

C.9. Quality Management and Health Outcomes

- a. Provide a detailed description of how the Vendor will support the Department in achieving its goals to transform the Medicaid program to empower individuals to improve their health and engage in their healthcare and to significantly improve quality of care and healthcare outcomes, and to reduce or eliminate health disparities. At a minimum, the Vendor's response should address:
 - i. How it will structure its organization to provide for a comprehensive and holistic approach to meet these goals, including coordination with Subcontractors and providers.
 - ii. Strategic solutions the Vendor will use in quality management, measurement, and improvement.
 - iii. Innovative strategies and enhanced services, if any, that the Vendor proposes to implement to enhance the health and well-being of Enrollees and to improve health outcomes, including examples of successes with similar Medicaid populations.
 - iv. Internal tools and technology infrastructure the Vendor will use to support improvements in health outcomes and to identify, analyze, track, and improve quality and performance metrics as well as the quality of services provided by Network Providers at the regional and statewide levels.
 - v. Methods to ensure a data-driven, outcomes-based continuous quality improvement process, including an overview of data that is shared with providers to support their understanding of progress in achieving improved outcomes.
- b. Indicate if the Vendor has received NCCA accreditation for the Kentucky Medicaid market, and if not, the proposed timeline for achieving accreditation.
- c. Provide the Vendor's proposed use of the Quality Improvement Committee (QIC) to improve the Kentucky Medicaid managed care program.
- d. Provide the Vendor's proposed use of the Quality and Member Access Committee (QMAC) to improve the Kentucky Medicaid managed care program, including the following information:
 - i. Proposed stakeholder representation.
 - ii. Innovative strategies the Vendor will use to encourage Enrollee participation.
 - iii. Examples of successful strategies the Vendor has implemented to obtain active participation in similar committees.
- e. Provide a comprehensive description of the Vendor's proposed Quality Assessment and Performance Improvement (QAPI) Program that meets all requirements of this Contract.
- f. For each of the below quality measures, demonstrate how the Vendor will work to make improvements in Kentucky's Medicaid population. Include discussion of strategies and interventions specific to each measure, partners that will be necessary to achieve improvement, data analytics, and anticipated timeframes for success in achieving improvements. Describe potential challenges the Vendor anticipates, if any, and how those will be addressed. Provide examples of successes in other state Medicaid programs, and how that success will be leveraged in the Kentucky Medicaid market.
 - i. Medication Adherence for Diabetes Medications
 - ii. Tobacco Use and Help with Quitting Among Adolescents
 - iii. Colorectal Cancer Screening
- g. Describe the Vendor's proposed approach to collaborating with the Department, other MCOs, and providers to ensure Performance Improvement Projects (PIPs) are effective in addressing identified focus areas and improving outcomes and quality of care for Enrollees, including the following:

- i. Lessons learned, challenges, and successes the Vendor has experienced while conducting PIPs, and how the Vendor will consider those experiences in collaboration with the Department on identified PIPs.
- ii. Recommended focus areas, including those for regional collaborative PIPs, for the first two years of the Contract resulting from this RFP and rationale for these focus areas.
- iii. Methods for monitoring and ongoing evaluation of progress and effectiveness.
- h. Provide a description of opportunities the Vendor has identified to collaborate with the Department for Public Health to support improvement in public health outcomes. Where does the Vendor anticipate that collaborating on initiatives would have the most impact in addressing quality care and outcomes for Medicaid Enrollees? Explain the Vendor's rationale.
- i. Describe the Vendor's approach to monitoring and evaluating progress in improving the quality of health care and outcomes on an ongoing basis. Describe the following:
 - i. How the Vendor will use data to inform and prioritize initiatives to address Enrollee needs.
 - ii. Methods for measuring provider performance against practice guidelines and standards adopted by the QIC and follow up activities to be conducted with providers based on ongoing review of findings.
 - iii. A summary of the Vendor's approach to annual evaluation of the overall effectiveness of the QAPI program and how the Vendor will use findings for continuous quality improvement efforts.
- j. Provide a summary of how the Vendor will collaborate with the Department and other Vendors in developing and implementing a value-based payment (VBP) program. Include proposed approaches for the following at a minimum:
 - i. The Vendor's lessons learned in developing and implementing VBP models, examples of models that have been most effective in improving performance and outcomes.
 - ii. Recommended goals and focus areas in the first two years of implementation of the VBP program.
 - iii. Proposed approaches to collaborate with the Department and other MCOs to develop the VBP program and to implement a coordinated approach to achieve statewide improvement in outcomes.
 - iv. Potential challenges specific to Kentucky and the Vendor's proposed methods for addressing identified challenges.
 - v. Regardless of the model implemented, the Vendor's approaches to analyzing performance against targets, frequency of analyses, reporting results to DMS, and use of analyses to modify interventions that are not making progress towards achieving targets.
- k. Will the Vendor and Subcontractors implement VBP arrangements with providers? If so, describe the following:
 - i. The types of VBP arrangements the Vendor and Subcontractors plan to use and why these models were selected. As part of your description, map your proposed VBP arrangement to the HCP-LAN APM Framework maturity level.
 - ii. How improvement in health outcomes will be addressed through the VBP arrangements implemented.
 - iii. Methods for evaluating the effectiveness of VBP, including tracking of costs and improvement in health outcomes.
- l. Provide results of any provider satisfaction survey reflecting the Vendor's performance in Kentucky or any other state Medicaid program over the last three (3) years. Where results identified provider dissatisfaction, describe strategies the Vendor has implemented to address improvement, and examples of how those strategies have been effective.

Passport Highlights: Quality Management and Health Outcomes

How We're Different	Why it Matters	Proof
<p>Twenty-plus (20+) years of provider-driven clinical innovation in Kentucky.</p>	<ul style="list-style-type: none"> • Deep relationships and trust established with providers, member advocates and community organizations are essential for success of new clinical initiatives • A long history of collaboration and partnership with the Department for Medicaid Services (DMS) as the program has evolved. Many of the initial pilot programs were rolled out initially at Passport and then expanded throughout Kentucky. • Passport's focus on aligning with the provider community has enabled access to the top clinicians in the Commonwealth around pressing clinical or public health issues. This collaboration has established the model of care for the Medicaid population 	<ul style="list-style-type: none"> • Passport has worked collaboratively and been an early adopter with the Commonwealth on major changes to the Medicaid program such as in integrating behavioral health, improvements in foster care, Medicaid expansion, KCHIP etc. • Passport's access to local clinical leaders in developing clinical treatment pathways for areas such as AIDS, hepatitis, child psychology disorders has set the standard for quality care across the Commonwealth. • Passport's reputation for quality is reflected in metrics consistently well above market averages: <ul style="list-style-type: none"> • Overall provider satisfaction is 71.4% (vs. avg of 66.6%). • Provider retention rates are very strong at 96.5% • Overall plan rating from child CAHPS is 89.5% (vs. avg of 71.7%) • Overall plan rating from adult CAHPS is 82.5% (vs. avg of 77.0%)
<p>Demonstrated success in engaging Kentucky Medicaid members with more complex needs and elevating their health status.</p>	<ul style="list-style-type: none"> • Strong focus on provider and member engagement drives early identification of health risks, high participation in our clinical programs, and industry leading program graduation rates. • Graduated members demonstrate demonstrably better self-management skills and health outcomes 	<ul style="list-style-type: none"> • Engagement rate for high-risk complex members is 42% (33% above industry averages). • 99.4% of members under care management in 2019 had personal care plans created. • The Transitions Care management program 2017-2018 study showed 8% lower total cost, 14% lower inpatient admits, and 8% lower emergency department (ED) visits (n = 1,016 members).

How We're Different	Why it Matters	Proof
<p>Culture of quality integrated through the entire organization.</p>	<ul style="list-style-type: none"> • Commitment to continuous improvement led by Kentucky provider community with representation on the Passport board, Partnership Council, and quality committees. • Member health outcomes and provider engagement with member's whole person health benefits from our integrated quality approach. 	<p>Countless quality improvement initiatives have significantly elevated the health status of Passport members. A few include:</p> <ul style="list-style-type: none"> • Worked with Family Health Centers primary care practice end-to-end on VBP, from quality metric selection to provider reports to program results and payment review process. • Integration has led to focus on special population programming including foster care, guardianship, and community transitions for formerly incarcerated members. • Improvement in maternity and early and periodic screening, diagnostic, and treatment (EPSDT) over the past five (5) years: <ul style="list-style-type: none"> • A 35% decrease in low-birth weight deliveries. • A 37% decrease in very low-birth weight deliveries. • A 39% decrease in preterm deliveries (less than 37 weeks). • A 46% improvement in Adolescent Immunization, Combo 1 (Meningococcal, Tdap/Td).
<p>Passport's population health programs use the best-in-class, nationally recognized, clinical program structures from the NCQA.</p>	<ul style="list-style-type: none"> • Members and providers benefit from in-depth analytics, predictive models, clinical program interventions and continuous Quality Improvement processes that focus on improving member health and self-management skills as well as reducing unnecessary utilization and cost 	<ul style="list-style-type: none"> • The Population Health Program that Passport uses for its members is the <i>first such program ever accredited by the NCQA</i> and is a cornerstone of our care delivery model. • Our programs have received independent validation from The Validation Institute (a leading national certification body) for their rigor, efficacy and consistent ability to drive demonstrable outcomes.

Introduction

Passport focuses on a culture of quality across the entire organization rooted in our overarching quality improvement philosophy and investment in technology, which emphasizes four principles:

- **Improving the health and quality of life of our members**—through a data-driven, continuous cycle of quality improvement.
- **Ensuring clinical effectiveness, member safety and improved quality and outcomes**—through ongoing intensive measurement and monitoring of clinical programs.
- **Improving the efficiency and effectiveness of provider and member programs and services**—through leveraging innovation, advanced technology and automation.
- **Enhancing the effectiveness of the delivery system**—through promoting coordination with and collaboration among our providers, subcontractors and community agencies and partner.

As a Kentucky-based organization, we have developed deep relationships with local providers and many community organizations that serve our population and Kentucky as a whole. Our long-standing relationship with the community and our members, along with our quality focus, nationally accredited clinical program constructs, and our demonstrated engagement success, has improved the health and quality of life of our members and supports the goals of DMS. ***We proudly commit to continuing to deliver demonstrated quality results.***

As an example of our ongoing quality focus across the entire organization, we recently led an internal campaign to ensure that ***quality is at the heart of all our interactions*** and to deliver on our commitment to DMS through our **Culture of Quality** Program. The program emphasizes to all Passport employees that quality is not just a department in the Passport organization, it is ingrained in every employee's work and every interaction with members, providers, DMS, and any of our stakeholders. We ask our employees, "what's your why?"—encouraging them to reflect upon and understand ***why*** they do what they do and how their actions affect our members and the members' health.



Throughout our response, we make a note of methods, tools, and principles used to improve processes and outcomes at Passport. As an overarching theory, we adopt W. Edwards Deming's quality management principles and philosophy when creating our total quality management strategy and culture of quality. Deming's principles were used by the Associates in Process Improvement, quality improvement industry thought leaders, when they developed *the Model for Improvement*. *The Model for Improvement* is a method that serves as the foundation for our continuous quality improvement process. One of the critical tools in *The Model for Improvement* is the use of the plan, do, study, act (PDSA) cycle. When performing more intensive process improvement across the organization, Passport applies Lean Healthcare principles. Through Lean Healthcare, we use Kaizen events to conduct root cause analysis, create value stream maps, and perform A3 problem-solving.

Passport currently complies with all the requirements outlined in the DMS contract, especially this vital section on Quality Management and its related provisions in the attachments and appendixes.

“Passport Health Plan has been a valued partner for the past two decades, helping the Family Health Centers (FHC) expand access to high-quality primary health care for the most vulnerable residents of our community. FHC’s eight locations serve over 43,000 individuals annually, including low-income working families, persons with mental health and substance use disorders, individuals experiencing homelessness, and a fast-growing foreign-born population. Working closely with Passport, we are able to provide access to integrated primary care, behavioral health, oral health and pharmacy services to these at-risk individuals and families, helping improve health outcomes and lower the total cost of care. Passport has always valued the input of ‘safety-net’ providers and encouraged our participation in quality management and program oversight through its various committees and the Partnership Council.”

William B. Wagner, CEO, Family Health Centers Inc.

C.9.a. Provide a detailed description of how the Vendor will support the Department in achieving its goals to transform the Medicaid program to empower individuals to improve their health and engage in their health care and to improve quality of care and health care outcomes significantly and to reduce or eliminate health disparities. At a minimum, the Vendor’s response should address:

Passport Supports DMS in Achieving its Goals to Transform the Medicaid Program

Our quality program and culture of quality philosophy rely on data-driven continuous improvement, stakeholder engagement, and support from empirical evidence. These align with our organizational goals, which mirror the Commonwealth’s goals to transform the Medicaid program to empower individuals to improve their health, engage in their health care to improve the quality of care and health care outcomes, and reduce or eliminate health disparities. Our clinical and quality strategy embeds these goals across the organization through:

- Reducing the burden of substance use disorder (SUD) and engaging members to improve behavioral health (BH) outcomes; we address this through our integrated BH program, where we bring together behavioral health providers and primary care providers (PCPs) to collaborate and intervene with members.
- Increasing the usage of preventive services through our EPSDT program and physician engagement around member care gaps.
- Reducing the burden of and improving outcomes for chronic diseases through population health programs that employ NCQA-accredited, nationally recognized clinical program structures.
- Promoting access to high-quality care and reducing unnecessary spending through our value-based payment (VBP) programs and by increasing our network footprint with additional providers and specialties.

- Our collaboration with our BH subcontractor, co-managing members with serious mental illness, and Passport's incarcerated member transition program, which highlights our improving care and outcomes for children and adults, including special populations.

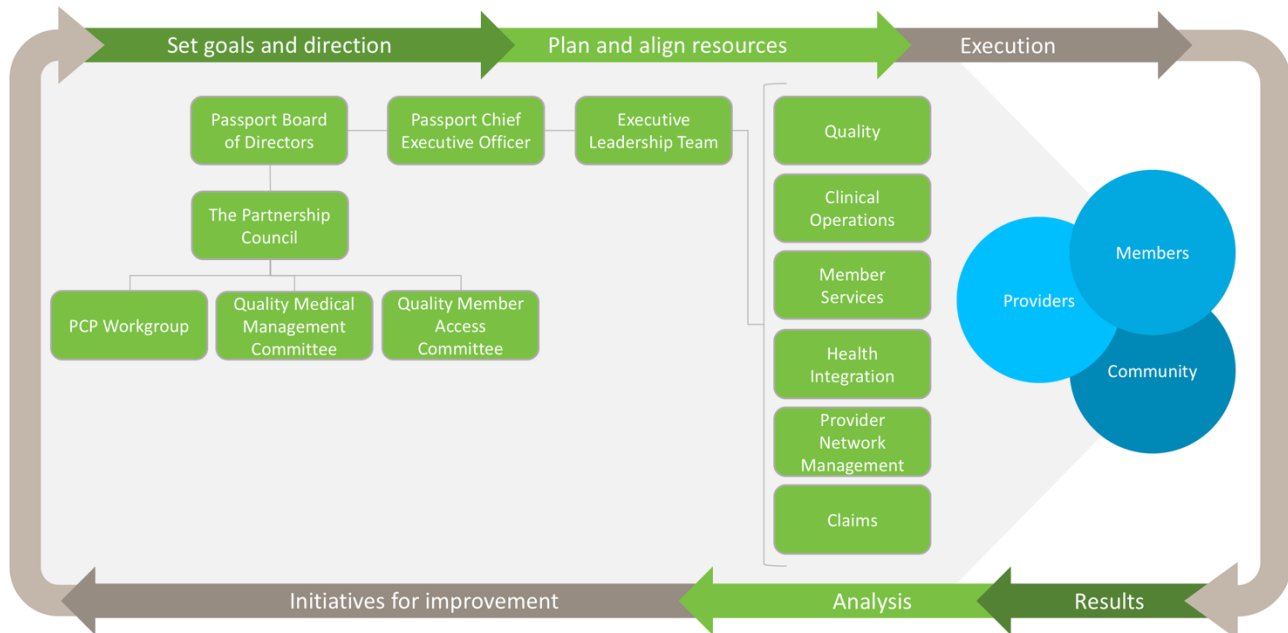
Passport follows a comprehensive approach to quality measurement and improvement that complies with 42 C.F.R. 438 Subpart E, requirements of the Contract, and the Department's Quality Strategy. Passport operates a comprehensive Quality Assessment and Performance Improvement (QAPI) Program in compliance with the State requirements of 42 C.F.R. 438.330. All materials and documents identified in our response to C.09 will be submitted to the Department to the Department's Division of Program Quality & Outcomes, Managed Care Oversight Quality Branch Manager.

C.9.a.i. How it will structure its organization to provide for a comprehensive and holistic approach to meet these goals, including coordination with Subcontractors and providers.

Passport's Organizational Structure Supports a Comprehensive and Holistic Approach to Meeting Quality Goals

Passport's quality organizational structure enhances our provider-driven voice and facilitates Passport's **whole-person, integrated care approach**. Our commitment to quality flows from our Board of Directors throughout the organization. **Exhibit C.9-1** depicts how our organizational structure supports overall quality improvement. Through this organizational structure, Passport is well-positioned to meet the stated goals of DMS and the DMS quality aims. Our committee structure, starting with the Board of Directors, sets goals and direction for Passport that align with the goals and contract expectations of DMS. Through our chief executive officer and executive leadership team, resources are identified and aligned to ensure that our organization is supported to execute our goals. Various Passport departments collaborate and work cross-functionally to put in place initiatives framed around its members, providers, and community. It is through this framework that we monitor performance and results. After we have collected data, we then perform an analysis to see how well our organization did in meeting the goals and direction set forth. Passport identifies initiatives for improvement. The cycle continues with our committee structure, applying those lessons learned or new actions to direct new goals and priorities for our organization.

Exhibit C.9-1: Quality Structure Supports Meeting DMS Quality Goals



Our approach to quality improvement not only engages all the stakeholders at multiple levels; it is structured to drive a holistic approach that directly contributes to improving the health of Kentuckians. Passport believes our organizational structure and continuous improvement process is crucial to meeting DMS’ stated goals of transforming the Medicaid program by:

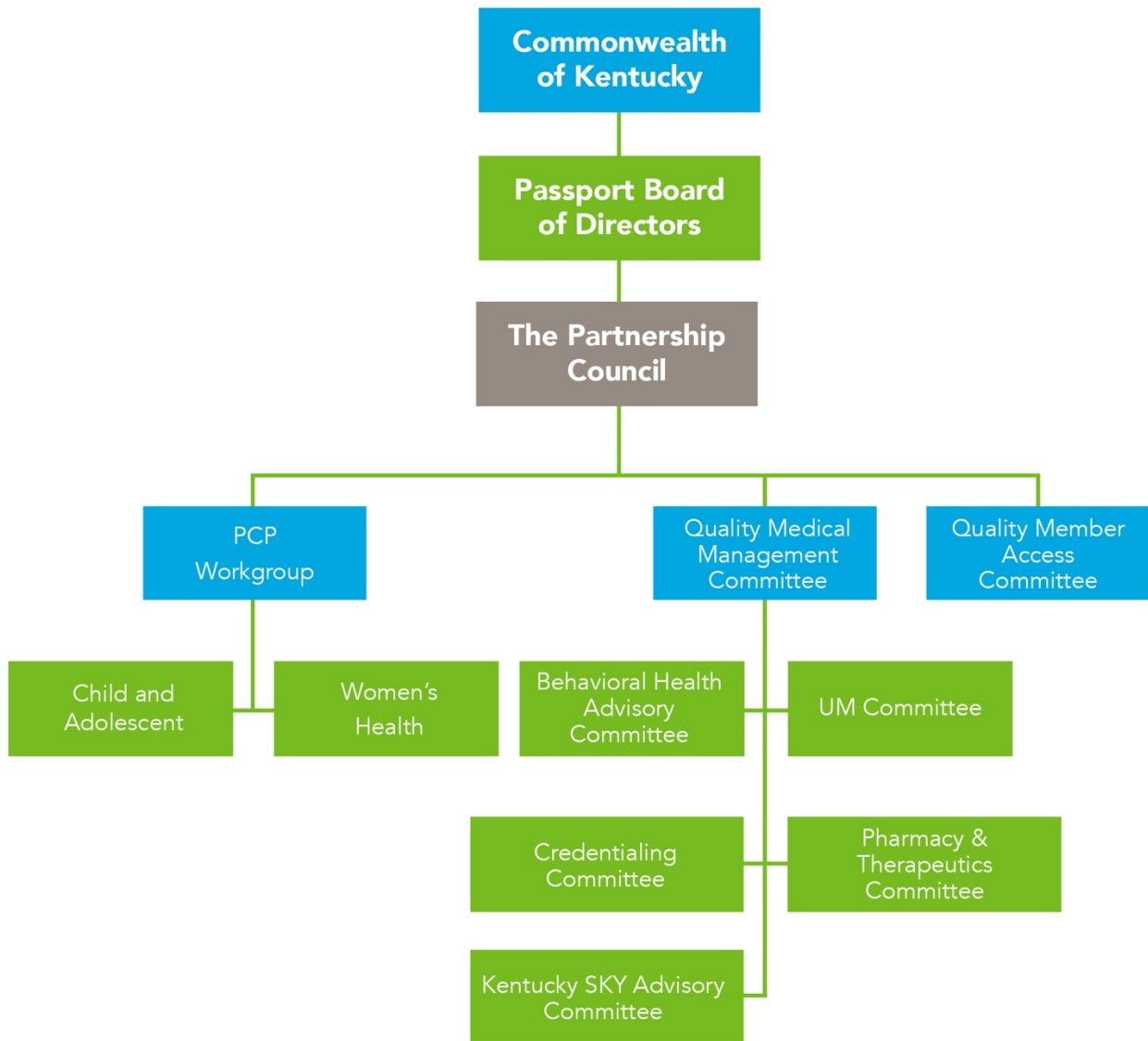
- Improving the member’s health and quality of life of our members—through a data-driven, continuous cycle of quality improvement.
- Ensuring clinical effectiveness, member safety, and improved quality and outcomes—through ongoing intensive measurement and monitoring of clinical programs.
- Improving the efficiency and effectiveness of provider and member programs and services—through leveraging innovation, advanced technology, and automation.
- Enhancing the effectiveness of the delivery system—through promoting coordination with and collaboration among our providers, subcontractors, and community agencies and partner.
- Committing and collaborating to devise multiple methods for reducing or eliminating health disparities using traditional, nontraditional, and extended community resources.

