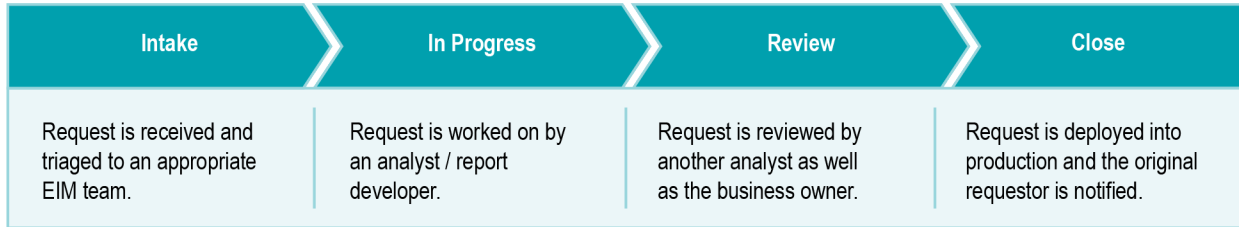
### f. PROVISION OF AD HOC REPORTS REQUESTED BY THE DEPARTMENT

Our VP of Government Contracts will be the point of contact for the Department’s requests regarding ad hoc reports and other materials as required in Draft Contract, Appendix D. The VP of Government Contracts will have an open, collaborative relationship with the Department, providing continuous support to meet the Department’s needs. Regardless of the requested turnaround time, whether it is one day or one month, ad hoc requests will be given high priority. With oversight from our CEO, the VP of Government Contracts ensures we meet the Department’s requirements for a timely and accurate response.

To complete these requests, the appropriate business owner and approver are notified via email. Upon receipt of the request, an initial touch-base meeting is scheduled within one business day, and calendar reminders are scheduled to indicate internal and external due dates. Following our standard reporting



request procedure, the business owner collaborates with the EIM team to pull and format any required data/information. A final response is submitted to our government contracts department by the business owner after their review and approval from the previously assigned approver. Government Contracts then performs a final review of the response and either requests revisions or submits an on time, accurate, and complete report to the State. An overview of the EIM ad hoc report development process is illustrated below in Exhibit C.27-28.

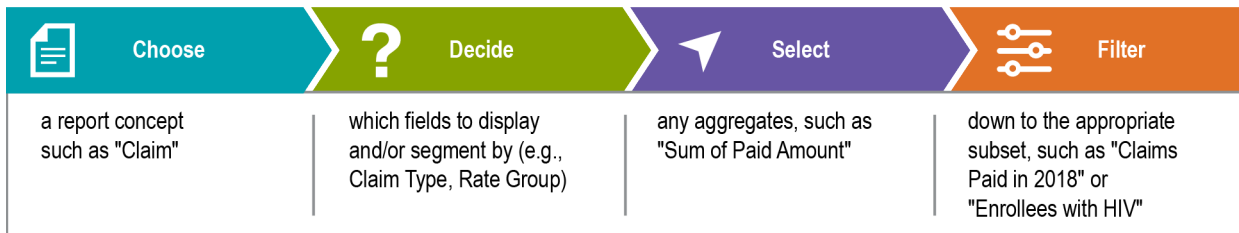


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**Exhibit C.27-28. EIM Ad Hoc Report Development Process**

## THE MOLINA DATA LAKE SUPPORTS ACCURATE AND TIMELY DELIVERY OF AD HOC REPORTS

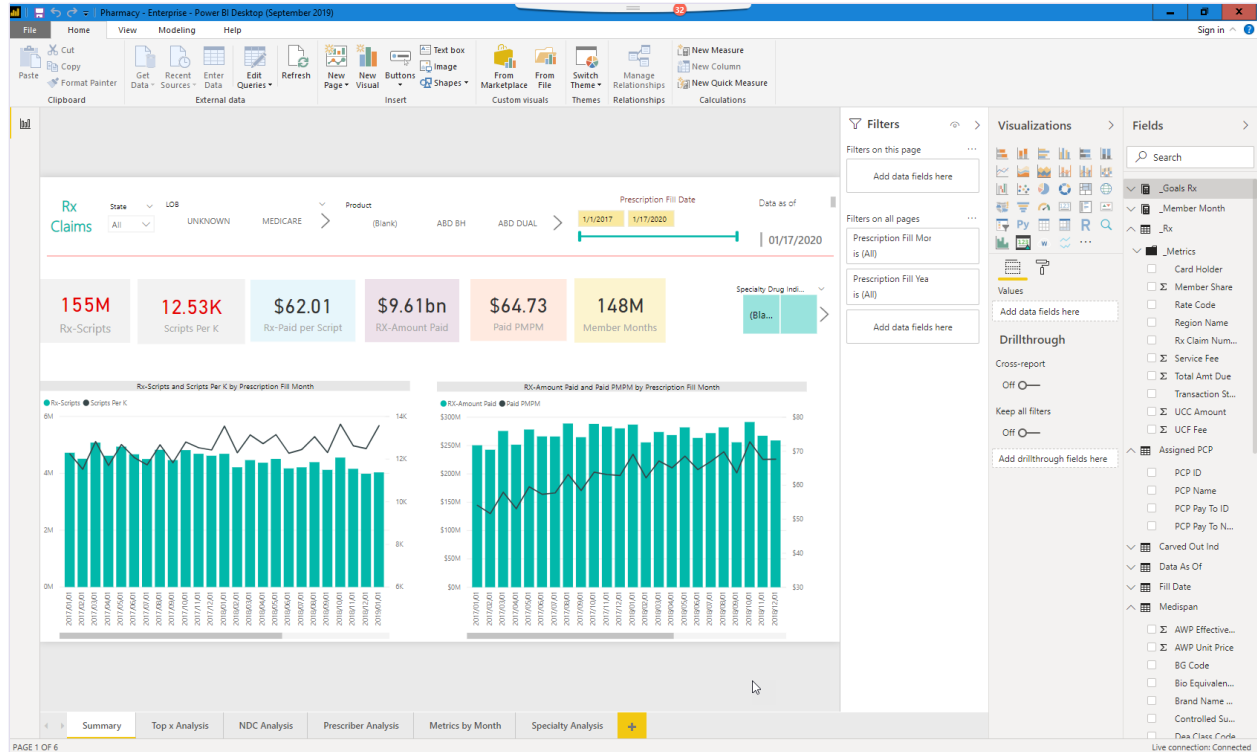
Once the ad hoc report development process is complete, the Molina Data Lake makes fulfilling the report relatively simple. In fact, it is key to our ability to deliver timely, accurate, and complete reports on an ad hoc basis. Because data is stored logically according to the concept being reported on, and because data is predefined, pre-calculated, and stored centrally, we can deliver custom ad hoc reporting much faster and more reliably than a health plan that does not have a similar platform. No time is spent redefining old concepts/fields or figuring out how to combine disparate data sources. In most cases it is a simple four-step process, as shown in Exhibit C.27-29.



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**Exhibit C.27-29. EIM Ad Hoc Report Development Process**

As an example, one element of the Molina Data Lake is the RX Cube, which integrates pharmacy, member and financial data into a single dataset. This dataset contains summary and detail information, which is presented through a pre-defined Power BI template like that shown in Exhibit C.27-30.



**Exhibit C.27-30. SAMPLE RX Cube Template**

Molina analytics staff can quickly and easily customize the report or conduct ad hoc reporting/analysis by dragging and dropping attributes or KPI's into the template, adding filters and slicers, defining drilldown paths, and customizing visualizations and tables.