Structure

To achieve the aims of improving health and outcomes to transform the Medicaid program, Passport’s collaborative structure, detailed in the high-level organization chart below, shows participation by the Commonwealth, members, and our community in its current committee structure. Passport implemented the necessary structure to provide oversight, ensure engagement of its subcontractors or delegates, incorporate the voice of the member, and partner with supportive and committed community resources. Passport’s QAPI program governing body consists of the Board of Directors, the Partnership Council, and the Quality Medical Management Committee (QMMC). The QMMC serves as the Quality Improvement

Committee (QIC) for Passport. The Partnership Council is an approving body for the QMMC, as illustrated in **Exhibit C.9-2: Passport Health Plan Quality Committee Structure**. Formal committees, subcommittees, and workgroups advise and guide the quality improvement process. Nearly one hundred (100) volunteer providers, members, and community members participate in this structure.

Exhibit C.9-2: Passport Health Plan Quality Committee Structure



Board of Directors

Passport has a provider-driven Board of Directors (BoD) with seven (7) members. The BoD includes both behavioral health and physical medicine representatives, providing perspective across the continuum of health care delivery. This group is instrumental in strategic planning.

The Partnership Council

Providers are essential partners in improving the health outcomes of the Medicaid population and contributing to the transformation of the Medicaid Program. Our Partnership Council is the overarching provider governance committee, which receives and reviews quality management and improvement activities from Passport's quality committees. The Partnership Council is one of many ways in which we coordinate with providers. It has more than thirty (30) individuals representing multiple Kentucky-based provider sectors, consumers and community interests (advocates).

Quality Medical Management Committee

The QMMC is the name we use for Passport's QIC. The QMMC performs all the functions stated in the Model Contract for the QIC. The QMMC oversees quality improvement and accreditation activities throughout the health plan and the provider network. Dr. Stephen Houghland, our chief medical officer, chairs the committee, which includes representatives from Norton Healthcare, the University of Louisville, a rural community mental health center, a clinical pharmacist, and a private-practice OB/GYN, among others. The QMMC is the primary conduit for achieving our holistic organizational goals for quality, which flow from DMS' goals. It also facilitates our organization's focus on whole-person care across the full spectrum of needs and services.

The QMMC:

- Directs and oversees: subcommittees responsible for the quality of clinical care and services; services provided by Passport or its subcontractors; quality-of-care concerns surfaced by the Credentialing Committee; the peer review process for monitoring and assessing the potential quality-of-care or quality-of-service concerns.
- Approves: the annual Quality Improvement (QI) and Utilization Management (UM) Program descriptions. Biannually reviews the QI Work Plan and annual QI/UM evaluations.
- Evaluates, offers feedback, and approves: all clinical practice guidelines (CPGs), under-and overutilization findings, UM criteria, clinical and service audits and findings, and administrative policies and procedures (such as confidentiality) that affect members' health care.
- Recommends: provider education, interventions, health education programs, and other initiatives.
- Reviews and evaluates: member and provider surveys and interventions; clinical program descriptions and evaluations; external quality review organization (EQRO) focused studies, audits or findings; and member complaints and sentinel events.
- Oversees: PIPs.
- Analyzes aggregate data on: performance, member complaints, sentinel events, and provider audits.
- Makes determinations for: any corrective action required from oversight and evaluations.

Subcommittees of the QMMC

The QMMC has several subcommittees that advise QMMC and Passport on various issues specific to populations and/or therapeutic areas, subcontractors, and advancing its goal of integrated whole-person care. Each subcommittee monitors the achievement of improved health outcomes and implements improvement strategies. These committees include:

- **Behavioral Health Advisory Committee:** In collaboration with our behavioral health subcontractor, the BHAC provides feedback and recommendations related to behavioral health care and pharmacy.
- **Credentialing Committee:** The committee administers policies and procedures for credentialing, recredentialing, certification and recertification for practitioners and organizational providers following Passport Health Plan and NCQA standards. It also monitors and evaluates related trends and issues in collaboration with the credentialing delegates.
- **Utilization Management Committee:** The committee supports provider clinical decision-making by providing essential expertise regarding medical necessity criteria selection and approval. It provides a continuous review of the entire UM program and all subcontracted entities to ensure the UM program meets the needs of Passport and DMS. Chaired by Passport's medical director, our UM Committee includes Kentucky-based providers that oversee clinical service delivery trends across Passport's membership, including evaluating utilization, patterns of care, and critical utilization indicators. Our UM committee evaluates the need for and approval of UM policy, standards, or procedural changes, including the adoption and implementation of clinical guidelines and approving and monitoring the UM program description and work plan. The UM Committee also reviews Passport's grievances and appeals (including expedited Appeals and State Fair Hearings) related to UM activities to determine needed policy changes.
- **Pharmacy and Therapeutics (P&T) Advisory Committee:** The committee provides direction to and oversight of pharmaceutical issues concerning members using pharmacological, economic and clinical information. Its responsibilities include the review, evaluation and delivery of recommendations related to utilization (under and over) of medications and pharmacologic agents, additions to and deletions from the formulary, and monitoring and review of pharmacy programs and program results.

Quality Member Access Committee

The QMAC enables Passport members, consumers, and advocates to provide input regarding access to care and quality of care for the membership. It also identifies opportunities for improvement. For Passport, the QMAC acts as one source of the voice of the customer to better understand and serve member wants and needs. The QMAC reviews and recommends improvements for:

- Member education materials
- Outreach programs and community activities, including new efforts or refinements to existing programs
- Access standards
- Grievance and appeals processes and policy modifications, based on a review of aggregate grievance and appeals data and member handbooks
- Contractor/subcontractor and department policies that affect members.

We describe our QMAC in more detail in the response to question 9.d, below.

Collaboration with Subcontractors and Providers to Achieve Goals

The QMMC also oversees all activities of our Delegation Oversight Committee (DOC) as it pertains to subcontractors relevant to our NCQA Accreditation. The DOC reports through our compliance organization and is a central body in overseeing subcontractors to which utilization and quality management, credentialing, member services, provider services, claims operations, and other administrative functions are delegated. The DOC reviews all contractual metrics for each subcontractor, including Service Level Agreements (SLAs), performance reports, and QI/UM reports (if applicable). It also discusses the annual delegation audit to ensure compliance with all federal, state, department, and contract requirements as well as any pre-delegation assessments before the effective date of new delegation contracts. With its focus on quality, the QMMC strives to ensure these delegated entities work as one, so that Passport serves the member holistically, and so neither the member nor the provider experience abrasion as a result of engaging with delegates. To them, Passport wants every interaction to be seamless, regardless of whether Passport directly provides the service, or a subcontractor provides it. With an affiliation agreement through the Partnership Council and our Board of Directors, the QMMC has the authority and accountability for subcontractors relevant to NCQA Accreditation.

Alignment to DMS Goals and Quality Aims

Exhibit C.9-3: Passport’s Alignment to DMS Goals and Quality Aims provides examples of our approach to meeting the DMS State Quality Aims for 2019 with the use of subcontractors, vendors, or providers; all of these align and support all stated DMS goals.

Exhibit C.9-3: Passport’s Alignment to DMS Goals and Quality Aims

DMS State Quality Aims 2019	Passport’s Approach to meeting aims
Reduce the burden of SUD and engage members to improve behavioral health outcomes	Passport’s integrated BH program enables providers to address the entire spectrum of needs our members have from a physical and behavioral health perspective. The work is conducted in concert with our BH subcontractor.
Reduce the burden of and outcomes for chronic disease	In collaboration with a vendor, we use remote care monitoring to help members take control of their health by checking vitals daily in managing chronic disease. We use population health programs that employ nationally recognized clinical program structures.
Increase preventive service use	Passport’s EPSDT program and provider engagement teams work with provider offices around member care gaps and primary care provider visits.
Promote access to high-quality care and reduce unnecessary spending	Through our nationally recognized care management programs and our VBP programs, Passport is increasing its footprint with additional providers and specialties. Our staff engages providers, members, and community resources to ensure a high level of care that is efficient and incentivized to meet member needs. Passport uses Healthify as a social needs community resource database.
Improve care and outcomes for children and adults, including special populations	Passport co-manages members with serious mental illness in partnership with our BH subcontractor. We also found an opportunity to specifically support our members experiencing Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) by taking part in a DMS and Department for Community Based Services (DCBS) program targeting women who are transitioning from incarceration back into the community.

C.9.a.ii Strategic solutions the Vendor will use in quality management, measurement, and improvement.

Strategic Solutions in Quality Management, Measurement and Improvement



Total Quality Management Solution

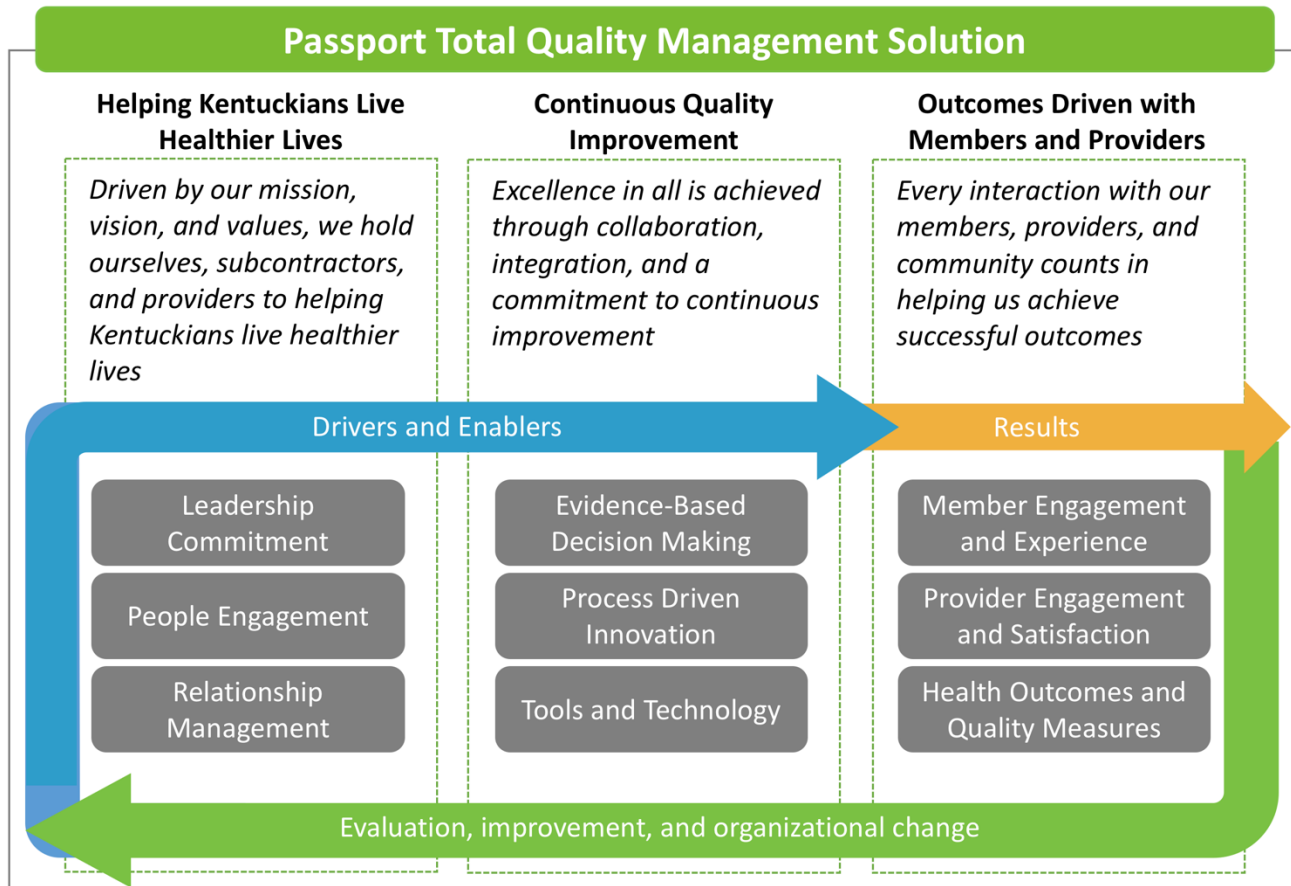
Our Total Quality Management (TQM) solution is depicted in **Exhibit C.9-4**. Passport aligned our commitment to sustainable long-term quality improvement by applying W. Edwards Deming’s principles of quality management. We frame our overall quality strategy around the member, provider and community. The TQM solution involves all Passport departments, employees and stakeholders in our continuous quality improvement process.

Through the TQM solution, we enable and drive continuous quality improvement with a strong commitment to our mission, vision, values and culture of quality. The Passport team is engaged through targeted communications and training on quality management and improvement. We hold our providers, subcontractors and delegates accountable through relationship management in contracting and oversight with service-level agreements tied to their performance in helping Kentuckians live healthier lives.

Continuous quality improvement requires collaboration and integration of people, data, tools, and technology to enable evidence-based decision-making and process-driven innovation. Leveraging the IdentifiSM technology platform and partnership with subcontractors, Passport continuously evaluates our processes to implement improvement strategies for its members, providers and community.

To have outcomes driven with members and providers, we ensure that every interaction with our members, providers and community counts. Passport uses data on member engagement and experience, provider engagement and satisfaction, health outcomes, quality, and operations measures to evaluate performance. Through this evaluation, Passport identifies areas for improvement and implements initiatives to drive organizational change.

Exhibit C.9-4: Passport Total Quality Management Solution



Applying our TQM solution. The focus of the 2020 quality strategy is to ensure *every interaction counts* to deliver a thoughtful, consistent and sustainable message regarding quality and to improve health outcomes. The goal of the plan is twofold: (1) create satisfaction for our members in services they receive, and (2) build an understanding with each member on their path to better health by strengthening the member-primary care provider relationship.

Quality Measurement Solutions

Our comprehensive suite of performance measures identifies weaknesses and prioritizes opportunities for improvement. Measures are also used to determine what works (best practices) and what does not work to drive organization-wide improvements. The Quality Improvement Workplan is our primary tool for tracking quality, process and outcome measures on a routine basis. We have measures in place to monitor:

- preventive care;
- acute or chronic physical or behavioral conditions;
- social determinants of health and high-volume high-risk and special health care-need populations;
- over-, under- and misuse of services;
- disparities in care delivery and the outcomes; and
- operations, including member services, provider network management, and utilization management.

Data and Tools Supporting Measuring Quality Indicators and Measures

Passport is committed to our investment in advanced technological tools that enable us to measure processes, outcomes, HEDIS scores, resources, and operational structure and build composite scores. Building on our member activation and provider engagement efforts, our technology platform generates care insights and initiatives to maximum effect providing solutions or enhancements to working solutions. Our technology platform consists of a highly integrated data and analytics environment that provides differentiated data integration capabilities, drives insights based on multiple data sources, and identifies solutions to impact care activity for each member. For more detail, please see the **Internal Tools and Technology Infrastructure** section in the response to question 9.a.iv.

Our technological tools enable Passport to aggregate and analyze disparate data sets. These data sets include items such as claims, social determinants of health (SDoH), continuity of care document (CCD) feeds, third-party laboratory data, and others, to provide insights on the quality of care delivered and the health of our members. Because of our ability to integrate and normalize this wide variety of data, Passport can use the data to drive innovative and effective solutions. Our technology has data “pipelines” to minimize the time between the origination of new data and the execution of powerful machine learning models. This technology tool allows our ***predictive models to identify changes*** in member health trajectories in real time and identify and track those at risk at their most critical and impactable moments.

Access to more data, such as the Kentucky Health Information Exchange (KHIE), and advances in technology are creating a paradigm shift in how we approach identifying, engaging and managing members to improve the quality of care we deliver and member health outcomes. Passive and active rules engines use clinical, financial, administrative, social determinants of health, and self-reported data to build and maintain rich profiles for each member. The technology intelligently maps member groups to the right mix and intensity of clinical interventions and creates critical actions to drive workflow. Through real-time member profiling and predictive models, the engine prompts interventions at the most vital stages in a member’s care. Powerful utility user interface tools enable highly agile rules authoring, testing, and scalable deployment without the need for custom software development.

Of particular importance is our use of data related to SDoH. Because of the importance of psychosocial and socioeconomic issues on health outcomes and the identification and reduction of disparities, we leverage a variety of assessment data and publicly available data sources to understand and address a population’s SDoH . The American Community Survey (ACS) from the U.S. Census Bureau tracks more than one hundred (100) data elements on education, poverty and housing status by neighborhood. We use the location affordability index, walkability index, food access, and supermarket availability from the U.S. Department of Transportation, as well as the Environmental Protection Agency’s Smart Location Database, to supplement social, economic and environmental information. The U.S. Department of Agriculture tracks food deserts, which is part of our risk scoring determination. We also leverage Google technology (e.g., the technology that allows users to locate amenities in Google Maps) to calculate distances to the nearest pharmacy, grocery store, physician’s office, and hospital, which may identify potential gaps in the community’s health care access.

To improve health outcomes across the Commonwealth, we are driving provider engagement and satisfaction through participation in targeted quality initiatives at the provider and practice level. Passport implements training and practice optimization, ensuring members receive delivery of care that demonstrates best practice. Using established quality measures such as HEDIS and CAHPS, the Passport strategy leverages a population health management and provider network management partnership to address issues and education. Engagement also takes place through HealthPlus, a VBP program that incentivizes major provider partners to target specific quality measures relevant to the Passport population. Passport will work with DMS to introduce new value-based payment opportunities and outreach in 2020.



Passport’s Engagement Strategies Deliver Results

One hundred percent (100%) of patients engaged in care programs in 2019 completed comprehensive assessments

Over ninety-nine percent (99%) of patients under care management in 2019 had personal care plans created

Engagement rates for high-risk patients* ranged from fifty-nine percent to seventy-two percent (59%-72%) versus an industry standard of less than thirty percent (30%)

* Members in catastrophic care and complex care programs

Priority Goals for 2020 Based on Findings from the 2018 Program Evaluation and Accreditation Cycle

Passport will support DMS in achieving its goals to transform the Medicaid program by engaging in initiatives to:

- **Empower Individuals to improve their health and participate in their health care:** Passport's quality strategy will use interventions in collaboration with providers to improve the overall health of its population and activate members in taking ownership of their health. Specific areas of focus will be colon cancer screening, diabetes, adolescent tobacco cessation, and social deterrents.
- **Significantly improve the quality of care and health care outcomes:** Expansion of the existing Population Health Management Strategy will address the entire spectrum of care and improve health outcomes. Our Population Health Management Strategy aligns with NCQA Health Plan Accreditation program requirements, aimed at keeping members healthy, managing members with emerging risk, outcomes across all settings, and managing members with chronic illness.
- **Reduce or eliminate health disparities:** Identify health care disparities in the population and implement interventions to decrease the impact of disparities on overall health and wellness.
- **Aid the transformation of the Medicaid program through initiatives with members and providers:** To address compliance with quality standards and requirements set forth by DMS regarding policy, processes and reporting, continuous monitoring of QAPI program results guarantees that Passport will continue to regularly adapt its programs and services to achieve optimum quality and cost-effectiveness.
- **Support community engagement efforts to help individuals succeed independently:** Passport has created tools and processes to engage stakeholders and the community to educate current and future members on how to maintain their benefits.

Quality Improvement Solutions

Passport's Quality Management program involves systematic activities that monitor, assess and improve the quality of care and services provided to our membership. We are committed to working with the department to develop focused and achievable approaches. We have allocated significant resources to improve quality and outcomes related to substance use disorder, chronic disease management, wellness and prevention, and overarching population health management and our value-based care approaches.

Key attributes of our 2020 quality improvement solutions strategy include:

Improving health care quality and efficiencies. Passport will focus on several areas to improve health care quality and the efficiency of care and service delivery:

- Reduce the burden of substance use disorders and improve behavioral health outcomes through whole person-centered care.
- Reduce the burden of chronic disease, specifically diabetes.
- Reduce tobacco use.
- Improve preventive health screening rates.
- Advance development of connections between community engagement, health behaviors and health outcomes.

- Improve care for children and adults.

Educate, engage and empower our members in their health care journey. One important activation strategy focuses on new Passport members. Our research showed that disenrollment rates were highest within the first ninety (90) days of a member’s tenure with Passport. Disenrollment frequently is the result of members not fully understanding their available benefits and how they can be easily accessed. The longer a member remains with the same plan, the better coordinated their care, and the better the results. To help retain members over the long term, Passport developed a comprehensive ninety (90)-day New Member On-Boarding Plan. Our New Member On-Boarding Plan has identified objectives, such as making positive connections with our new members and providing education on the benefits we offer. This plan allows members to share with us about themselves and empowers them to take control of their health.

Supporting and Rewarding Providers through Value-Based Programs to improve health outcomes. As a provider-driven plan, Passport maintains and fosters a close alignment with our providers and engages them at all levels in the organization, from our Board of Directors to our PCP Workgroup and various committees and pilot programs. In 2018, we expanded our provider alignment strategy through a value-based program with many large provider partners. Passport launched its primary care HealthPlus VBP program after consultation with its PCP Workgroup and approval by DMS. Our primary care VBP program touched thirty-seven (37%) of our members and sixty-one percent (61%) of our PCPs.

Training and educating our employees. The Passport quality team conducts ongoing training, education and communication across the organization through several methods. The quarterly Lunch N’ Learn series addresses the different aspects of a quality improvement program. Some examples of the Lunch N’ Learn series are updates on the NCQA accreditation standards, understanding HEDIS and CAHPS, and how to write an analysis. The Quality team also attends departmental meetings and educates on applicable HEDIS measures and discusses the impact of interventions. In addition, the Quality team publishes educational information on its internal site. The information includes, at a minimum, reference materials about NCQA, PIPs, HEDIS, CAHPS, and regulatory guidelines.

Here is what we have planned:

- Expansion of our texting and member portal engagement program, meeting them where they are.
- Engaging members, via text, in ongoing feedback through short surveys (1-2 questions) monthly.
- Expansion of our member incentives to include activation-focused behavior (non-health outcomes-based rewards that will ultimately impact health outcomes as well, e.g., updating contact information, annual completion of Health Risk Assessment (HRA), participation in an ambassador program to improve member satisfaction).
- Leverage the proposed Passport Health & Well-Being campus to provide on-site screenings and services for preventive care in conjunction with health departments.
- Provide in-home testing and services for members with SDoH that may prevent them from having to see their PCP.

Quality Improvement in Action:

Improving Immunization Rates

Define Problem Statement: Childhood Immunization Status (CIS) and Immunizations for Adolescents (IMA) rates were below target.

Set Goals and Direction: Our Quality team and CMO reviewed immunization performance data with the Passport's QIC called the *Quality Medical Management Committee (QMMC)*, in early 2019. The group discussed the importance of these measures in the context of DMS and Department of Public Health goals, but also acknowledged that immunizations are often drivers for well-care and EPSDT visits with their PCP. QMMC set the following goals:

- Increase performance on immunization measures;
- Increase engagement through various communication modalities;
- Increase the use of member rewards for immunizations.:

Plan, Align Resources, and Execute: The QMMC called for an interdisciplinary committee across *Quality, Member Services and Population Health Management* teams to identify specific tactics and interventions to achieve the goals. QMMC and CMO provided final approval on the following interventions:

- Live Outreach: Clinical Quality Advisors conducted live outreach for members with CIS and IMA gaps. Care Connectors from Member Services outreached to members who were not reached prior for EPSDT visits.
- Automated Outreach: Interactive Voice Response reminder calls for members/parents for EPSDT visits
- Text Messaging: Wellness reminder texts targeted at immunizations
- Mailings: Members who were unable to reach by phone were sent an EPSDT reminder mailing
- Member Rewards: Incentives were offered for members who completed their immunizations Quality

Analysis & Results: Performance and outreach data was collected over 2019. Observed results include:

- CIS performance improved 3% points from Q1 2019 to Q4 2019.
- IMA performance improved 7% points from 2018 to 2019 year-end results.
- Use of member rewards for immunizations resulted in an additional 140 immunizations completed.
- Screening rates for EPSDT increased from 64% in Q1 to 88% by Q4 2019.

No significant change was observed in EPSDT participation rates.

Continued Improvement Efforts: Upon review of the data, our quality committees identified several opportunities to improve data for outreach efforts including increasing opt-in selection for text messages, reviewing our selection process for EPSDT outreach, and addressing transportation, which was noted as a barrier to receiving EPSDT care.

C.9.a.iii Innovative strategies and enhanced services, if any, that the Vendor proposes to implement to enhance the health and well-being of Enrollees and to improve health outcomes, including examples of successes with similar Medicaid populations.

Enhancing Member Health and Well-Being and Improving Health Outcomes Through Innovative Strategies and Enhanced Services

Across our organization, we leverage multiple innovative strategies and enhanced services to uphold our Passport Promise to our members. Our strategies, some of which are listed in more detail below, focuses on innovative methods to achieve DMS’ quality goals. Passport leverages our experience serving the Kentucky Medicaid population in developing innovative strategies to improve he health and well-being of our members. Our subcontractors collaborate with us in that development and Passport is able to leverage their experience providing similar services across the nation. **Exhibit C.9-5: Passport’s Innovative Strategies Meet DMS Quality Program Goals** shows how our strategies map to DMS quality goals. In the sections that follow, we describe each Passport innovation.

Exhibit C.9-5: Passport’s Innovative Strategies Meet DMS Quality Program Goals

Passport innovation	Empowering individuals to improve their health and engage in their health care	Significantly improving quality of care and health care outcomes	Reducing or eliminating health disparities
Member education and communication	✓	✓	✓
Health incentives	✓	✓	✓
Population health management programs	✓	✓	✓
Passport quick questions		✓	✓
Building the member-provider relationship	✓	✓	
Understanding the member journey	✓		✓

Member Education and Communication

Passport reaches out to all members to promote engagement and to educate them on available benefits, the importance of screenings and preventive care, as well as other pertinent topics, such as these two training guides, *How to Avoid the Emergency Room* and *When to Talk to Your Doctor*. We provide traditional outreach materials such as health literacy materials, disease-specific mailings, reminder postcards, and newsletters. We also conduct telephonic outreach and conduct local outreach in collaboration with community agencies. Some of our more innovative outreach techniques include:

- **Community Health Worker Program:** In 2018, we implemented a new program where our community health workers (CHWs) conduct face-to-face visits in members' homes, provider offices, and community service organizations. The CHWs act as advocates, helping members to schedule doctor appointments and obtain the necessary resources to resolve social determinants of health. CHWs also assess for required literacy and interpretation services. CHWs provide information to the member, teaching the member how to engage in health care and take charge of making resource arrangements.
- **Homeless Services:** Since 1997, Passport has partnered with community organizations engaged in addressing the needs of its community's homeless population. Throughout the year, Passport provides face-to-face member/benefits education sessions. We conduct these sessions at transitional and homeless shelters throughout the Commonwealth. As a Kentucky-based plan, Passport has deep connections with community organizations serving the homeless population. We give special attention to victims of domestic violence who are residing in emergency shelters. Passport also has a social worker embedded in two clinics in Louisville, where many local homeless individuals seek primary and specialty care. The social worker assists with accessing needed care, acquiring a cell phone, and more.
- **Refugee Services:** Passport provides a Refugee Care Specialist program to help refugee members get the care they need. The refugee specialist works directly within local refugee resettlement agencies and offers face-to-face support to newly arrived refugees to help ensure they can navigate, access, and receive quality health care in the communities within which they now live. This case manager assists with addressing barriers that refugees face when in the health care system. The case manager often works with the members face-to-face or on the phone to address transportation issues, language access problems, and navigating cultural differences; the case manager also explains how best to navigate the system.



**Closing the Loop
on Social
Determinants**

Through these programs we have seen higher engagement with members who have episodic needs. This engagement in addressing episodic enrollee needs has impacted health outcomes for members in these programs. For instance, Passport members experiencing homelessness visit the ED on average 3.5 times per year versus the national average of 5.0 (or 30% less frequently than the national average). To continue building on our success with this engagement we are partnering with local community agencies to address systemic issues and SDoH; both of which are impacting more sustained long-term engagement with members.

Passport Community Health Workers Help Build Family Ties

Since August, Community Health Worker Rhonda Wooten has been working with Susie,* a pediatric Passport member. During that time, the family had many social needs arise. Rhonda worked closely to build rapport with the mother. As a result of her hard work, Rhonda was able to provide Susie with clothing, formula, diapers, baby wipes, household supplies and food. The family also had an open case with Child Protective Services, and the mother was very concerned about Susie being removed from the home. She asked Rhonda to attend the meeting with CPS at her home. Rhonda attended the meeting and Susie was allowed to stay in the home with her mother.

"This story is special to me because the trust the mother developed with me allowed her to feel comfortable asking me to be present for support during a trying time," says Rhonda.

*Member name changed for privacy.

Health Incentives

To improve health outcomes, Passport continuously looks for opportunities to encourage members to get screenings and address other social determinants of care. Passport's Member Rewards Program emphasizes to members the value of preventive health care and community engagement. It provides vouchers or gift cards from retail stores, drug stores, or restaurants for completing appropriate wellness activities. We revise this program annually based on Passport's Population Assessment, HEDIS performance, and other inputs, to align with Passport's quality improvement activities. **Attachment C.9-1_ 2021 Proposed Member Rewards** summarizes our proposed 2021 program, including which members are eligible, what incentives are available, and what screenings or tests must be completed to earn the incentive. The attachment also shows how the incentives align with the 2019 DMS quality strategy goals.

In 2019, member's use of health incentives was lower than expected. We evaluated potential barriers and have made it a focus in 2020 to increase awareness and make it easier for members to earn these rewards. Our community engagement team is positioned through events, social media and targeted texting campaigns to bring broader awareness of the health incentives. To make it easier for members, we partnered with a new vendor in 2019 to administer the incentives.

Even with low participation counts in 2019, health incentives offered through the Member Rewards Program have contributed to a three (3)-percentage point improvement in the Childhood Immunization Status (CIS) Combo 2 rate in 2019. One hundred forty (140) members took advantage of the rewards program, and CIS improved from thirty-seven percent (37%) to forty percent (40%).

Over the past five years, the Member Rewards Program has contributed to:

- A thirty-five percent (35%) decrease in low-birth weight deliveries.
- A thirty-seven percent (37%) decrease in very low-birth weight deliveries.
- A thirty-nine percent (39%) decrease in preterm deliveries (less than thirty-seven [37] weeks).

- A forty-six percent (46%) improvement in Adolescent Immunization, Combo 1 (Meningococcal, Tdap/Td) achieving and maintaining a rank above the Medicaid Quality Compass ninetieth (90th) percentile.

Population Health Management Programs

Passport's unique approach to population health management (PHM) is data-driven. It combines the early identification of impactable, at-risk members with clinically validated programs to efficiently and reliably deliver better care at a lower cost. By identifying members for whom we can improve the care journey, we can have the most significant impact on the cost and quality of care for the overall population. Passport's PHM approach leverages strategies used by Passport to promote the transition to value-based care in its contracted network. We can also identify subpopulations of members whose needs differ due to their particular circumstances. Combining approaches based on individual needs with strategies to meet the specific needs of subpopulations makes Passport's programs unique. Passport's Population Health Management Programs are based upon its subcontractor's Medicaid Model of Care, developed specifically to support Medicaid members in provider-sponsored health plans in many states, including Indiana, Florida, Massachusetts, New York and especially Kentucky.

Below, we describe specialized programs for our populations. Specially trained care managers are part of each program, providing additional support to members. These programs include the following:

- **Foster Care Program:** Many children in foster care have complex health needs, including higher levels of physical, oral and behavioral health issues than the general pediatric population. Today, Passport has a specific Foster Care program to provide the needed care and guidance for these vulnerable children. It will modify and expand this program to serve the needs of Kentucky Supporting Kentucky Youth (SKY) members when selected as their MCO. Serving as their advocate, our foster care specialists provide foster children with compassionate and caring support during their transition and care program. The specialist establishes a safe and appropriate medical home for each foster child. The care management process includes physical health and behavioral health assessments, monitors psychotropic medication use, and offers access to dental care. The specialist develops and continuously monitors a member-centric care plan for the duration of the program and the child's plan membership.
- **Guardianship Program:** Passport finds that members in state guardianship often have fragmented health care, resulting in care gaps for both medical and behavioral health and increased hospital readmissions. To address this issue, we employ a guardianship specialist who acts as a liaison between Passport and the Department for Aging and Independent Living (DAIL), personal care homes, state psychiatric hospital social workers, community mental health centers, and other key stakeholders. As the liaison, the guardianship specialist builds relationships with state partners in each DAİL region throughout the Commonwealth. By developing these stakeholder relationships, the guardianship specialist can better serve our disabled members. Our Guardianship Program includes member health assessments, the establishment of a medical home, monitoring of psychotropic medication use, behavioral health evaluations, coordination of specialized medical care, and the determination of dental treatment services needed.



- **Community Transition Program:** To support its justice-involved members as they transition from a correctional facility back into the community, Passport provides wraparound care for physical and behavioral health services and addresses any social determinants of health issues they may currently have (e.g., literacy challenges, lack of education or job skill training) and needs they may experience in the future (e.g., employment, housing or transportation). During the program, we provide supportive care, outreach and access to a network of community-based and psychosocial services. Our care coordinators also assist with preauthorization for health care treatments they will need during and after their transition to the community. Post-release, our care coordinators contact each member weekly for targeted care management evaluations, review their utilization patterns, and measure their program progress.

Passport implemented care programs with our subcontractor that have been accredited through NCQA; including the NCQA accredited Population Health Management program. Collaborating with our subcontractor and using our local experience, has allowed Passport to better address enrollee needs, demonstrate decreased unnecessary utilization, and improve health outcomes for our members. For example, with our Transition Care program, Passport saw a 14% decrease with inpatient utilization, an 8% decrease in ED utilization, and an 8% decrease in total cost of care.



Closing the Loop
on Social
Determinants

Passport Quick Questions

When a member utilizes their health care benefits in a suboptimal way, Passport wants to understand why. Our outreach specialists call members with Quick Questions, a very brief survey that explores the root cause of why a member used certain services. For example, the specialists ask members utilizing the ED for nonurgent care a very brief series of questions about why they used the ED, whether they were aware of the other options available to them, and whether changes in the availability of providers (e.g., extended hours) would change their behavior. These Quick Questions help uncover the drivers of behaviors that affect cost and continuity of care and connect members to options that will better meet their needs.

Building the Member-Provider Relationship

As a provider-focused organization, we emphasize and nurture the relationship between providers and members. A strong relationship between member and provider leads to more frequent preventive care, greater connection to the community, and a higher level of member engagement in their health. Key strategies toward this end for the coming year include:

- Ensuring that providers see every member at least once annually. Passport is working closely with its provider partners to make direct contact with their Passport panel, encouraging members to set up annual visits and incentivizing members to engage in preventive care.
- Reducing avoidable emergency department and hospitalization use by reinforcing the relationship with primary care providers. Passport Quick Questions are part of a pilot PIP to understand and remove the barriers to access that drive members to the ED instead of their PCP.

- Passport’s strategies to build the member-provider relationship also come from adapting effective programs used by its subcontractor in Medicaid and commercial programs in other states. For example, Passport’s embedded Care Advisors, who support and connect members and providers, leverage an embedded model successfully used by its subcontractor in multiple states; we adapted the model to work within the Kentucky Medicaid program.

Understanding the Member Journey

Getting a new health insurance plan can be difficult and confusing. It can be overwhelming for members to decipher the medical, behavioral, pharmacy, dental and vision benefits available. To alleviate this, Passport provides education and assistance to members to ensure they have a full understanding of the benefits and services available to them. Passport works to convey that there is no wrong door for how they access their benefits, and that Passport will help them access the services they need. To meet this need, Passport introduced a series of initiatives to understand and improve the member journey as they embark upon a relationship with Passport Health Plan.

All our efforts with new members are designed to enhance the critical touch points. Passport introduced a full suite of initiatives to support new members, including a full on-boarding plan, a customized web page, a simplified and informative ID card carrier, and a new member survey to ensure members are satisfied with the plan. Of interest are the following innovative tools and best practices:

- **New Member On-Boarding ninety (90)-Day Plan**—To welcome new members to the Passport Health Plan community and prepare members for a valuable experience with Passport, Passport has created a comprehensive ninety (90)-Day New Member On-Boarding Plan. Identified objectives include:
 - Making positive connections with new members
 - Providing education about Passport and the benefits it offers
 - Allowing members to share information with Passport about themselves
 - Empowering members to take control of their health



The plan pairs these objectives with hands-on tactics such as personalized outreach to our new members, providing information sessions, encouraging member portal registration and use of benefits, and earning member rewards. We have established metrics we can use to confirm that we met the objectives for every new member. Each new member receives a personalized outreach contact, we track enrollment in educational classes, and we analyze data from returned mail and surveys and review claim data. Previously, we completed many of these onboarding activities over an indeterminate amount of time. Our New Member On-Boarding ninety (90)-Day Plan combines these activities in a simplified effort to enhance the experience for our new members.

- **New Member Online Videos**—Passport strives to keep our new members engaged throughout their first ninety (90) days on the plan. We have created a series of short instructional videos to guide our new members during this time. Our new member videos include topics such as: *What’s in the New Member Kit*, helping members understand all the material they will be receiving in the mail and how these materials can help them; *About the HRA Form: 7 Simple Steps*, highlighting what new members can complete during the new member process; the importance of having a PCP; how to sign up for texts and emails and how to follow Passport on social media; and the perks of being a Passport member, including how to earn member rewards. These videos will be available on Passport’s New Member Web Page and shared through Passport’s social media accounts.
- **New Member Survey**—To confirm that its new members had a positive and educational experience during the Ninety (90)-Day On-Boarding Program, Passport has created a New Member Survey for its new members to complete. On our new members’ ninety (90)-day anniversary of enrollment, we administer the New Member Survey, which takes about five (5) minutes to complete. Our questions focus on measuring how well our members understand their benefits and how to use their plan, and how satisfied they are after the first ninety (90) days with Passport. We will compile and analyze the results from the New Member Surveys on an ongoing basis so that we can continue making improvements for our new and current members.

Looking Ahead

We developed many of these innovations in collaboration with DMS through the PIP process. Below, we list some of the innovative PIPs we propose to address needs currently faced by our members. We describe these in greater detail in our response to question 9.g.ii, below.

- Integrating behavioral health into primary care, exploring different delivery and payment models for integrated care and/or incentives for improved collaborative care.
- Increasing SBIRT referrals and working to identify individuals earlier and connect them with needed treatment.
- Increasing post-inpatient follow-up to reduce readmissions, leading to greater coordination of care and better outcomes.
- Assessing the impact of food insecurity and diabetes in partnership with local health departments.
- Understanding how to appropriately and effectively treat pain through a comprehensive pain response study to address the opioid crisis.



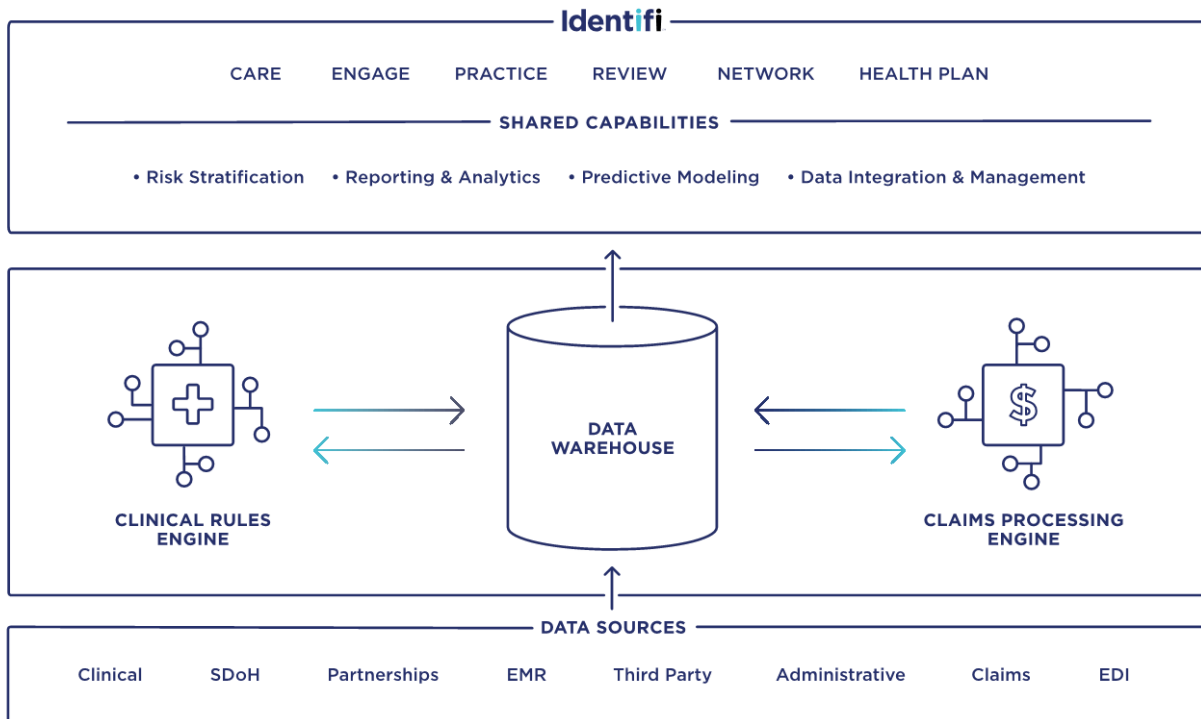
C.9.a.iv Internal tools and technology infrastructure the Vendor will use to support improvements in health outcomes and to identify, analyze, track and improve quality and performance metrics as well as the quality of services provided by Network Providers at the regional and statewide levels.

Supporting Improvements in Health Outcomes and Quality of Service Through Tools and Technology

Passport’s technology infrastructure helps glean insights from various sources of health care data. We have significant experience leveraging the right business intelligence (BI) tools to enable data-driven decision making to provide the right service at the right time for our members, thus achieving the goal of improved

overall quality outcomes. We call this technology infrastructure Identifi. The available tools in Identifi, showcased in **Exhibit C.9-6**, offer significant data visualization, predictive and drill-down capabilities that support users across several teams, including quality, care coordination, network performance and providers themselves.

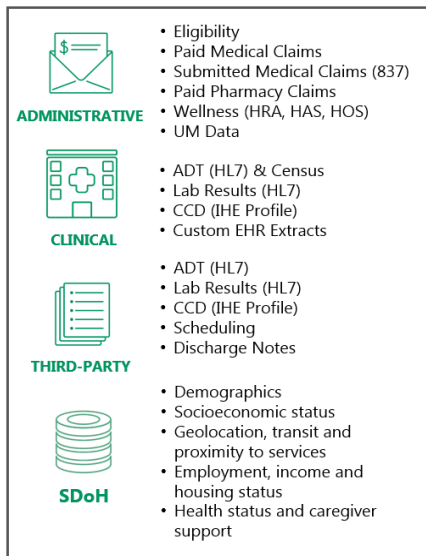
Exhibit C.9-6: Identifi Capabilities and Data Sources



The Identifi Population Health Management platform component and modules enable Passport staff, care teams, physicians and administrators to operate from the same connected platform, sharing a unified view of member health history, activity and care. This component houses the Utilization/Quality Improvement Subsystem. By using diverse data sets, the system identifies “impactable” members with high precision, engages both members and physicians in best practice management of care and analyzes both clinical quality and financial performance in near real time. The Identifi Population Health Management system derives these capabilities from its intelligence engine. It uses proprietary stratification and predictive modeling algorithms that transform data into a comprehensive profile of member health.

At the core of our population health management system are our data integration services, a member-centric enterprise data warehouse (EDW) and advanced clinical profiling logic scalable to support different lines of business, stratification and predictive analytics. The suite of predictive models and evidence-based criteria to identify and prioritize the most impactable members at the right time for the most appropriate clinical program and or intervention. The system stratifies the designated members into risk levels through a predictive modeling process to prioritize outreach and management. The predictive models rank members based on their likelihood of experiencing specific impactable outcome within the next six to nine (6-9) months, such as ambulatory care sensitive hospital admission. Identifi derives insights from multiple data sources, including claims and administrative data, EMR and other clinical data, as well as external data sources, including social determinants of health, such as census tract and location data, to precisely identify impactable members.

Exhibit C.9-7: Passport Aggregates the Data Needed to Manage Populations and Quality



As shown in **Exhibit C.9-7**, standard data types that Passport exchanges with its partners include administrative data (medical claims, pharmacy claims, eligibility data), clinical data (ADT - admissions, discharges and transfers, lab, biometric, HRA/HAS, CCD) and provider data (provider relationships to practice, location and hospital affiliations).

All data is fed into a dynamic and customizable rules engine that powers predictive models, medical economics, risk adjustment analytics and quality metrics to drive insights and workflow management.

The platform is explicitly configured correctly for each Medicaid population to ensure that it targets the most relevant outcomes for our members. The configurable rules engine uses proprietary clinical content, algorithms and best practices. It goes through an iterative process of improvement, involving rigorous evaluation and innovation based on evidence from an ever-growing underlying data

set. The rules engine intelligence includes 1,400+ preconfigured clinical rules and measures, including risk management, clinical and quality rules. It offers the ability to develop custom predictive and stratification logic to solve local market problems.

Identifi Care is Passport’s NCQA-compliant care management workflow and performance management application, which enables the Passport care team to efficiently and effectively engage members in the care management process to support DMS’s Population Health Management requirements. The application supports multidisciplinary care teams in triaging members, conducting assessments, developing care plans and managing their list of prioritized action items in a guided workflow aligning with the clinical model. Cross-functional collaboration within the application helps to engage the broader care team (physicians, pharmacists, dietitians, social workers, Care Advisors and care coordinators) on a standard set of problems, goals and interventions—thereby maximizing ROI on care management by focusing on high-risk members.

Identifi Practice (Practice) is Passport’s provider-facing portal that supports utilization/quality improvement. Practice informs providers about actionable opportunities within their member panels by furnishing information about gaps in care, active care management programs and cost and utilization metrics. Identifi Practice integrates with provider electronic health record (EHR) systems to promote data exchange, which improves care efficiency and the accuracy of our risk stratification models. Providers can also obtain additional detail by drilling into a specific member’s record from one of the rosters or by searching for members individually. Once on the member profile page, providers can view problems, goals and interventions for members enrolled in care management or see the complete care plan provided by the Care Advisor to the member. Providers can also show detail about open care gaps for that member, as well as close care gaps based on education provided to the member or EMR chart review.

Practice includes detailed interactive reports that highlight compliance with quality measures relative to targets or additional details about their panels, including recent medical and pharmacy service history. The system calculates compliance with quality measures using a customizable rules engine that includes both NCQA-certified HEDIS measures and custom measures that include some variation from HEDIS specifications (e.g., relax continuous enrollment requirement). Member-, provider- and practice-level results are available to providers/practices through Identifi Practice, but Passport can support broader quality improvement initiatives through access to the complete data set. This allows Passport staff to define quality improvement initiatives targeting either specific measures or providers and practices based on current and historical performance.

Passport has been making investments in building efficient technology infrastructure and advanced analytics tools for quality across both administrative and clinical elements with the following views:

- Health Plan Performance
- Network Performance
- Member Care and Satisfaction
- Clinical Operations

Next, we describe our approach to each of these views.

Health Plan Performance

Our Health Plan Performance module analyzes performance by quality metric. This tool tracks, trends and forecasts our performance on quality metrics both over the past twelve (12) months and year to date and compares performance against national and regional thresholds. Our data hierarchies enable drill-down and data visualization from health plans to practice location to a provider to members. We use this data to identify trends and improve areas that then inform our member, provider and health plan intervention strategy. We leverage views of performance data at the region and statewide level to monitor performance and identify opportunities at the health plan level. Some example uses for this module include the following:

- Use Case #1: Plan Resource Allocation.** Through this performance view, the tool compares Passport quality performance to national and regional benchmarks, enabling Passport to quickly identify measures that fall below established criteria and benchmarks or whose performance is decreasing year after year. This allows us to create a timely supplementary provider and member-facing programs. For example, historical analysis has shown an opportunity for improvement in comprehensive diabetes care measures; as a result, a crucial part of our 2020-member intervention strategy is oriented toward diabetes live-member outreach and pharmacy adherence.

Result: We can rapidly respond to areas of health need within our populations to improve health outcomes for our member population.
- Use Case #2: Member Outreach Activity.** By comparing quality measure performance within a given measure year with performance over the prior twelve (12) months, Passport can quickly identify negative trends. In these instances, we can then identify members with overdue services (e.g., care gaps unaddressed within the past twelve (12) months). We then deploy our member outreach coordinators to conduct member outreach with provider offices or have our population health managers deliver educational campaigns to practices within the Passport network.

Result: Targeted outreach to providers and members, based on overdue services, improves the quality of care for some of our most chronic and vulnerable members.
- Use Case #3: Impact of Pilot Interventions and Member Incentives.** To best make use of our resources, we consistently examine the effects of pilot programs and member incentives. Our health plan performance module allows us to measure the effects of these programs by comparing the results of the intervention group with a control group.

Result: We can quickly understand which programs (interventions and incentives) to scale and which to deprioritize, helping Passport ensure that our resources are focused on programs that genuinely improve member outcomes.

Network Performance

Our Network Performance module tracks the performance of providers and practices within our network on metrics, such as care gap closure rates, PCP visit rates, member and provider satisfaction rates as well as utilization-related metrics. Our flexible data structure enables the segmentation of our network by practice, provider, region, quality metric performance and size of membership, which together can help determine the most effective practice-based interventions. Using historical performance data, the tool can also forecast and trend future performance. Some example uses for this module are as follows:

- Use Case #1: Customized Practice-Based Messaging:** The Network Performance module compares provider and practice performance by measure to the network. This enables customized interaction during practice-facing outreach focused on an issue area for that practice. The in-year performance tracking functionality allows population health managers to recognize practice or provider-specific improvements, creating a level of provider partnership and trust not otherwise possible. Furthermore, we can combine outreach activities with findings from our chart audits to provide tangible educational examples to practices.

Result: Because Passport’s education is quality focused and customized to the providers’ performance, we achieve greater provider engagement and partnership.

- **Use Case #2: Member Outreach:** The Network Performance module allows population health managers to quickly deliver a high-priority outreach list by practice that shows members who have multiple care gaps. This outreach list includes member information, outstanding care gaps per member, last date of member visit and other vital information to support effective communication.



**Providers are
in Our DNA**

Result: Targeted member outreach improves the quality of care for some of our most chronic and vulnerable members.

- **Use Case #3: Provider Performance Transparency:** This allows us to accelerate performance accountability by displaying provider measure closure rates versus established benchmarks (e.g., Passport network, their provider group or practice champion performance).

Result: Positive provider peer pressure regarding member quality performance.

- **Use Case #4: Identification of Clinician Champions:** Analysis of provider performance data allows us to identify the strongest performers and showcase them appropriately as formal or informal physician champions.

Result: Recognition for our best-quality providers as well as a collection of prominent provider voices around the member-focused quality activity.

Other tools we leverage to engage providers in improving quality of service include the annual CAHPS® member experience survey, member concerns and the yearly provider satisfaction survey. Annually, we administer the CAHPS survey to a sample of members to gain insight into the member experience as it pertains to interactions with network providers. When we receive the results of this survey, Passport convenes an interdisciplinary work group to analyze the results and strategize about opportunities for improvement for the member experience. The work group identifies barriers, implements interventions appropriate to the findings and monitors progress throughout the year through metrics and anecdotal evidence when necessary. For example, based on opportunities identified in the CAHPS Care Coordination section, we created a survey that we administer upon completion of the new member onboarding process. The results provide interim feedback on opportunities to improve member quality of service.

Passport also tracks potential quality of service issues by reviewing member concerns. A member can express a concern or complaint to any Passport staff member. We capture, catalog and report the issue for follow-up. The interdisciplinary team reviews these reports and can identify trends applicable to the region based on complaint type and then respond accordingly. For instance, if there are complaints regarding access and availability for a provider type in a specific region, the team works closely with the Contracting and Provider Network teams to identify opportunities for additional contracting and enrollment in the network.

Using the provider satisfaction survey, Passport also identifies trends and opportunities within the provider network. A task force collaboratively reviews the satisfaction survey and identifies specific areas for informal performance improvement projects. Any area of dissatisfaction with the provider network can have a

downstream impact on the satisfaction of our members. By addressing issues with our providers promptly, Passport can improve all aspects regarding quality of service.

Member Care and Satisfaction

Our Member Engagement team and our provider network use the Member Care and Satisfaction module. It helps make decisions for delivering the right care at the right time. The tool tracks a member's performance on various metrics, such as number of open care gaps; last member interaction; number of PCP visits; last PCP visit date; other biometrics, including HbA1c; and previous refill date. The module offers several data visualizations that show member behavior over the past twelve (12) months; these help the Member Engagement team make decisions about how to best intervene with the member, including what mode of communication to use. This results in a positive health outcome through closing a member's care gap, engaging him/her in a health program or arranging a member visit to the PCP.

Clinical Operations

In addition to tracking the performance of the network and the member, Passport has also been making investments in tracking various operational metrics, such as engagement rates and reach rates. This helps us understand the effectiveness of our operations and interventions and develop best practices based on what the data is telling us. For example, we can determine which member engagement modality works for a specific member demographic.

The tools and technology infrastructure that Passport has implemented support improvements in health outcomes. Through these we identify, analyze, track and improve quality and performance metrics, as well as the quality of services provided by Network Providers at the regional and statewide level. Passport will continue to make investments in technology and tools to help us make better decisions that drive positive health outcomes for our members.

C.9.a.v. Methods to ensure a data-driven, outcomes-based continuous quality improvement process, including an overview of data that is shared with providers to support their understanding of progress in achieving improved outcomes.

Passport Drives Continuous QI with a Data-Driven and Outcomes-Based Approach

Passport uses a multifaceted TQM approach to ensure a data-driven, outcomes-based continuous quality improvement process. These quality improvement methods include the following:

- **Annual QI Program Evaluation:** The Passport Quality team conducts an annual program evaluation looking across Passport departments to define our impact and identify recommendations for improvement to implement in the next year. Using a data-driven approach, we evaluate the effectiveness of quality improvement activities; quality of clinical care; clinical practice guideline adoption; quality of service; member and provider satisfaction; UM, network and provider management; and regulatory compliance.

- **External review from the EQRO on Behalf of DMS, NCQA Accreditation Status Reviews and Yearly Reevaluations:** Passport works collaboratively with DMS through their EQRO, for example, with PIPs, program audits and routine data reports. External review holds Passport accountable for using data to continuously drive quality improvement that is aligned with the goals and objectives of DMS. Our other external reviews include the NCQA evaluation of standards for Health Plan Accreditation. Through the NCQA accreditation cycle, Passport is evaluated on how well we have adopted standards and demonstrate our commitment to evidence-based quality improvement and measurement.
- **QMMC Oversight and Direction:** The QMMC routinely monitors performance measures, evaluates and adopts initiatives to drive organization-wide quality improvement. The broad set of performance and outcome measures include NCQA-certified HEDIS measures, Healthy Kentuckian's measures, member and provider satisfaction, UM, member services, access and accessibility of service.
- **Target and Goal Setting:** Passport has adopted organization-wide goals and targets that we hold ourselves, providers and subcontractors to help us achieve. For example, we use the Quality Compass® 90th percentile benchmark as a target for clinical quality measures. Through target and goal setting, we ensure that we are continually striving to improve year over year.
- **Direct Provider Engagement and Feedback:** Using a standard set of tools, we share data on utilization, quality and clinical outcomes with our providers. This data is used to plan and take action to build on the practice's current infrastructure, including in-office workflows, documentation and staff. We work to meet our providers where they are and provide resources as they move into more advanced value-based payment models with Passport.

Overview of Data Shared with Providers

Passport collects and analyzes a wide range of data to evaluate performance in our programs and in the care our providers deliver. As a provider-driven organization, we know that one of the most valuable tools we can give our providers is *information*. Using dynamic data and sophisticated tools, we provide them the information they need to understand how they are performing against their peers and established quality standards and give them data to effectively review their programs for best practices, enhancements and possible future programs and focus points. Passport delivers this information to them in many ways, including point-of-care tools such as Identifi Practice, reporting for value-based payment, in-person discussions with population health managers and care conferences for those engaged in value-based payment models.



Identifi Practice

Identifi Practice provides physician practices with reporting that is timely and relevant to provide insight into their performance and make a meaningful difference in their practices. Having access to timely, accurate and applicable reports provides users with valuable insight. Identifi Practice delivers reports featuring provider, practice and/or member details, which exposes the information needed to make data-driven decisions that are critical to a value-based business.

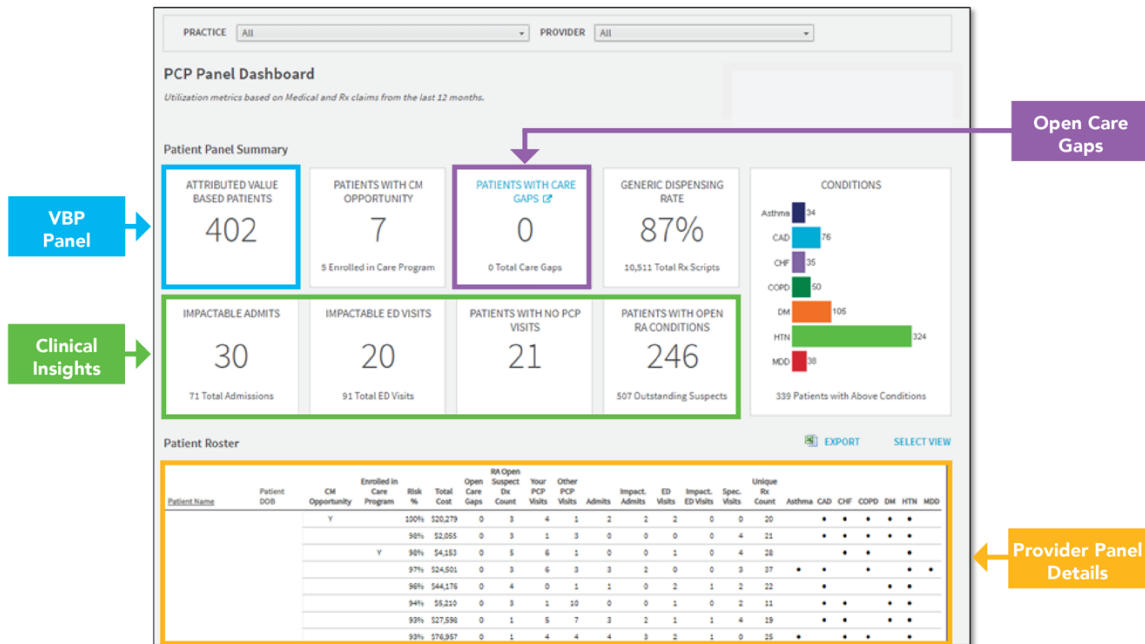
Identifi Practice is purpose-built for physicians to help support and improve performance in their value-based operation. It provides secure, role-based access to physicians and provider staff for the following:

- Member panel opportunity insights
- Risk-adjustment workflow
- Care plan and care gap workflow
- EMR single sign-on
- Performance management through integrated reporting

Some of the most popular and impactful dashboards and reports available through Identifi Practice include the following:

- **PCP Panel Summary Dashboard (Exhibit C.9-8):** This simple and singular view empowers providers and brings focus to the actionable opportunities of their panel of attributed members. This dashboard categorizes a provider's or practice's full panel of attributed members into key practice-level objectives:
 - Gaps in care
 - Comprehensive diagnosis opportunities
 - Care management activity
- **Physician-Level Quality Compliance:** The Quality Compliance Report (QCR) summarizes quality measure performance at provider, practice and system levels. QCR allows comparisons to client average and line of business-specific benchmarks (e.g., MA Stars, HEDIS).
- **Categorized Member Rosters:** Identifi Practice presents the provider with a series of interactive rosters of their attributed members, aligned explicitly to crucial performance objectives to ensure the highest level of usability and accessibility for the provider. These portable, exportable rosters of members provide the contextual data needed to identify high-impact members and augment their clinical workflow.

Exhibit C.9-8: PCP Panel Summary Dashboard



Reporting for VBP Initiatives

For VBP initiatives, Passport has the technical capacity and engagement resources to continue to administer Alternative Payment Model (APM) with providers. Passport provides customized analytics using a standard set of VBP measures displayed in a VBP scorecard. Passport also makes Identifi Practice available to VBP providers to give them point-of-care access to our care management (CM) and member-level details. As described earlier, this platform documents care gaps and coding accuracy opportunities on a member-by-member basis and enables providers to understand in near real time precisely how to close the care gap and thereby improve their performance metrics. Our responses to 9.a.j and 9.a.k describe our VBP approach in more detail.

Helping Providers Understand Reports and Monitor Progress

Passport Population Health Managers work with physician offices to understand their practices’ opportunities and disseminate local and national best practice strategies to improve performance in the areas of quality care gap closure, addressing most accurate member diagnosis coding and engaging the most complex members in our population in the appropriate clinical management programs. These population health managers are critical assets to provider practices. They work together with physicians, care managers and office staff to ensure that they have access to complex member rosters and gaps in care reporting. They are a resource to the practice to enable



them to fully apply the Identifi Practice tools, analytics and reporting capabilities to better manage the physicians’ member panel.

We take a two-tiered approach to physician engagement and scorecard report distribution.

- **Joint Operations Committee (JOC) Meetings:** The quarterly in-person JOC meeting collaborates with the provider organizations’ executive leadership teams to discuss group-level medical expense ratio (MER) and program performance data, best practices and macrolevel areas of focus that ultimately lead toward improved quality and satisfaction for members while reducing unnecessary costs. Passport has an interdisciplinary team that provides comprehensive support for scorecard reports. These meetings allow us to work with the practitioner group leadership to review interventions, measure progress and jointly determine opportunities for improvement whether that is 1) further root cause analysis to identify actionable information at a practitioner level or 2) opportunities for improvement on the practice side, including workflow efficiencies, administrative burden or practitioner engagement.
- **Care Conference (CC) Meetings:** The purpose of the monthly CC meeting is to engage organizations’ key practice managers and providers to ensure that they understand the VBP program and have the information they need at the point of care to successfully participate and be able to test and learn from practice-level adjustments discussed at the JOC meetings. Passport’s PHMs play a critical role in supporting practice-specific performance. PHMs are different than provider network representatives because they are specific subject matter experts on practice transformation, population health and, specifically, clinical CM programs and VBP initiatives. Key activities led by PHM with practitioners include the following:
 - Sharing broad to specific practice-level actionable information on the member panel
 - Helping providers improve quality population health and risk-adjustment performance more broadly and specifically based on the VBP program elements
 - Educating providers on and supporting member engagement in appropriate Passport CM programs

C.9.b. Indicate if the Vendor has received NCQA accreditation for the Kentucky Medicaid market and, if not, the proposed timeline for achieving accreditation.

Health Plan Accreditation. Passport has held Health Plan Accreditation from NCQA since 2002 without interruption.

NCQA Accredited Programs. Passport also uses NCQA accredited population health and clinical programs in CM and UM from its operating partner and subcontractor Evolent Health. The Population Health program that Passport uses for its members is the first such program ever accredited by the NCQA.



C.9.c. Provide the Vendor’s proposed use of the Quality Improvement Committee (QIC) to improve the Kentucky Medicaid managed care program.

Chaired by the chief medical officer and the director of quality, the QMMC is responsible for Passport’s Quality Program and its actions. This committee provides the central point for initiation, oversight and evaluation of quality efforts for all Passport programs. The QMMC also serves as a primary connection to the Kentucky Medicaid Program’s goals and activities in support of the Medicaid managed care program. The QMMC plans, designs, implements, coordinates and evaluates key aspects of member care, clinical quality,

provider compliance and management and organizational improvement activities within Passport. These activities are delegated to the QMMC by the Partnership Council.

Through its oversight of quality for the entire Passport organization, the QMMC facilitates and integrates our organization's focus on whole-person care across the full spectrum of needs and services, regardless of whether these services are delivered directly by Passport or via a subcontracted arrangement. The QMMC also facilitates quality improvement activities for administrative policies and provider-facing efforts that can strengthen Kentucky's programs. These may include, for example, activities to encourage greater KHIE participation or adoption of EHRs.

The QMMC is responsible for the following:

- Establishing the direction and strategy for the QI Program, incorporating the improvement goals of the Commonwealth
- Recommending policy decisions, reviewing and evaluating the results of quality activities, instituting actions and overseeing follow-up as appropriate. These include clinical, administrative and operational issues
- Reviewing, approving and providing feedback on the QI and UM program descriptions, QI work plan and QI and UM program evaluations on an annual basis
- Reviewing the status of the QI work plan quarterly and approving the plan twice annually
- Overseeing, supporting and coordinating the work of its subcommittees, including the BH Advisory Committee, Credentialing Committee, UM Committee and the Pharmacy and Therapeutics Committee
- Coordinating with the PCP work group and subcommittees (child and adolescent, women's health) in joint improvement projects
- Reporting results to the Partnership Council and up through to the BoD, which holds overall responsibility for Passport and its programs.

QMMC Coordinates with PCP Workgroup to Implement Improvements

The Child and Adolescent subcommittee of our PCP work group had concerns over the number of children that needed follow-up and psychotropic medication refills. The pediatrician did not feel comfortable with the medications and/or dosages. Investigation as to why this was happening noted limited psychiatric access, especially outside Jefferson County. QMMC coordinated with the Child and Adolescent Subcommittee to develop a new process. Because of this, Passport initiated a 24/7 Psychiatrist Line for the PCPs to use. Access to psychiatric care in limited access areas was developed and our BH program offered training to providers on these medications. From this effort, other subsequent initiatives followed, including SBIRT training, resources and tools. A positive "side effect" of this response to an immediate need was the development of stronger integration between BH services and primary care, which is a cornerstone of Passport's "whole-person" approach to care.

The QMMC also oversees all activities of our DOC (subcontractor) as it pertains to subcontractors relevant to our NCQA Accreditation. The DOC reports through our compliance organization. It oversees subcontractors to which utilization and or quality management, credentialing, member services, provider services, claims operations and other administrative functions have been delegated. The DOC reviews all contractual metrics for each subcontractor, including Service Level Agreements (SLAs), performance reports and QI/UM reports (if applicable). It also examines the annual delegation audit to ensure compliance with all federal, state, Department and contract requirements as well as any pre-delegation assessments before the effective date of new delegation contracts. With a direct line of accountability through the Partnership Council to our BoD, the QMMC has clear authority and responsibility for subcontractors relevant to NCQA accreditation and contractual requirements with DMS. The QMMC supports DMS's goal of improving the Kentucky Medicaid program through its accountability for executing the quality plan.

C.9.d. Provide the Vendor's proposed use of the Quality and Member Access Committee (QMAC) to improve the Kentucky Medicaid managed care program, including the following information:

The QMAC is a means for Passport Health Plan members, consumers, advocates and public health representatives to provide input and offer critical feedback directly to Passport's clinical, quality, operations, member services and senior leadership regarding access to care and quality of care for the membership, in addition to identifying opportunities for improvement. It is *one of the most important committees* at Passport because it provides senior leadership the **voice of the customer**. Attendance by both Passport leadership and our members is vital to its success and progress, so it is explicitly designed to bring the two groups together, face-to-face. Despite not having a specific vote on decisions affecting our membership like our BoD does, our senior leadership will not move forward with any significant member-facing initiatives without the consent approval of the idea, its value proposition and a summary of the operational plans from the QMAC.

The QMAC's primary role is to recommend community outreach activities and provides review and comment on materials and policies, including the following:

- Quality and access standards
- Grievance and appeals process and policy modifications based on the analysis of aggregate grievance and appeals data
- Member Handbooks
- Member educational materials
- Passport and Department policies that affect members

QMAC attendance is incredibly important not only to this committee meeting but also for our ongoing member-facing operations and clinical program engineering. Ensuring participation from Passport leadership and staff is mandatory. Every area from senior leadership to clinical, quality, operations and member services is required to have representation. From the member side, Passport draws from its long-standing relationship in the community, capitalizing on heavily engaged volunteer members. The Committee meets every two (2) months and must meet at least four (4) times during the year to meet QI program objectives.

Long-standing membership and a genuinely collaborative environment of trust and commonly aligned goals around care improvement has enabled consensus and has made getting a quorum rarely a challenge. Since 2007, Passport has proudly hosted sixty (60) meetings, four (4) to six (6) per year, during the period. QMAC has routinely been able to recruit and maintain the service of ten to fifteen (10-15) members on the committee without significant turnover. Thirty-four (34) members of our community have served on QMAC since 2007, and there have only been two (2) meetings where a quorum was not present.



Passport provides DMS, and other stakeholders and members, at least ten (10) days advance notice of all regularly scheduled meetings of the QMAC, including a meeting agenda and all related meeting materials, as available. The QMAC supported directly by Passport will provide approved meeting minutes to DMS within ten (10) days after each meeting. Also, we will provide DMS with an annual summary listing the members participating in the QMAC, recommendations received from attendees and information about whether recommendations were implemented or not.

C.9.d.i Proposed stakeholder representation.

QMAC Stakeholder Representation

Stakeholders of our QMAC include members or parents of members, consumer advocates, educators, public health officials and other members of the community. The 2019 QMAC had six (6) voting members. DMS receives the notification of upcoming meetings ten (10) days prior and is welcome to attend. We make committee appointments with consideration to geographic location, age, gender and aid category, as well as racial and ethnic diversity, to ensure diversity within the representation of our overall membership.

Committee membership is shown in **Exhibit C.9-9: Passport Health Plan QMAC Committee Membership**.

Exhibit C.9-9: Passport Health Plan QMAC Committee Stakeholders

Voting Members	Nonvoting Staff
Members *	Executive Leadership team members
Parents of members *	Chief marketing and communications officer
Consumer advocates	Director of community engagement
Educators	Clinical operations director/manager
Public health officials	UN director/manager
Members of the community	Quality and performance director/manager
Community agencies	Member Services director/manager
* Specific emphasis on having the diversity of members and parents of members represented, including geographic, age, race, gender, disability, foster parents, etc.	Customer service senior manager
	Provider relations director
	Specialty populations manager

C.9.d.ii Innovative strategies the Vendor will use to encourage Enrollee participation.

Encouraging Active Member Participation in QMAC

Collaboratively, we specifically strategize how to ensure diversity, attendance and active participation in this most crucial committee. The following are examples of key strategies.

Proactively identify and engage with members who are interested in improving our programs based on their experiences

- A member who is/was enrolled in a substance recovery care management program and wants to help improve the program
- Mother, to include a teen mom, who participated in our maternity program and wants to help improve the program
- Parents with a special needs child who desire to be advocates for others
- Adult member with autism or special needs
- Word of mouth and referrals from our current QMAC members

Leverage our strong community ties and have community organizations encourage and refer members

- March of Dimes
- National Organization for the Advancement of Colored People (NAACP)
- Provider referrals
- Local school counselors
- Faith-based organizations



Communications and invitations to the meetings

- Advertise meeting dates
- Engage community agencies
- Potential member letters: outlining their responsibilities and benefits
- Current members: at the December meeting, a schedule of meetings for the next year is distributed and discussed to make sure the chosen days work for members
- Ten (10) days in advance an invitation letter is sent announcing upcoming meetings and informing participants about the agenda

Convenient meeting locations and times

- Hold meetings closer to where the members live, including community centers or schools
- Plans include holding meetings at Passport's future community located headquarters at West Louisville Health and Well-Being Center. Hold meetings in our future interactive center
- Schedule meetings based on member participants' ideal time of day, not Passport's

Participant meeting support and reimbursement

- Offer transportation and or mileage reimbursement to and from meetings
- Offer member incentive approved by the Department

- Offer childcare reimbursement or provide childcare during the meeting
- Provide light meals to the entire committee, which also encourages open, nonintimidating conversation between Passport staff, stakeholders and members

Additional innovative strategies to encourage active participation

- Members offer agenda topics to ensure that we discuss those issues that are important to our member community
- Leadership positions of QMAC chairperson and vice chairperson are elected from the member participants every two (2) years
- Active participation, including meeting order with a consent agenda review and vote for topics
- Create a member panel for educational seminars (i.e., have members with asthma, high-risk pregnancy, diabetes, etc., talk to members about their experience and how they improved their health)
- Committee participation is beneficial for members too. Example:
If an agency has a community fair, they are welcome to advertise that fair to all the other members of the committee who will share that information with those at their organizations



Current members of the QMAC are also encouraged to be active participants with leadership positions. QMAC chairperson and vice chairperson are elected every two (2) years. Their role, in addition to presiding over the meeting, is to motivate committee members to be active participants and to serve as the committee coordinators, gathering the documentation necessary to provide reimbursement to QMAC members for mileage, attendance, parking, childcare and other transportation costs.

Most of the materials and routine reports that are reviewed/approved by the QMAC are combined and driven through a consent agenda for review and vote. This allows time during the meeting for a section of the agenda that is dedicated to committee member updates, where they can talk about what's going on in their lives and how it relates to either something they have experienced working with our health plan or something we could do for members based on their feedback and experiences. By including this topic, we make committee participation beneficial for the members too and give them a voice that details real-time thoughts, concerns and opportunities. For example, if an agency has a community fair, participants are welcome to advertise that fair to all the other members of the committee, who will share that information with those at their organizations. If a member is experiencing some personal difficulty, Passport staff and advocates from other agencies are ready to help when possible.

To measure QMAC members' level of comfort in being active participants, Passport conducts an annual verbal review with members of QMAC to ensure that they continue to feel engaged and understand the importance of QMAC to Passport.

Passport will continue to draw upon our successful approach to ensuring QMAC members continue to provide valuable guidance and insight into our membership.

C.9.d.iii. Examples of successful strategies the Vendor has implemented to obtain active participation in similar committees.

Experience with Successful Strategies for Participation in Similar Committees

Passport uses similar successful strategies to encourage participation in all its committees that have members and community agencies, including the QMAC, Partnership Council, Pharmacy and Therapeutics Committee and the BH Advisory Committee. It is within these committees that we are very intent on integrating the “voice of the member” into our quality process.

Our focus on a member-centered approach starts with the following:

- Developing trusting relationships with our members through each interaction
- Having locally based teams that work and live in the same communities as our members
- Soliciting feedback

We use similar strategies to be successful in obtaining active participation in all committees with the addition of the Pharmacy and Therapeutics Committee, where we advertise meeting dates and encourage open participation as required by DMS.

Please see Section C.9.d.ii to see the full list of successful strategies to encourage member participation in all our committees that include members and community participants.

Passport will continue to draw upon our successful approach to ensuring that members continue to provide valuable guidance and insight into our membership for these committees.

C.9.e. Provide a full description of the Vendor’s proposed Quality Assessment and Performance Improvement (QAPI) program that meets all requirements of this Contract.

Passport’s QI Program serves as our **QAPI program** and includes both quality assurance and performance improvement plans. It provides the infrastructure for continuous monitoring, evaluation and improvement in care; under and overutilization; health outcomes; health-related social needs; and safety and service while complying with standards and requirements of regulatory and accrediting agencies, including the Kentucky DMS and the NCQA.

The QI Program establishes standards and criteria and provides processes, procedures and structure for the quality of care and service delivered to our members. QI activities, based on NCQA standards and guidelines, are integrated with other performance monitoring activities and management functions, including UM, case and disease management, population health management, risk management, member safety, cultural and linguistic competency, credentialing, claims, member and provider Services, Ombudsman services, provider credentialing and network development. Also, collaborative health outcome measures are developed with DMS and the EQRO.

The scope of our quality review is reflective of the health care delivery systems, including quality of clinical care, health outcomes, grievances and appeals, ongoing and active monitoring and safety and quality of services, including nonclinical services. All activities reflect Passport Health Plan’s population in terms of age

groups, disease categories, special risk status and cultural and linguistic needs of the members. The scope of services includes services provided in institutional settings, ambulatory care, home health care and services provided by primary care, specialty care and other practitioners. Also, all our subcontractors are required by contract to support the QI Program, held by the same requirements and are monitored, measured and evaluated on their performance and impact on the care delivery system. Passport will submit our QAPI Program Plan to DMS within thirty (30) days of Contract execution, by each June 30th and upon request for review and approval.

Our QI Program meets the requirements of **Section 19.3** of Attachment F, Draft Medicaid Managed Care Contract and Appendices and includes the following components, as shown in **Exhibit C.9-10: Passport Health Plan QI Program Meets Draft Contract Requirements**. Also, along with meeting DMS contract requirements, Passport proudly stands by our (seventeen) 17+ years of NCQA Accreditation, (fifteen) 15 of which received the highest rating, and through our subcontractor leveraging clinical programs from the first-ever NCQA Accredited Population Health Program.

Exhibit C.9-10: Passport Health Plan QI Program Meets Draft Contract Requirements

Draft Contract Requirement for QAPI	How Passport Meets the Requirement
<p>A. Requirements outlined in the Department’s quality strategy and accordance with federal regulations at 42 CFR 438.330, including the following:</p> <ol style="list-style-type: none"> 1. Conducting and assessing PIPs as further described in Section 19.6: Performance Improvement Projects of this contract 2. Collecting and submitting to the Department performance measurement data that enables the Department to calculate performance on required measures, including an indication of progress on actions and related outcomes 3. Establishing mechanisms for detecting underuse and overuse of services 4. Tools to assess the quality and appropriateness of care furnished to members with special health care needs as defined by the state 	<ol style="list-style-type: none"> 1. Passport conducts and assesses PIPs as part of our QI Program, as discussed in response to question 9.g below 2. Passport collects and submits to DMS performance measurement data in our annual program evaluation. This data includes HEDIS, CAHPS and Healthy Kentuckian’s measures. Please refer to our response to question 9.a.v below. 3. Passport has mechanisms in place to detect under-overuse of services. These programs are fully described in the discussion of our UM program in response to question 10 and are detailed in our QI Work Plan, described in our response to question 9.e below. Please see Attachment C.9-2_Passport 2019 QI Work Plan. 4. Passport assesses the quality and appropriateness of care for members with special health care needs in our QI Work Plan, described in our response to question 9.e below and please see Attachment C.9-2_Passport 2019 QI Work Plan.
<p>B. A QIC to provide oversight of QAPI functions</p>	<p>Passport’s QIC is our QMMC, which is described in our response to question 9.a.i above.</p>
<p>C. Methods for seeking input from and working with stakeholders, such as the Department, members, providers, subcontractors, other contracted MCOs, other community resources</p>	<p>Passport seeks input from our key stakeholders through our committee structure (described in response to 9.a.i), our participation in collaborative PIPs (described in response to 9.g) and regular operational meetings with DMS.</p>

Draft Contract Requirement for QAPI	How Passport Meets the Requirement
and agencies and advocates to actively improve the quality of care provided to members	
D. Methods for addressing Department mandated performance measures	Passport addresses Department-mandated performance measures through careful monitoring of HEDIS, Healthy Kentuckian and other metrics as described in our response to 9.a.v.
<p>E. Integration of BH indicators into the QAPI program and a systematic, ongoing process for monitoring, evaluating and improving the quality and appropriateness of BH Services provided to members</p> <p>F. Methods to collect data and monitor and evaluate improvements to physical health outcomes resulting from BH integration into the member’s overall care</p>	Passport ensures integration of BH indicators in our QI program through our holistic approach to care. Our Partnership Council and QMMC have oversight of this holistic approach and are accountable for the full spectrum of care, of which BH is a part. Further, we assure integration through our NCQA accreditation, which requires continuity and coordination of care between medical and BH care. Our NCQA Accreditation is described in response to 9.b. BH integration worked in concert with our BH subcontractor, and how we monitor it is also discussed in our QI program description and QI Work Plan (both described in 9.e) and provided as Attachments C.9-3_Passport 2020 QI Program Description and C.9-2_Passport 2019 QI Work Plan , respectively. Our critical investments in data tools specifically outline in the MIS section response to actively monitor, track and analyze essential data submission from providers and our submissions to DMS, such as claims and encounter data.
G. Use of a health information system to support collection, integration, tracking, analysis and reporting of data analytics specific to health care outcomes and performance metrics, including stratification of findings (e.g., by region, provider type, member populations)	<p>Passport’s health information system is Identifi. It offers a suite of fully integrated and clinical applications with access to data in real time from any location. All our system capabilities are fully integrated and work together to provide plan administration, medical and UM, population health and reporting.</p> <p>Passport also conducts a population assessment on an annual basis, which is described in our response to 9.e.</p>
H. Methods to evaluate data and findings reports to assess QAPI program activities, review progress on objectives and identify areas for improvements and processes to implement changes, including methods for providing feedback or other information to providers and members	To assess the QI Program (described in response to question e, below), Passport collects and evaluates analyzes data, prioritizes potential areas for improvement and conducts an annual Program Evaluation, described in our response to 9.i.iii. Relevant findings are shared with our Quality Medical Management Committee (QMMC) and Quality Member Access Committee (QMAC). The QMMC reviews and provides feedback on all clinical quality materials, policies, and reports. The QMAC reviews all member-facing materials and applicable policies. Department minutes, agendas and packets are provided to members of the committees one week in advance. Feedback is provided to all members and providers through member and provider newsletters and on our member and provider portal.

We developed a QI program description, which meets the requirements of the draft contract, as shown in **Exhibit C.9-11: Passport Health Plan QI Program Description Meets Contract Requirements.**

Exhibit C.9-11: Passport Health Plan QI Program Description Meets Contract Requirements

Contract Requirement for Program Description	How Passport Meets the Requirement (all described in response to 9.e below unless otherwise noted)
A. A Detailed QAPI program description that addresses goals and objectives, all program elements and the scope of activities	Passport’s QI program description addresses goals, objectives, program elements and the scope of activities
B. Discussion of innovative approaches the contractor will implement to support the Department in achieving improved outcomes	Passport’s QI program description updates goals annually with innovative approaches to address issues based on findings from our evaluations, the population assessment and recommendations from DMS.
C. A detailed description of the contractor’s staffing to meet QAPI program goals and objectives, including a listing of staffing resources, roles, qualifications and experience and total FTEs percentage of time	The QI program description contains this information. Passport’s QI Department is 100% dedicated to meeting QAPI programs and goals and is supported by individuals throughout Passport’s organization.
D. Description of QAPI activities to be conducted by providers and subcontractors, if separate from the contractor’s QAPI activities and integration of those into the overall QAPI program	QI activities conducted by providers are described in the program description under the topics of Provider Engagement Committee, HEDIS gap closure activities and provider relations. Subcontractors under delegated arrangements are addressed in the delegation oversight section.
E. A work plan that provides the scope of activities and timelines, including reporting cycles and annual evaluation	The QI program description provides information on the development of the QI Work Plan, which provides the scope of activities and timelines, including reporting cycles and annual evaluation.
F. Clearly defined approaches to QI efforts, including PIPs, that the contractor will implement	The QI program description clearly defines Passport’s approach to QI and outlines our PIP process.
G. A process to continually evaluate the impact and effectiveness of the QAPI program and approach to modify the QAPI program to address deficiencies	The QI program description describes the process to evaluate the impact and effectiveness of the QI program and the steps Passport takes to address deficiencies going forward.

On an annual basis, Passport establishes goals and objectives based on findings from QI activities, survey results, grievances and appeals, performance measures and EQRO findings, among other information.

QI Program Scope

The QI program encompasses the range of clinical, safety and service issues relevant to external and internal customers. External and internal customers are defined as eligible members, practitioners, providers, DMS, the Centers for Medicare and Medicaid Services (CMS) and Passport employees. The scope of quality review

is reflective of the health care delivery systems, including the quality of clinical care, safety and quality of services, such as nonclinical services. All activities reflect Passport Health Plan’s population in terms of age groups, disease categories, special risk status and cultural and linguistic needs of the members. The scope of services includes, services provided in institutional settings, ambulatory care, home health care and services provided by primary care, specialty care and other practitioners.

Exhibit C.9-12: Highlights of our QAPI Program provides a summary of our QA and performance improvement (PI) components.

Exhibit C.9-12: Highlights of Our QAPI Program

QAPI Program Component	Passport Health Plan QAPI Program Activities
Prospective Quality Improvement	<ul style="list-style-type: none"> ● Implementation of best practices for quality management and performance improvement ● Credentialing activities ● UM activities ● Adoption of nationally recognized preventive health guidelines ● Adoption of nationally recognized clinical practice guidelines ● Clinical focus activities ● PI projects ● Process improvement projects
Concurrent Quality Improvement	<ul style="list-style-type: none"> ● CM activities ● Disease management activities ● EPSDT and adult preventive health activities ● Wellness activities
Retrospective Quality Improvement	<ul style="list-style-type: none"> ● Appeals and grievances ● Claims reprocessing ● Member inquiries ● Peer review ● Medical record review audits for compliance with documentation and continuity and coordination of care standards ● Clinical practice guideline audits ● Preventive health guideline audits ● EPSDT audits ● Health outcome audits

Passport Health Plan has mechanisms to identify the quality of care and service issues that have occurred and uses that information to prevent future incidents of noncompliance in care, safety and service.

QI Activities

Passport Health Plan has ongoing QI activities to fulfill the scope of the QI program. These activities are summarized in our QI program description and detailed in our QI Work Plan along with associated time

frames for completion, responsible parties and planned monitoring and evaluation. Passport QI activities include the following:

- Assessment of our population, member safety, member satisfaction, practitioner satisfaction, continuity and coordination of care, practitioner access and availability, Member Services, clinical programs and UM
- Delegation oversight
- Credentialing and recredentialing of practitioners and providers
- Medical management programs and activities
- Assessment of the QI program
- Annual assessment completed by the ERQO

Please see Attachment C.9-3_Passport 2020 QI Program Description and to Attachment C.9-2_Passport 2019 QI Work Plan.

Member Safety

A primary goal of the quality program is to provide members with appropriate and safely delivered care. Simultaneously, Passport provides feedback to practitioners and providers (e.g., hospitals, home health, behavioral health treatment facilities and surgical centers) in efforts to monitor and reduce the likelihood of medical errors. Passport achieves this goal through ongoing member, practitioner, provider and employee education and activities—activities that improve member safety.

- Monitoring sentinel events and member complaints related to the clinical quality of care issues
- Annual member and provider safety plan for prevention and detection of unsafe practices
- Prescription drug medical review and reconciliation through the prior-authorization process
- Collection and trending of adverse prescribing events
- Provider audits to validate adherence to documentation standards and guidelines
- CMO and Medical directors' assistance with clinical decision making through UM and the sentinel and quality of care concern process
- Monitor potential safety and environmental hazards within provider offices

Quality of Care Concerns. The Passport quality review process ensures that issues involving clinical quality of care, safety and environmental concerns are investigated and addressed. It is the responsibility of Passport employees who perceive an inherent quality, risk management or safety issue to refer the matter to the Quality and Member Safety Department. Referrals may originate in any Passport department. The referring department staff documents the problem and forwards it to the designated employee for investigation.

Peer Review Process. Passport uses a strict peer-review process when monitoring and assessing the potential quality of care or quality of service issues. Peer review is conducted by the Credentialing Committee to provide collaboration with the credentialing/recredentialing processes. This collaboration ensures appropriate tracking and trending of practitioner/provider concerns. The process for peer review/appeal documents the criteria and remedies available to the committee upon the conclusion of the

review. Such solutions include development of time-bound corrective action plans; evidence of education; counseling, policy and procedure creation and implementation; monitoring of metrics; and limitation, suspension or termination of the contract with Passport.

Peer review focuses on the identified quality issue; however, it could extend to further analysis if trend data suggests prior concerns that meet established thresholds. In such cases, the process may use utilization data, medical necessity, cost, medical record review, provider credentials and previous quality concerns. Peer review engages necessary departments, such as Clinical Operations, Provider Relations, Member Services, UM and Compliance, to provide pertinent information. The peer-review process may enlist external consultants of the same or similar specialty.

The peer-review process is governed by applicable local, state and federal laws and contains confidentiality and immunity provisions for the committee members. All documentation is nondiscoverable and maintained in a safe, confidential location. Passport adheres to any state-mandated reporting and regulatory requirements.

Member Satisfaction

The Member Services department supports the quality program through interactions with the member population. Some of the responsibilities of the Member Services team are as follows:

- Member inquiries and grievances
- Monitor member services call center metrics to meet performance goals
- Member satisfaction analysis and interventions
- Member outreach calls
- Inform members of rights and health plan benefits and services

Passport does and will continue to measure member satisfaction through an annual satisfaction survey, monitor member complaint and appeal reports and review average speed of answer and abandonment reports for member areas.

Practitioner Satisfaction

The Provider Relations department supports the quality program through the monitoring of and communication with the provider network. It monitors practitioner and provider satisfaction through the following means:

- Accuracy and timeliness of claims processing reports
- The average speed of answer and abandonment reports for Provider Services areas
- Provider/practitioner appeal trends
- Annual practitioner satisfaction survey
- Provider/practitioner complaint reports



Continuity and Coordination of Care

Passport monitors continuity and coordination of care for both medical and BH through our case and disease management programs, BH programs, medical records review, investigation of member complaints and oversight of internal policy implementation related to practitioner terminations.

The integration of BH aspects into the quality program is done through the review of regular reporting of BH metrics, minutes of activities from the BH Advisory Committee and regular oversight of the BH delegate. All activities and leadership are performed by the vice president of health integration/BH director. Members of the Health Integration team also participate in the Primary Care Workgroup, Women’s Health Committee and QMMC to ensure a focus on the integration of care, addressing the SDoH and supporting the whole person’s view of members. In addition, the BH health practitioner serves as a member of the QMMC and provides insight into opportunities for improvement, actions and corrective action as it may apply to the quality program.

Practitioner Access and Availability

The Provider Relations department supports the quality program through the monitoring of and communication with the provider network. It monitors the availability, accessibility and effectiveness of the provider network, as well as the linguistic and cultural makeup of the network to ensure that it meets the needs of the membership. It supports the quality program through the following means:

- Provider site visits
- Provider education, including on coding requirements
- Provider/practitioner access and availability reports
- Review of member complaints regarding access
- Analysis of member utilization reports
- Review of member satisfaction surveys

Delegation Oversight

Passport Health Plan assesses delegated compliance with health plan standards through an annual on-site review and monthly report review via the DOC. The DOC reports through the compliance organization to the Compliance Committee of the Board of Directors but is overseen on a dotted-line basis by the QMMC, as described previously. The annual on-site review is conducted using Passport Health Plan delegate audit tools that meet NCQA requirements. Review of the appropriate policies and procedures, programs and files may require a corrective action plan. The corrective action process includes follow-up tracking of compliance in accordance with preset time frames. The DOC reports at each Partnership Council meeting regarding oversight of all delegated activities.

Passport currently uses a carefully selected and tightly controlled small set of subcontractors. We integrate subcontractors as part of the service and operational model where their focus will maximize and support better access, care, quality outcomes and financial results. These relationships enable Passport to leverage

specific expertise and support efficient service delivery. Passport only selects subcontractors who are aligned with our mission to improve the health and quality of life for our members in close coordination with network providers. We are fully accountable for the end-to-end delivery of our obligations to DMS, members, providers and the community. These principles inform our careful evaluation and selection of subcontractors, which we do in collaboration with our provider and community-led governance structure. We manage the implementation of the subcontractor services to ensure uninterrupted service and conduct deep ongoing governance and performance management through a multilayered oversight function.

The DOC handles oversight of all delegated entities and monitors compliance of contract requirements and reporting.

Credentialing and Re-credentialing of Practitioners and Providers

The credentialing committee administers credentialing/re-credentialing policies, procedures, trends and issues regarding health plan participation in collaboration with the credentialing delegates. It supports the quality program through sanction and license monitoring, as well as peer review of quality of care concerns and sentinel events.

Medical Management Programs and Activities

Passport offers numerous medical management programs and activities in support of quality efforts. These include:

- Rapid Response Team
- EPSDT Program
- Mommy Steps Program
- Diabetes Disease Management Program
- Chronic Respiratory Disease Management Program
- Congestive Heart Failure Program
- Cardiovascular Disease Program
- Phone and mail outreach activities for targeted populations
- Adoption and promotion of preventive health guidelines
- Adoption and promotion of clinical practice guidelines
- UM services
- Case management services, both medical and behavioral health
- HEDIS

Ongoing Assessment of the Population

Population health at Passport provides for the needs of the population across the continuum of care. It incorporates all levels of health, wellness and member needs. Through opportunities identified in an annual population assessment, Passport can decipher the specific characteristics and needs of the population through the evaluations described below:

- Analysis of the impact of relevant social determinants of health for the full member population

- Assessment of health status and risks through utilization data broken out into subpopulations of birth to eighteen (18) (child and adolescent), eighteen (18) to sixty-four (64) (adult), and sixty-five (65) and over (senior)
- Assessment of the needs of members with disabilities
- Assessment of the needs of members with severe mental illness (SMI)

The analysis of the population data determines if changes are necessary to care management programs or resources. Assessments of population data assist Passport with activities to support practitioners and providers with value-based care, coordinate across member programs and provide education to members regarding the availability of programs and services.

Assessment of the QI Program and Annual Assessment Completed by the ERQO

The QI Program evaluation is an annual assessment of the effectiveness of the QI Program that allows Passport to determine impact and effectiveness, address deficiencies and determine how well it has utilized its resources to improve quality of care and cultural and linguistic services provided to Passport's membership. When the program has not met its goals, barriers to improvement are identified and necessary changes are integrated into the subsequent annual QI Work Plan. Feedback and recommendations from various committees are also integrated into the evaluation as well as the external yearly review results conducted by the EQRO on behalf of DMS, accreditation status and annual reevaluation results. The final document is presented to the QMMC, the Partnership Council and the Board of Directors for review and approval. Please refer to **Attachment C.9-4_Passport 2019 QI Program Evaluation** for our most recent QI Program Evaluation.

Based on the results of the annual QI Program Evaluation and with input from all Passport departments, an annual QI Work Plan addressing planned and ongoing quality initiatives is developed. The QI Work Plan includes establishing new objectives and goals, expanding or enhancing the scope, identifying barriers and planned activities that address the quality and safety of clinical care, the quality of services, the quality of culturally and linguistically appropriate services, and reducing health care disparities for the year. Planned monitoring of issues previously identified by internal and external customers are integrated, including tracking of items over time and planned evaluations of the QI Program. Also included are the people responsible for each activity and the timeframe for achieving each activity. As a recommendation of the EQRO, quantifiable goals, a timeline for implementing activities and achieving goals, and an annual executive summary that highlights key milestones and dates is completed annually and incorporated into the QI Work Plan. The final document is presented to the QMMC, the Partnership Council and the Board of Directors for review and approval. Please refer to **Attachment C.9-2_Passport 2019 QI Work Plan**.



Closing the Loop
on Social
Determinants

C.9.f. For each of the below quality measures, demonstrate how the Vendor will work to make improvements in Kentucky’s Medicaid population. Include a discussion of strategies and interventions specific to each measure, partners that will be necessary to achieve improvement, data analytics, and anticipated timeframes for success in achieving improvements. Describe potential challenges the Vendor anticipates, if any, and how those will be addressed. Provide examples of successes in other state Medicaid programs and how that success will be leveraged in the Kentucky Medicaid market.

C.9.f.i. Medication Adherence to Diabetes Medications

Assisting Members with Diabetes in Managing Their Medication

With almost half of all consumers nationally failing to take medications as prescribed¹, adherence rates are an important indicator of quality and overall population health. It is especially true for members with Type 2 diabetes as poor medication adherence is a major barrier to achieving adequate glycemic control².

Strategies and Interventions

Passport’s medication adherence strategies include multiple ways to identify members who need help with adherence and several interventions. These include:

Multimodal member outreach through automated calls, mailings and lives call with pharmacists and pharmacy technicians. Through this outreach, Passport engages members, caregivers, prescribers and pharmacies to improve members’ adherence to both new and existing medication therapy. Examples of interventions include (1) counseling members on how to overcome adherence barriers, such as transportation through home delivery and transport options, low health literacy and proper administration through discussions (in non-clinical language) about the reasons for taking medications and how to make taking them easier, (2) contacting the dispensing pharmacy to synchronize fills of chronic medications, initiating auto-refill enrollments and dispensing pillboxes, and (3) optimizing dosing and reducing complexity of medication regimen, collaborating with other health care providers as necessary.

- Pharmacy technicians outreached to more than 3,200 Passport members to address adherence to diabetes, asthma and/or antidepressant medications, leveraging motivational interviewing techniques to increase medication adherence. These calls led to more than 3,700 adherence-related interventions, ranging from the recommendation of auto-refill at local pharmacies to providing a pillbox as an adherence tool.

¹ Zullig LL, Gellad WF, Moaddeb J, et al. Improving diabetes medication adherence: successful, scalable interventions. *Patient Prefer Adherence*. 2015;9:139-149. Published 2015 Jan 23. doi:10.2147/PPA.S69651

² Polonsky WH, Henry, RR. Poor medication adherence in type 2 diabetes: recognizing the scope of the problem and its key contributors. *Patient Prefer Adherence*. 2016;10:1299-1307. Published 2016 Jul 22. doi:10.2147/PPA.S106821

Member assistance in which clinical pharmacists refer members to appropriate assistance programs when the cost of medication therapies impact adherence.

Care management in which Passport care team experts, including Care Advisors, pharmacists, BH providers, etc., provide whole-person care to members. Medication non-adherence is a driving factor in our pharmacy care management stratification model, allowing us to identify and focus on members who appear to be struggling with adherence.

- In 2019, Passport clinical pharmacists completed more than 2,000 care management referrals for Kentucky Medicaid members, resulting in 4,505 identified safety-related interventions and 1,218 identified savings-related interventions.

Comprehensive medication reviews to monitor medication adherence for specific disease states, including diabetes. Working in concert with our Pharmacy Benefit Manager (PBM) partner, CVS/Caremark, our pharmacy team identifies members who are at risk for medication non-adherence and provides subsequent outreach. Our dynamic adherence modeling incorporates several key variables, including timing and cadence of pharmacy claims, utilization patterns, adherence calculations and member attributes. Results of the modeling include a prioritized list of potentially non-adherent members to diabetes medications as well as hypertension, cholesterol, asthma, antipsychotic and antidepressant medications. The stratification criteria changes throughout the year to target members who are most impactful and to allow for data-driven recommendations.

Rx clinical consultant program with field-based clinical pharmacists. The team has a fifteen (15)-year history and includes two (2) locally-based Kentucky licensed clinical pharmacist consultants who provide direct clinical and educational support for providers and pharmacies across the Commonwealth.

Specialist providers offer feedback and expertise on potential formulary changes to help construct recommendations for coverage and drug policies. For example, our clinical pharmacy consultants outreached to an endocrinologist in Somerset, Kentucky, to discuss and solicit feedback regarding formulary recommendations for antidiabetic medications. This provider expertise was incorporated, helping to construct our diabetic drug policies and formulary recommendations for review and approval at the Pharmacy & Therapeutics Advisory Committee meeting.

Partners Necessary to Achieve Improvement

Passport will work with our PBM, CVS/Caremark, as well as other retail pharmacies to continue to expand on these initiatives. We will also work actively with practitioners, both in designing additional interventions (through our physician advisory groups) and in supporting their work with members by providing education (described below) and care management resources. Our provider-driven organization draws from the insights of our physician advisory groups in developing these initiatives to ensure provider engagement.

Data Analytics

To measure the success of these initiatives, Passport will leverage our clinical data warehouse to identify our diabetic population using HEDIS technical specifications (less continuous enrollment). From the population identified, the next step is determination of which members have not been adherent to their medication based on claims for diabetic medications filled in the last twelve (12) months. Our highly skilled and experienced staff will examine this roster for trends by region, provider, age, etc., and determine the current percent of medication adherence. Using predictive analytics, Passport will identify at-risk members before a decline in health status occurs.

We will conduct outreach to the identified members to determine their non-adherence patterns and establish an initial baseline for medication adherence. Nationally, adherence rates may be as low as fifty percent (%), half possibly being primary non-adherence, meaning the initial prescription was never filled:

- Primary non-adherence (member did not fill the initial prescription)
- Secondary non-adherence (member does not fill a script on time)
- Unintentional non-adherence (member sometimes forgets to take the medication as directed)
- Intentional non-adherence (member decides not to take the medication as directed)

To monitor progress, we will use bi-weekly claims feeds from the PBM to assess non-adherence patterns and intervene accordingly.

After implementing the interventions, we will regularly evaluate the effectiveness of the interventions. We will also enroll a sample (subset) of the members in care management programs during the project to assess if the techniques used in care management increase adherence. (See **Section C6 MIS** for extensive detail into our advanced data analytics and tools.)

Anticipated Timeframes for Success in Achieving Improvements

In our twenty-two (22) years of experience working in the Commonwealth, we have seen demonstrated success within a period of three (3) to four (4) years following the implementation and application of interventions. Passport has operated its adherence outreach program for several years and has continually refined the approach to identifying members at the highest risk for non-adherence as well as best practices for member engagement. Quality management staff monitor HEDIS medication adherence measures at least quarterly and continually collect feedback from our pharmacists, pharmacy technicians and members who participate in the program to identify how we can further improve measured performance.



Potential Challenges and Mitigations

Typical challenges experienced in a program of this type may include a lack of provider and member engagement. Provider engagement issues are mitigated through Passport's provider relationship and history and extensive provider engagement strategies. When building programs such as this, our staff engage

providers to provide input on programs, interventions, measurements and targets to ensure participation and support.

Member engagement issues may be due to work or family priorities, cognitive impairment or caregiver availability. We address these through our integrated care team approach, leveraging any preexisting relationships with the member or provider. We also address motivation issues through sensitive member education to ensure that the member understands the importance of and feels empowered to engage in self-care. Members may also experience a lack of understanding regarding the impact of medication adherence or a lack of knowledge of programs available at their local pharmacies. For members who demonstrate transportation issues, we offer mail-order pharmacy services that allow home delivery to members every ninety (90) days. Alternatively, we also educate members on the availability of maintenance medications to be filled as a ninety (90)-day supply at retail pharmacy locations. Lastly, we inform the member of pharmacy-specific refill reminder programs such as auto-refill and other programs available via telephone or mobile phone applications.

Examples of Successes in Other State Medicaid Programs and How Success Will Be Leveraged in the Kentucky Medicaid Market

As a local plan focused solely on the Kentucky Medicaid market, Passport's core experiences have been helping the people of the Commonwealth. As part of our suite of care management programs, our pharmacy care stratification model identifies members who would benefit from a pharmacist-conducted comprehensive medication review. The model includes identification of non-adherence, polypharmacy and potential controlled substance misuse. These stratification criteria become a priority for our clinical pharmacists to address through engagement with both the member and provider. Overall, clinical pharmacists successfully engage with members and identify an average of 2.5 possible medication-related problems per care management referral. Our stratification tool also identifies members new to therapy and refers them to our Medication Adherence Outreach Program to ensure members adhere to the newly prescribed therapy. For example, in a recent analysis of 300 members who were new to metformin therapy, those who engaged in our program had higher refill rates compared to those members not engaged in the program (74.2% vs. 66.1%). A subanalysis demonstrated that members engaged in the program had double the reduction in A1c post-metformin initiation compared to members not engaged (-1.1% vs. 0.6%). The following example of a diabetes initiative in Kentucky demonstrates the impact that targeted interventions can have on member self-management of diabetes.

To improve diabetes care for our members, Passport implemented a Diabetes Care Program in 2016 that resulted in 51% of members with HbA1c levels below 8% a 12% improvement versus the prior year. Using ED data and risk stratification to identify high-risk members, interventions focused on member engagement and incentives, and provider and community engagement. While this particular diabetes program is no longer active, Passport continues to improve on HbA1c levels and addresses diabetes medication adherence through several care management program that also address additional comorbid conditions.

C.9.f.ii. Tobacco Use and Help with Quitting Among Adolescents

Decreasing Tobacco Use and Providing Help with Quitting Among Adolescents

Tobacco use is a concern for Kentuckians regardless of age. Annually, more than 8,000 Kentuckians die of illnesses caused by tobacco use; decreasing or preventing the initiation of tobacco use among adolescents is essential in reducing the number of preventable and premature deaths attributed to tobacco use. In Kentucky, 15.5% of high school students and 4.8% of middle school students first tried cigarette smoking before the ages of thirteen (13) or eleven (11), respectively (YRBSS 2017). Even more concerning, 44.5% of high school students and 15.1% of middle school students have used electronic vapor products (e-cigarettes, Juuls, etc.).

Passport's two (2) decades of experience supporting Kentuckians have given us an understanding of the needs of special populations, including those in rural areas, inner cities, members in foster care, expectant mothers and adolescents. Our knowledge of the adolescent population has enabled us to develop a specialized smoking cessation program targeted to engage them.

Strategies and Interventions

Passport addresses smoking cessation in adolescents in many ways, targeting interventions at the member, provider and community levels. These include:

Smoking cessation is a covered benefit, and Passport encourages network providers and all members who smoke to discuss quitting. Specific to adolescents, at the member level, smoking cessation counseling will be added to Passport's EPSDT program:

- Because adult-centric messaging does not often resonate with adolescents, this counseling will follow the "Best Practices for Youth Antitobacco Education" provided by the Kentucky Department for Public Health. We will work with our providers to integrate this messaging into their office workflow.
- We also provide access and referrals to the Quit Now Kentucky Program, as well as the smoking cessation program from teen.smokefree.gov. This program offers text messaging for both smoke and smokeless tobacco, a quitSTART app that provides tips, supportive messaging and challenges, live chat support and a supportive Instagram feed to appeal to and effectively support adolescents.
- We also provide support to several community based organizations that provide health education (including tobacco health risks) to students in middle school and high school classroom settings throughout the Commonwealth. Many of these models leverage younger peer-based educators which has been shown to increase teen responsiveness to taking action

Pharmacy coverage includes smoking cessation products, offered at a zero-dollar (\$0) copay to reduce the financial barriers that can be associated with quitting. It is available in multiple dosage formulations, without barriers such as quantity limits, maximum duration of therapy or prior authorizations. This approach is meant to inspire members not to get discouraged by multiple quit attempts and to minimize the additional burdens to quitting.

Member incentives are offered for those who complete a smoking cessation program and have a negative cotinine test conducted by their provider.

Partners Necessary to Achieve Improvement

Partners necessary to support this program include Smokefree.gov, Quit Now Kentucky, the American Lung Association and the Department of Public Health Smoking Cessation Programs.



Data Analytics

Passport will conduct medical record reviews and analyses of claims data for tobacco cessation products and predictive modeling based on exposure and SDoH. Because adolescent members may be reluctant to reveal their tobacco usage, our staff will examine data from parent and child HRAs to identify if parents smoke or if the parent believes his/her child has experimented with smoking, which is a contributor to the likelihood of a teen becoming a smoker.

Passport will also collaborate with DMS on ideas for identifying adolescents who may be reluctant to disclose their tobacco use.

Anticipated Timeframes for Success in Achieving Improvements

In the first year, modifications to the program will be made based on the feedback Passport receives. While Passport anticipates preliminary improvements in the first year, larger gains in the second and third years are expected as the program is refined collaboratively to identify those tactics with the greatest ROI. In our twenty-plus (20+) years of experience working in the Commonwealth, we have seen sustained success within a period of three (3) to four (4) years of implementation and application of interventions.

Potential Challenges and Mitigations

There are many potential challenges to achieving improvements. Kentucky has a long history of smoking acceptance. Among adolescents, social pressures to smoke or use e-cigarettes can be difficult to overcome. Leveraging the programs designed specifically for adolescents such as teen.smokefree.gov can help to introduce positive messages and role modeling. Identifying adolescent members who smoke could also be a challenge. Adolescents may not be forthcoming about their tobacco use either in surveys or to providers if their parent is unaware of their usage. Providing confidential surveys and educating providers on effective messaging tactics may assist in uncovering adolescent smokers.

Examples of Successes in Other State Medicaid Programs and How Success Will Be Leveraged in the Kentucky Medicaid Market

Before smoking cessation became a covered service for all members, Passport operated a smoking cessation program for adult members called "Yes, You Can!" during which the clinical care management team

conducted weekly outreach. At the time of this program, smoking cessation medications were not covered, but Passport covered the cost of medications as an additional benefit if the member enrolled and actively participated in the program.

In another initiative, Passport began partnering with Walgreens drugstores in select counties in January 2012 to initiate a new smoking cessation program. The program aimed to identify, assess, counsel and guide smokers through an individualized plan to help achieve their cessation goals. The participating pharmacists and technicians received specialized training on the impact of tobacco dependence and effective clinical interventions through the University of Louisville’s Kentucky Cancer Program.

In 2012, Passport consulted 230 members about smoking cessation. Of those members consulted, seventy-four percent (74%) set a quit date. Quit rates were highest for those members who received counseling along with pharmacotherapy, and 28.8 % of participants remained smoke-free after one (1) month.

There is a limited body of evidence outlining best practices for smoking cessation programs targeting adolescents. Most of the evidence that does exist is based on applying best practices for the adult population to the adolescent population. In addition, much of this research is from the early 2000s, with little new research available. There are several reasons for this lack of data, including the low uptake of smoking cessation by the adolescent population and the focus of public health campaigns on preventing smoking initiation. As such, a key part of any program is increasing awareness of the availability of cessation support programs for youth who have started smoking.



Early research suggests that programs that employ a cognitive behavioral therapy model are also useful. These programs help adolescents understand and address their tobacco use, provide motivation to quit, prepare them for what to expect when quitting and provide strategies to ensure they remain tobacco-free. This model allows for variation in delivery, such as in person, over the phone or via technology, reducing many of the barriers that prohibit teens from engaging in cessation such as time commitments, transportation and privacy concerns. One easy-access, cost-effective intervention is to refer teens to Quit Now Kentucky. Given the high use of cellphones among this population, texting and other online programs are another cost-effective means of increasing the likelihood of quitting when paired with other more intensive modalities such as telephone or face-to-face counseling. Finally, a 2017 Cochrane review suggests that group counseling is a promising intervention, with nine (9) studies showing evidence of an intervention effect (risk ratio of 1.35, 95% confidence interval of 1.03 to 1.77).

Recognizing the differences between adult and adolescent populations, the Centers for Disease Control (CDC) highlights specific considerations for a youth-focused approach, such as highlighting the short-term consequences of smoking, advocating cessation to all who want to stop regardless of their level of use, considering flexible modalities given time constraints and lack of transportation and helping to develop behavioral and coping skills. Finally, given the influence of family on adolescents, research from other substance abuse programs suggests that interventions that include targeting family members may be effective. This can include screening and providing cessation materials to family members during the same visit as the one for the youth. Despite the lack of research, the available evidence suggests that effective

adolescent cessation programs are likely those that implement screening and cessation guidance in the physician's office, include a group counseling option, are flexible in their delivery modality and adjust their approach to the specific needs and concerns of youth.

9.f.iii. Colorectal Cancer Screening

Increasing Colorectal Cancer Screening

Colorectal cancer is the second leading cause of cancer-related death in the US, but rates could drop if more people were up to date on their screening. As a result, the CDC has focused on improving screening rates by setting up a national campaign and a colorectal cancer control program to supply best practice information. Colorectal cancer screenings are not a typical focus of Medicaid programs due to several factors, such as a lack of a national Medicaid measure for screenings and limited funds. Without a national Medicaid measure, it is difficult for states to track their performance, and limited funds mean that most quality programs focus on the largest populations (women and children). These factors help explain why thirty-six percent (36%) of the Medicaid population is up to date on their screening compared to sixty percent (60%) of the Medicare population.

The recent Medicaid expansion and the resulting increase in adults eligible for Medicaid are leading plans to reevaluate what adult measures they focus on. Several expansion states, including Kentucky, are starting to target colorectal cancer screening and are implementing programs to increase screening rates. Kentucky's program receives funding from the CDC for fourteen (14) sites in the state to implement screening improvement programs. The state also collects and shares its colorectal cancer screening rate data with the Kentucky public health department. These efforts have already improved colorectal cancer screening rates across the state, particularly for the Appalachian area. However, programs in other states suggest that while these are reasonable first efforts, Kentucky could further improve its rates by employing a multifaceted approach.

Strategies and Interventions

Passport will implement multiple strategies and interventions to increase colorectal cancer screening. These include:

Outreach to members to encourage colorectal cancer screening predominantly through member education. Through telephonic outreach, Passport staff will help make appointments for screening and selecting the site of service.

Offer fecal immunochemical test (FIT) to high-risk members via their provider if they decline colonoscopy. While colonoscopy remains the gold standard for high-risk members, engaging in screening is very important, and a FIT kit can be a good option. For instance, if the test is positive, the recommended follow-up is to have a colonoscopy. A positive screening test could motivate a non-adherent individual to get a

colonoscopy. Passport will work with community providers and others to make FIT kits available at community events.

Distribute member education materials that providers can make available. These materials will leverage the messaging approach determined by the Kentucky Population Health Leadership Institute (KPHLI). The group decided what messaging was most effective for increasing screening in this high-risk group.

Identify preferred treatment centers, with a focus on ambulatory surgery centers, to streamline options for members and address member fear of hospitals.

Collaborate with the Colon Cancer Prevention Project to enhance our efforts and develop new strategies and interventions. Founded in 2004, this organization has led initiatives across Kentucky to increase colorectal cancer screening rates and awareness.

Passport's Collaboration with the Colon Cancer Prevention Project

The Colon Cancer Prevention Project has been able to demonstrate impressive results over the past several years, in part due to the participation and support of organizations such as Passport.

Outcomes of the project include:

- More than a doubling of colon cancer screenings from community health centers in Kentucky following a traveling lunch-and-learn program in 2017-2018.
- Colon cancer screening rates have increased from 37% to 71% over the past decade.
- Kentucky was ranked 49th and is now 17th nationally in colon cancer screening rates, the greatest increase in the country for screening.
- Disparities between blacks and whites in terms of screen rates and mortality have largely been eliminated in Kentucky as a result of these efforts.

The Colon Cancer Prevention Project was founded in 2004 by Dr. Whitney Jones, a Louisville gastroenterologist with a passion for preventing colon cancer.

Partners Necessary to Achieve Improvement

Partners necessary for this initiative include providers, lab vendors to provide FIT kits, the Colon Cancer Prevention Project and the Kentucky Colon Cancer Screening Program.

Data Analytics

Passport will leverage claims and medical record data analysis to identify those eligible for outreach based upon age and risk level. Passport will also examine historical data to predict who is at highest risk to guide our identification and outreach efforts.

Passport's staff will monitor claims every month to validate that members receiving outreach complete their screening. Given the enrollment churn for Medicaid, the Medicare HEDIS measure for colorectal screening is

not appropriate for this population. Instead, Passport proposes to monitor colonoscopies per thousand members over time.

Anticipated Timeframes for Success in Achieving Improvements

In the first year, modifications to the program will be made based on feedback received. While we anticipate preliminary improvements will be seen in the first year, we expect more significant gains in the second and third years as we refine the program to identify those tactics with the highest ROI.

Potential Challenges and Mitigations

Multiple challenges exist for this initiative. Medicaid members tend to move in and out of Medicaid, making it challenging to determine screening history, conduct outreach and follow up with the member. Collecting baseline data to identify eligible members will be challenging as well. Members may be embarrassed or fear the colonoscopy procedure. The KPHLI study showed the top two (2) reasons the men studied did not get screened were that they did not know about the screening recommendation and were afraid it would be painful. Member education will be used to address embarrassment. It may draw upon a similar approach to that used by the Colon Cancer Prevention Project: frank, occasionally light-hearted and fact-based. Member fear of the colonoscopy procedure can be remedied with the recommendation of the FIT kit for high-risk members. Members may also fear going to the hospital for screening. This can be mitigated by recommending standalone ambulatory surgery centers. Recommendations from the Passport-sponsored KPHLI group that investigated increasing colon screening in Appalachian men suggested the use of video and Facebook with messaging in a storytelling format to get the message out to this at-risk group. We also learned that more education was needed about the different types of screeners as well. Passport will apply these suggestions to help enhance such efforts.

Examples of Successes in Other State Medicaid Programs and How Success Will Be Leveraged in the Kentucky Medicaid Market

As this is a new measurement focus for the Medicaid population, there are limited results from programs specific to Medicaid. As such, this brief also presents vital information from similar programs for other populations.

There are a limited number of Medicaid plans focusing on improving colorectal cancer screenings. However, several of these plans have released data on their findings. For example, Minnesota started a pilot to increase colorectal cancer screening rates among Medicaid members from 2014-2015. The study targeted members age fifty (50) to seventy-four (74) who were overdue for a screening. The pilot targeted 41,829 women and 52,465 men and randomly assigned them a treatment or control group. The treatment group received three (3) mailers over the course of nine (9) weeks that encouraged them to get a screening and included a twenty-dollar (\$20) incentive for completing a screening paid upon receipt of a claim. The mailers prompted members to call member navigators who were able to help with scheduling appointments via a

three (3)-way call with the clinic of their choice. Results from the study show that members in the treatment group were significantly more likely ($P < 0.01$) to complete a screening, and the odds of completing a screening increased by twelve percent (12%). These results focused primarily on colonoscopies, but the data suggests that there were comparable results for other screenings.

In 2008, two (2) Medicaid plans in New York submitted PIPs detailing plans to increase colorectal cancer screening rates among women. HealthPlus planned a randomized control trial targeting eleven (11) community health clinics. The study included 751 women randomly assigned to the treatment or control group. The intervention took a stepped approach that started with sending members a letter from the medical director of their clinic, saying they were due for a colorectal cancer screening. After the letter, care managers conducted outreach to members and sent educational materials. The last step in the approach was a final call to the member. Results from the report show a twenty-nine percent (29%) improvement in the number of members compliant with the measure. MetroPlus submitted a similar PIP targeting female members overdue for a colorectal cancer screening. However, the goal of their PIP was to determine if specific engagement models were more effective than others. Their study assessed the effectiveness of scripted telephonic care management, member navigators doing case management and outreach, a combination of telephonic outreach and face-to-face intervention, and the control at increasing rates. Results from the study suggest that the scripted telephonic outreach and member navigators were the most effective methods, while the combined method and the control were the least effective.

The research from the Medicaid population suggests that a multimodal approach is the best way to increase screenings. Research focusing on underserved populations, many of whom qualify for Medicaid or experience similar barriers to care as the Medicaid population, supports this framework. For example, results from a randomized control trial on a safety net physician practice in New York show that a multimodal approach significantly increased the rate of colorectal cancer screenings. The study consisted of 366 members and randomly assigned 185 to an intervention group. The intervention consisted of a stepped approach over several months, where members received letters, interactive voice response (IVR) calls and free FIT kits. The results suggest that members who received these interventions were twenty-one percent (21%) more likely to have their screening than the control and that forty-four percent (44%) used the mailed FIT kit. Another similar study in Chicago suggested that a multimodal approach was effective in improving rates among underserved populations. The research also used a combination of mailers, IVR calls and free FIT kits, with results showing that members were significantly more likely ($P < .001$) to complete the screening than the control.

Most of the research supporting a multimodal approach as a best practice for improving colorectal cancer screening rates comes from large payers working in the Medicare or commercial space. For example, Cigna outreaches to all members fifty (50) and over and offers them free FIT kits. Members who complete a kit will automatically receive another free kit the following year, while members who have not had their screening receive a text or IVR call. Cigna reports seeing screening rates as high as sixty to seventy percent (60-70%). Gateway Health serves dual-eligible members in Pennsylvania, Ohio, North Carolina and Kentucky primarily, and uses a mix of IVR calls, free FIT kits and provider incentives resulting in a rate increase of fifteen (15) percentage points among the population.

C.9.g. Describe the Vendor’s proposed approach to collaborating with the Department, other MCOs and providers to ensure Performance Improvement Projects (PIPs) are effective in addressing identified focus areas and improving outcomes and quality of care for Enrollees, including the following:

Introduction

Passport monitors its own performance and that of our sub-contractors and uses the information to transform our clinical and non-clinical operations to benefit our membership and ensure our fiduciary responsibility for Kentucky Medicaid funds. This process informs our involvement with the EQRO, DMS and community leaders to identify measures for PIPs that address various aspects of clinical care and non-clinical services and have a positive effect on health outcomes and member satisfaction. Our years of local experience, unique to us, have provided a solid foundation for the development and implementation of PIPs in the Medicaid Affordable Care Act Expansion and current/traditional Medicaid population.

PIP topics are collaboratively selected based on clinical and non-clinical areas, as designated by DMS, the result of the EQRO review, and CMS. PIPs benefit our membership, the Kentucky Medicaid population overall. They are vital to DMS in achieving their goals and objectives of quality improvement, relating to access to care, structure, and operations. As well as quality measurement and improvement, as outlined in 42 CFR 438, Subpart D. Passport looks forward to working together with DMS, the EQRO, and other MCOs to identify regionally based collaborative PIPs that would be feasible and impactful for the Kentucky health care community. PIP topics are collaboratively selected based on clinical and non-clinical areas of focus that benefit our membership, the Kentucky Medicaid population overall and are key to DMS in accordance with their goals and objectives of quality improvement relating to access to care, structure and operations and quality measurement and improvement, as outlined in 42 CFR 438, Subpart D.

All PIPs will have mutually agreed upon objective quality indicators and measures and minimum performance levels as defined collaboratively by DMS, the EQRO, and Passport before the implementation of each PIP. PIPs will also include the following elements: interventions to achieve improvement in access and quality of care, evaluation of the effectiveness of the interventions based on performance measures and planning and initiation of activities for increasing sustained improvement.

C.9.g.i Lessons learned, challenges and successes the Vendor has experienced while conducting PIPs and how the Vendor will consider those experiences in collaboration with the Department on identified PIPs.

Passport’s History of Collaboration with DMS Has Provided Valuable Lessons for Future Efforts

Some of the most important lessons learned and challenges that Passport has identified in recent years are the following:

- **Defining the PIP based on outcomes rather than functions.** In our early PIPs, interventions were developed and executed specifically for internal staff or departments. We identified from barrier analyses that we needed to take a broader approach to act on more opportunities to engage with the community and providers to develop stronger interventions that would impact outcomes and sustainable, programmatic change. We have ***applied these lessons learned in full*** to the most recent collaborative PIP to reduce avoidable ED visits and hospitalizations for four (4) chronic conditions. A ***high-impact pilot*** was developed in collaboration with a local FQHC to outreach and engage members with high ED/hospital utilization and little to no PCP utilization. By providing data to the PCP office for outreach in conjunction with a short survey asking about barriers to receiving care at the PCP level, we identified opportunities to connect and forge better relationships between member and provider and how to address SDoH that may be barriers to care. This collaboration with providers ensures that ***we can expand the pilot further to impact potential ED/hospitalization on a larger scale.***
- **Engage the provider and the community.** As a provider-driven plan, Passport uniquely understands the importance of engaging the provider in performance improvement initiatives. Collaboration with providers ensures their buy-in and facilitates expansion beyond the pilot stage. The same is true of ***community engagement.*** By introducing concepts with community organizations, we gain acceptance of changes early on, making it easier to roll them out more broadly. For instance, for a recent PIP for SMI, Passport used a PCP workgroup to obtain feedback on barriers to care coordination between BH and PCPs and the challenges that PCPs face when working with the SMI population. From this feedback, we learned about the ***importance of coordination*** specific to the lab's need for this population when on antipsychotic medications.
- **Communication with DMS.** One of the most ***positive changes*** in recent years has been the identification of a single point of contact at DMS for each PIP. This allows Passport to stay in touch with DMS frequently to discuss how to address or overcome barriers, modify the PIP to remain aligned with DMS' objectives, etc.
- **Collaborative PIPs.** Historically, collaborative PIPs functioned more as "communal" PIPs, with the focus on a common goal across all MCOs. Having a single point of contact at DMS for collaborative PIPs has encouraged greater alignment between the MCOs and kept all organizations ***focused on the same objectives and tactics.***
- **Metric objectives.** In early PIPs, we were overambitious and set stringent data collection targets. Feedback from providers told us that it was too difficult to provide the information requested to support the PIP. By ***analyzing past PIPs,*** we were able to determine that we could ***achieve success*** while collecting fewer data points by selecting data elements that were more easily documented by providers. Choosing the right data and the correct number of measures to evaluate incrementally instead of annually has led to more control over interventions and has become essential to a successful PIP.

A few examples of successful collaboration to propose, design, implement and review PIPs include:

- The pilot site for our 2016-2018 SMI PIP with Centerstone Kentucky (Seven County Services) consisted of a forty (40)-member effort between the member, BH provider, PCP and care manager. This project was collaborative with all MCOs and DMS.
- Our 2016-2018 Prenatal Smoking PIP implemented interventions to collaborate with members, providers and the Kentucky Quit Line to improve prenatal screening for tobacco use and interventions to decrease tobacco use rates.

- The Healthy Smiles PIP conducted between 2015-2017 involved collaboration with PCPs, dental providers, members and Passport’s dental vendor, Avesis, to increase the number of members who take advantage of preventive dental services available through the plan.
- DMS’ Antipsychotic Monitoring for Children and Adolescents PIP ran from 2014-2017 and was a collaborative between all MCOs, DMS and University of Louisville Pediatric Faculty Group and its medical directors (see callout box below)

As we collaborate with DMS, our subcontractors and other key stakeholders on future PIPs, we will continue executing ***our process of constant improvement and build them, and other lessons learned, into*** our ongoing PIP process.

QUALITY IMPROVEMENT IN ACTION:

Antipsychotic Monitoring for Children and Adolescents

Define Problem Statement: Antipsychotic medication prescribing in children and adolescents has increased rapidly in recent decades. University of Kentucky study showed 270% increase in antipsychotic prescribing across the Commonwealth from 2000 to 2010, a trend that was substantiated within Passport’s population.

Set Goals and Direction: Passport’s Primary Care Provider (PCP) Workgroup and Behavioral Health Advisory Committee (BHAC) responded to DMS’s Performance improvement project (PIP) and collectively set goals to:

- Develop and adopt clinical practice guidelines and increase adoption of appropriate non-psychotic medication first-line treatments
- Reduce prescribing use and increase provider, member, and caregiver education regarding appropriate use

Plan, Align Resources, and Execute: *PCP Workgroup* identified provider concerns and solicited provider feedback on the initiative including metric selection, interventions, and education materials. *BHAC* was involved in determining study design as subject matter experts. *Pharmacy Committee* was involved in reviewing data and clinical practice guidelines and developing provider education.

Quality Medical Management Committee and *PCP Workgroup* had final approval of recommended interventions:

- PCPs were offered telephonic and in person education on clinical practice guidelines and a modified prior authorization process to facilitate appropriate prescribing practices
- PCPs received HEDIS measure education and reports on metric performance
- Members outreached if they were non-compliant with monitoring and had education on BH conditions and appropriate medication
- BH Network was expanded statewide
- Enhanced Psychotropic Drug Intervention Program (PDIP) put in place to identify medication issues and provider and member interventions

Analysis & Results: Member data were collected over 12 months. Observed results include:

- 49.6% reduction in use of multiple concurrent antipsychotics from baseline
- 31.3% reduction in use of higher than recommended dosing from baseline
- 10.8% improvement in antipsychotic metabolic monitoring from baseline

No significant change was observed in rates of metabolic screening for new members on antipsychotics or use rates of first-line psychosocial care measure.

Continued Improvement Efforts: Upon review of the data, our quality committees and provider leaders identified areas for provider incentive innovation to garner higher engagement from BH providers (currently in development). The results of this PIP prompted the continuation of PDIP programming with an upgrade to machine learning algorithms to improve accuracy of prescriber identification.

C.9.g.ii. Recommended focus areas, including those for regional collaborative PIPs, for the first two years of the Contract resulting from this RFP and rationale for these focus areas.

Recommended Focus Areas for Future PIPs

Collaboratively, we select topics that address the preventive and chronic health care needs of our members, including whole or focused subpopulations into certain categories. This includes, but is not limited to, Medicaid eligibility category, type of disability or special health care need, race, ethnicity, gender and age. Our recommended PIPs also **address the specific clinical needs of members** with conditions and illnesses that have a higher prevalence in the Passport population. For collaborative PIPs, we work with DMS, the EQRO and other MCOs to identify feasible and impactful PIPs.

Once **we as a collaborative team**, we determine areas of focus for future PIPs by aligning the needs of the member population with the goals and aims of the Department. Based on our unique and extensive experience with our members and our stakeholder collaboration efforts, Passport proposes some or all of the areas for Passport or regional collaborative PIPs in the first two (2) years of the contract shown in **Exhibit C.9-13**.



Exhibit C.9-13: Passport Proposed Regional Collaborative PIPs

Proposed PIP	2019 DMS Quality Aim	Passport Quality Aim
Integrating Behavioral Health into Primary Care	<ul style="list-style-type: none"> Reduce the burden of SUD and engage members to improve BH outcomes Increase preventive service use Promote access to high-quality care and reduce unnecessary spending 	Improve the member and PCP relationship to increase preventive service and reduce avoidable ED utilization
Increasing SBIRT Referrals	<ul style="list-style-type: none"> Reduce the burden of SUD and engage members to improve BH outcomes Increase preventive service use Promote access to high-quality care and reduce unnecessary spending 	Improve continuity and coordination of care to increase access to appropriate care and reduce avoidable ED utilization

Proposed PIP	2019 DMS Quality Aim	Passport Quality Aim
Increasing Post-inpatient Follow Up to Reduce Readmissions	<ul style="list-style-type: none"> • Reduce the burden of SUD and engage members to improve BH outcomes • Reduce the burden of and outcomes for chronic diseases • Increase preventive service use • Promote access to high-quality care and reduce unnecessary spending • Improve care and outcomes for children and adults, including special populations children and special populations 	Improve continuity and coordination of care to increase access to appropriate care and reduce avoidable readmissions
Food Insecurity and Diabetes	<ul style="list-style-type: none"> • Reduce the burden of and outcomes for chronic diseases • Promote access to high-quality care and reduce unnecessary spending 	Address disparities in care and SDoH to improve access to care and reduce avoidable ED use and hospitalizations
Comprehensive Pain Response	<ul style="list-style-type: none"> • Reduce the burden of SUD and engage members to improve BH outcomes • Promote access to high-quality care and reduce unnecessary spending 	Reduce the overuse or dependence on opioid pain medication

Integrating Behavioral Health into Primary Care

Given DMS’ interest in expanding integrated care for members, Passport recommends a collaborative PIP for MCOs to develop different clinical models and payment models for integrated care and/or incentives for improved collaborative care. Through Passport’s quality management team and related internal and external committees, this likely could include a higher focus on BH screening in PCP offices (depression, anxiety, SUD, social needs) as the first step toward more effective collaborative integration and increased delivery of primary care services in community mental health centers since few have developed this service since corresponding regulations were modified to allow it. The program might examine medication-assisted treatment in primary care as a component of integrated care by increasing the number of clinics that provide such treatment for opioid use disorder. The PIP could include looking at the ROI and health outcomes for members already served by providers engaged in integrated care to learn who is doing the best work and try to accelerate that type of program in the Commonwealth. Similar to the joint and collaborative success and adoption of SBIRT for substance use, this program could work to promote early identification and treatment for BH disorders, in turn leading to improved health and well-being, as well as reduced medical spending when BH issues are addressed early.

Early identification of BH needs and intervention is needed in Kentucky now more than ever before. In 2017, Kentucky had sixty-four (64) deaths/100k due to alcohol, drugs and suicide compared to a national average of forty-six (46)/100k (Pain in the Nation). If we do nothing, that number is expected to rise for the Commonwealth to eighty-one (81)/100k people per year in 2025. Integrated care, in which BH and medical health care come together in a single practice, can help to increase access to much needed BH care **by reducing the perceived stigma and offering immediate care in the PCP office.** Too few members identified as needing BH care by their PCP access the service; nationally, PCPs only screen for depression about four percent (4%) of their member encounters. Of those who do screen, two-thirds are unable to get their member the BH or substance use treatment they need. Warm hand-offs by the PCP to a BH program when the member is in a moment of need and activated to change helps to prevent the loss to follow-up found in traditional referral processes. And there is growing evidence that medication-assisted treatment programs that offer both the medication assistance and counseling integrated into primary care are effective and have the potential to meet members where they are at. Moving from volume to value is the holy grail of health care for all stakeholders: payer, provider and member. Integrated care offers a population-level approach to BH with ROI results.

Passport’s long-held vision of integrated care is a far better approach to whole-person, member-centered, “no wrong door” care. Kentucky, due to multiple factors, lags other states in moving into high-fidelity models of integrated primary care, and Passport has sought to be a leading partner in moving the Commonwealth into this approach.

Passport’s clinical subject matter expert in integrated care and accountable health communities has built strong relationships with PCPs interested in integrated care across the Commonwealth. Passport’s local and national experts have brought an added lens of understanding on what types of integration move the needle on health outcomes and provide the ROI needed to make these critically needed changes into discussions that try to maximize outcomes and eventually move toward alternative payment models for integrated care. While providers in the Commonwealth are not ready for the risk associated with all payment models, other states have shown promising results with regards to per member per month (PMPM) for integrated care. The **SHAPE Demonstration Project** in Colorado, for example, estimated a prospective \$1.08 million in savings for its public payer population after an eighteen (18)-month pilot across six (6) primary care clinics. Although Kentucky is likely not ready to implement integrated care across the board for this type of approach, Passport would be excited to participate in a PIP that has a chance at moving the needle positively forward for integrated care...helping Kentucky take another step closer to outcomes like those in Colorado’s SHAPE Project within the Commonwealth.



Increasing SBIRT Referrals

Passport recommends a PIP to implement a SBIRT program with a strong focus on the Referral to Treatment (RT) aspect. By focusing specifically on the RT, we will address early identification and build stronger

collaboration between the member’s PCP and BH/SUD providers for those identified as at-risk or within the misuse/abuse level for substances. This PIP will tie in with the Commonwealth’s plans to expand access to treatment and recovery services for individuals with SUD. The new waiver extends access to SUD providers, allows Medicaid to reimburse for short-term residential stays (up to thirty [30] days) in mental health facilities and adds coverage for methadone, a form of medication-assisted treatment not currently covered under Kentucky Medicaid. Our proposed SBIRT PIP will work to identify individuals earlier and connect them with treatment.

While many providers use the SBIRT approach to screen members, not all use a standardized screening tool. The program would issue a standardized tool to evaluate members consistently. Further, while screening is straightforward for providers, intervention and RT can be a challenge due to the time constraints and workflow adjustments needed. There is also a perceived lack of community resources for the referral to the treatment component. As of 2016, Kentucky ranked 5th among states with the highest number of drug overdose-related deaths³. As opioids have become a crisis in Kentucky, SBIRT becomes a more important tool for early intervention. However, billing codes for SBIRT have not evolved in this time to meet the changing needs for the full activities required for SBIRT. The PIP could examine ways to expand billing for follow up BI or to better assess if a member is referred to treatment secondary to an SBIRT positive screen. The PIP could potentially help practices develop a standard for using SBIRT and determine when and how to refer members. For this reason, this PIP would be an excellent choice for a collaborative PIP across all MCOs to improve prevention and early identification and treatment.

Increasing Post-inpatient Follow-Up to Reduce Readmissions

Passport recommends a PIP focused on improving provider follow-up after inpatient admission. Our current readmission rate is approximately thirteen percent (13%), and each percent point reduction equates to approximately **\$2.7M savings in medical spending**. A study⁴ published in *JAMA Internal Medicine* showed that members who completed an outpatient follow-up visit within seven (7) days had a twelve to twenty-four percent (12-24%) lower risk for thirty (30)-day readmission. Increased follow-up would also lead to greater coordination of care and, ultimately, better outcomes for the member. The PIP would apply to adults and children, including potentially the Kentucky Supporting Kentucky Youth (SKY) population, and would address both medical and BH mental/SUD stays. By having the MCOs work collaboratively together toward a common goal, it will help prioritize this issue with providers and assist them in designing tracking systems they could use with all MCOs. This would reduce the burden for providers of creating multiple measurement methods for similar concepts. Having shared metrics for capturing data across MCOs would

³ <https://www.khcollaborative.org/2018/08/sbirt-toolkit-released-for-healthcare-providers-to-address-opioid-crisis/> Accessed 6/5/2019.

⁴ Shen, E. et al. Association of a Dedicated Post-Hospital Discharge Follow-up Visit and 30-Day Readmission Risk in a Medicare Advantage Population. *JAMA Intern Med.* 2017;177(1):132-135. doi:10.1001/jamainternmed.2016.7061. <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2587083>

allow for ***scaling the impact of the interventions***. MCOs could also be required to have value-based contracting in place for this PIP, which would help a large group of providers become familiar with alternative payment models. Providers would be incentivized to provide greater follow-up. The incentives or contracts would not have to be uniform across MCOs: each one could design its method for engaging with providers, which would also allow for the collective group to learn more about the effectiveness of different types of incentives.

For example, Passport could introduce a program where BH providers would accept a reduced per diem with an opportunity to earn those dollars back, and more, for higher quality performance. Achieving these additional incentives will result in payment over the traditional per diem if they meet two (2) goals: connection to an outpatient visit within seven (7) days and avoidance of thirty (30)-day readmission. The other provider performance per diem could be managed through cost savings and contracting shifting more funds to better performing provider organizations. The member could win by having access to better-coordinated care that better meets his/her needs in an outpatient environment after transitioning from a facility into the community. The provider wins because it can demonstrate it is providing more effective interventions to meet needs and earn more payment because of it. Passport and DMS would win because members receive the right care, at the right time, in the right location and at the right cost.

Passport Works to Improve Access to Affordable, Healthy Food in Kentucky

Passport is focusing on food insecurity because members who do not have access to healthy food have a direct link to poor health outcomes.

As part of Passport's partnership with the American Heart Association, Urban League and the Jewish Community Center, several Passport associates volunteered to cook and serve healthy refreshments for attendees at the Future of Food Security in Louisville forum.

During the forum, representatives from local organizations (including the Louisville Medical Society, Office of Health Equity, 2018 Food Innovation Fellows and more) came together to brainstorm innovative ways to solve the problem of food insecurity in Louisville.

This is just one of many steps Passport is taking to address food insecurity (meaning inadequate access to affordable, nutritious food) across the Commonwealth. In Lexington, Passport has partnered with Bluegrass Harvest to increase access to local, fresh fruits and vegetables.

Across the Commonwealth, Passport's health education efforts team up with partners like the American Heart Association and attend special events to teach members how to find ways to eat healthier and improve their lifestyles.

Food Insecurity and Diabetes

Passport recommends a PIP to assess the impact of food insecurity for diabetic members and determine the number of food-insecure diabetic members across health plans. Food insecurity has been associated with

diabetes. *National Health Examination and Nutrition Examination Survey (NHANES) 1999-2002* notes that “among adults with food insecurity, increased consumption of inexpensive food alternatives, which are often calorically dense and nutritionally poor, may play a role in this relationship”.⁵⁵ To address this, Passport recommends partnering with local health departments and other agencies to advocate for increased access to low glycemic foods in food pantries. Passport will also work with food pantries (a) to prepare information to share with providers to help them know where to send members for low glycemic food and (b) to help them better define their scope of care and enhance their ability to engage in platforms like United Community in Jefferson County. We will also encourage providers to write “prescriptions” for members with diabetes to us in the low glycemic areas of the food pantry. Passport will measure the impact of these activities on health outcomes for the food-insecure diabetic population.

Comprehensive Pain Response

To combat the opioid crisis, it is essential to understand how to appropriately and effectively treat pain. Passport also recommends a **collaborative PIP** in which MCOs gather the latest knowledge about the treatment of pain. They would then be charged to work collaboratively with DMS to generate policy changes, provide member and provider education, increase awareness and use of existing interventions, and implement preventive and alternative therapies. This could include preventive solutions such as new lab technology and pharmacy policy changes. Education could be provided to promote better utilization of evidence-based pain treatments that are already part of the care continuum, such as physical therapy interventions like dry needling or cognitive behavioral interventions. The PIP could also address the evaluation and implementation of alternative therapies such as acupuncture and massage therapy. By better understanding the spectrum of pain treatment options, MCOs will be better positioned, and members will have more options to address chronic pain from a whole-member approach to care and reduce the use of opioids for pain management and their potential future misuse.

9.g.iii Methods for monitoring and ongoing evaluation of progress and effectiveness

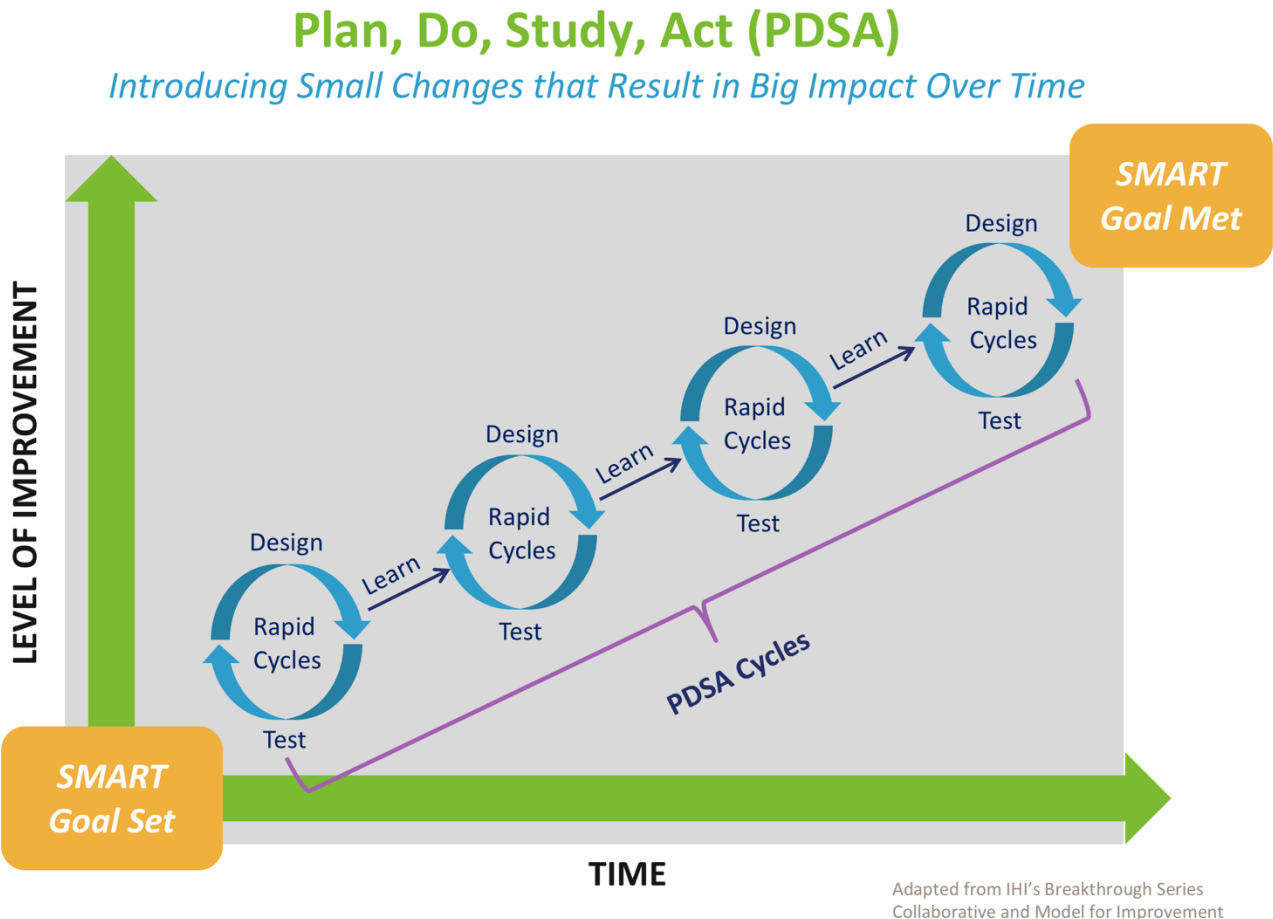
Monitoring and Ongoing Evaluation of Progress

Passport actively tracks, monitors and evaluates progress in improving the quality of health care and outcomes on an ongoing basis, providing updates to the Department during quality meetings and when requested. We review program metrics such as preventive care, study and prioritize SDoH for performance measurement, and improve, review or develop/adopt new practice guidelines from our quality committees.

⁵ Seligman HK, Bindman AB, Vittinghoff E, Kanaya AM, Kushel MB. Food insecurity is associated with diabetes mellitus: results from the National Health Examination and Nutrition Examination Survey (NHANES) 1999-2002. *J Gen Intern Med.* 2007;22(7):1018-1023. Doi: 10.1007/s11606-007-0192-6

Our performance improvement activities include a robust suite of methodologies to ensure the reliability and validity of results, resulting in the development of comprehensive and well-planned interventions. We also incorporate into our processes the recommendations of our EQRO annual evaluation, HEDIS scores, results of member and provider satisfaction surveys as well as findings identified by the Department. PIP interventions are continuously monitored using specific, measurable, achievable, relevant, time-bound (SMART) goals, validated against data and improved using the PDSA cycle showcased in **Exhibit C.9-14**.

Exhibit C.9-14: PDSA Cycle



Monitoring and Ongoing Evaluation of Effectiveness

Our performance improvement activities include a robust suite of methodologies to ensure the effectiveness, reliability and validity of results. This results in the development of comprehensive and well-planned interventions. We also incorporate into our processes the recommendations of our EQRO annual evaluation, HEDIS scores, results of member and provider satisfaction surveys, as well as findings or focus areas identified by the Department.

Internal monitoring and ongoing evaluation include the following:

- Data collection processes that verify timeliness, accuracy and completeness of data, and apply both standardized NCQA standards and other externally and internally algorithms focusing on additional best practices
- Barrier/root cause analysis that enables us to decipher issues and modify or review barriers
- Workgroup/committees collaborative work that applies an extensive amount of system and community knowledge, leadership and guidance
- Oversight and input at QMMC to hold us all accountable and transparent
- Partnership Council approval that ties us all together in the decisions we make

External monitoring and ongoing evaluation:

- Quarterly DMS collaborative PIP meetings
- Quarterly DMS quality committee meetings (with all MCOs)
- Monthly internal stakeholder meetings for the work plan, accreditation, PIP and additional regulatory reporting

A cross-functional Passport team actively reviews outcome data for each program in care coordination, member and provider service metrics, identified national trends for improvement, and member/provider satisfaction surveys to identify areas for improvement, both pre-and post-program development. This team meets at various frequencies but at a minimum annually. Passport then presents its suggestions to DMS and the EQRO for discussion and approval. Passport submits proposals for each PIP to the EQRO and DMS on their required submission cycles according to their guidelines. Once a PIP is initiated, it is followed up with periodic measurements evaluating its current success or failure. The updates including a baseline measurement (one [1] calendar year after the project proposal); an initial PIP re-measurement (no more than two [2] calendar years after baseline measurement); an intermediate PIP re-measurement (no more than one [1] calendar year after the first re-measurement); and a final PIP re-measurement (no more than one [1] calendar year after the second re-measurement).

To ensure our PIPs are effective in addressing identified focus areas and improving outcomes and quality of care for members, Passport conducts a rigorous PIP monitoring and management process. We utilize our providers, community-based health/social agencies, local health departments, BH agencies, subcontractors and members to work together on improvement related to the PIP subject. These community and internal leaders participate in topic selection and development of interventions, as collaborative partners in participation, and to provide feedback on results. These collaborative teams review progress on a monthly or quarterly basis, revising interventions if PIP goals are not achieved. Passport collaborates with external providers and facilities to identify barriers to success. Collaboration between the MCO and public health agencies is an essential element for the achievement of public health objectives. ***Passport is committed to ongoing cooperation with DMS and public health agencies in the area of service and clinical care improvements through the development and dissemination of best practices and the use of encounter data-driven performance measures.***

C.9.h. Provide a description of opportunities the Vendor has identified to collaborate with the Department for Public Health to support improvement in public health outcomes. Where does the Vendor anticipate that collaborating on initiatives would have the most impact in addressing quality care and outcomes for Medicaid Enrollees? Explain the Vendor's rationale.

Over our twenty-two (22) years of working in Kentucky, we uniquely understand that there are many opportunities to impact the health and well-being of our members and the community at large. As we continually strive to collaborate, we recognize our great partners in many of these are the Department of Public Health (DPH) and the local health department (LHD). Our experience and long-standing work efforts with our partners have been the key to numerous initiatives that had an impact on Medicaid members and Kentuckians overall.

Examples of the historical and ongoing collaboration with DPH include:

- **Newborn health.** Passport collaborated with the LHD to improve preventive services for children. One (1) initiative involved the provision of cribs for newborns in the Lincoln Trail service area in concert with that health department. In 2016 and 2017, after the crib program started in the Lincoln Trail region, there were zero (0) infant deaths due to unsafe sleep environments. In 2018 and 2019, the only infant deaths that occurred in the five (5) counties were families who were not program participants.
- **Childhood health/EPSTD.** Another preventive service initiative for children included working with willing LHDs to conduct outreach campaigns to increase EPSTD services. Passport provided participating LHDs with the contact information of our child and adolescent members in their area who were missing expected EPSTD services. Now, LHDs augment our attempts to engage members to receive care. We are exploring alternatives with some LHDs to potentially perform the appropriate EPSTD preventive service and coordinate with the member's PCP.
- **Childhood immunizations.** Providing access to immunizations is a foundation of public health, and we work closely with our providers to make sure that they are participating in the Vaccine for Children Program as well as fully participating in the immunization registry. The registry is important in cataloging administered vaccines so that any provider can know what a member needs without exposing them to unnecessary services. The addition of this information into the KHIE is also an excellent opportunity to streamline access for providers and increase the likelihood of its use. We are fully supportive of the widespread adoption and utilization of KHIE providers across Kentucky, which is covered in Section 8 of this RFP response. Passport will provide technical assistance and help providers apply for funds to defray costs of connectivity to the KHIE as well as potentially help decrease costs further.
- **Women's health and maternity care planning.** Passport has worked closely with the DPH, LHDs and DMS to make long-acting reversible contraceptives more accessible. Passport believes that allowing the appropriate spacing and planning of pregnancies is an important factor in having a healthy child. As a result, Passport worked with providers (including our Women's Health Committee) to educate on the safe and effective use of such contraceptives post-delivery as well as removing some of the administrative hurdles preventing reimbursement. Passport created a mechanism that allows reimbursement for the devices outside of the DRG for delivery to aid the process. This was communicated to obstetricians as well as the birthing facilities.

- KPHLI.** Sponsored by Passport in 2015-2016, the KPHLI brought public health leaders, including predominately public health department leaders, together to participate in a competitive entrance one (1)-year leadership training program. The **program teaches public health leaders to identify and build collaborations to solve a real problem in the community.** Through our support, KPHLI graduates have developed interventions for public health issues in our state including improving colon cancer screening rates in Appalachian men by determining how to craft messaging to this group; developing lesson plans about the impact of social media on nutrition choices and childhood obesity; developing a wellness guide for schools; developing a document for agencies on reducing barriers to integrated care; developing written communication procedures for adoption by local health departments; and conducting a case study for increasing the participation and retention of WIC participation at the Lake Cumberland Health Department that addressed workflow and staff morale initiatives. We also work with DPH regularly to assist with outreach for EPSDT if we are unable to reach the member about available services.



As we continue to collaborate with DPH, we have identified several potential opportunities to collaborate to support improved health outcomes. Initiatives that we and our committees and stakeholders have identified that would be the most impactful in addressing quality care and outcomes for Medicaid members are diabetes, obesity, cardiovascular disease, lung cancer and SUD.

Below, Passport lists several opportunities where we would welcome collaboration with DPH to support DMS's goals to transform the Medicaid program.

- Data Sharing.** Perhaps the most impactful means of collaborating with DPH can be found in sharing data between DPH and Passport. Sharing de-identified data on Passport's membership and receiving statewide and regional data from DPH provides additional information to both parties to help us understand population hot spots, shifts and changing needs so we can better focus resources where needed and provide the most appropriate services. Data received from DPH would especially help Passport address localized issues in areas where Passport membership is small and its population dataset is incomplete. Data sharing would be between both parties under a Health Insurance Portability and Accountability Act (HIPAA)-compliant transaction.

 - For example, data sharing would directly impact our ability to effectively address the most staggering problem of SUD within the Commonwealth by improving our shared understanding of areas where SUD is prevalent. Passport's data shows that the total number of members with SUD diagnosis is about 35,000 (eleven percent [11%] of Passport members). The prevalence rate among adults is nineteen percent (19%). These members contributed to \$448 million in total medical and pharmacy costs, making up twenty-seven percent (27%) of the total spend of our health plan. The breakdown of total spending is forty-two percent (42%) inpatient, twenty-four percent (24%) outpatient, nine percent (9%) ED and eighteen percent (18%) professional.

As large as these numbers are, data sharing across the entire statewide population would help us determine how to break down our plan response and potential opportunities to partner with practitioners. Only together with the DPH statewide data, local presence statewide and potentially a partnership with all MCOs will we be able to curb the extent of the prevalence and help Kentuckians break free of addiction. Similarly, on an equally important scale for our babies and youth, additional data would help us understand where gaps in fulfilling needed immunizations exist for EPSDT, and we could partner with DPH to fill those gaps.

- **Diabetes and Obesity.** Diabetes is a common disease in Kentucky and the nation, with type 2 diabetes being the most common form. The prevalence of diabetes among Kentucky adults nearly doubled between 2000 and 2017, according to the 2019 Kentucky Diabetes Report issued by the Cabinet for Health and Family Services (CHFS). DPH’s Kentucky Diabetes Prevention and Control Program (KDPCP) and associated Diabetes Prevention Program (DPP) are excellent resources. Passport could leverage the Kentucky Diabetes Resource Directory available through this program for community resources available to its members at risk for or diagnosed with diabetes. It would help educate our providers on the availability of the resource. We could then inform and ask providers to refer members to DPP resources. Similarly, we would work with these resources to educate providers and encourage them to refer Passport members who outreach to them and refer them to Passport for participation in our Condition Care program for diabetes. Related to this, Passport has also been participating in DMS’ evaluation for the Senate on the potential for including DPP as a covered benefit.
- **Tobacco Cessation.** Encouraging cessation of smoking and vaping will have multiple positive impacts for Kentuckians, including prevention of lung cancer, lowering the rate of chronic lung disease, decreasing the rates of vascular disease and addressing the emerging dangers of vaping. According to the 2017 Kentucky Behavioral Risk Factor Surveillance System (BRFSS) survey, 46.2% of low-income adults and 42.2% of those with less than a high school education in Kentucky currently smoke cigarettes. Passport currently leverages DPH’s Quit Now Kentucky program as its primary resource for smoking cessation for its members and will continue to use this excellent resource. We propose a collaborative effort with the DMS, DPH, all MCOs and other stakeholders to make even greater strides in addressing this ongoing public health issue.
- **Substance Use Disorder.** Another area of SUD management that would be augmented with DPH collaboration is a collaborative PIP such as the one we have proposed in our response under Section C.9.g above, focused on increasing SBIRT referrals. DPH clinicians are well-positioned to aid in expanding the footprint of the SBIRT approach, and Passport recommends that DPH be included in the development and monitoring of that recommended PIP. Part of the PIP would address the need to expand the codes for appropriate reimbursement for DPH staff; Passport believes that DPH would have insight into assisting with the expansion.

C.9.i. Describe the Vendor’s approach to monitoring and evaluating progress in improving the quality of health care and outcomes on an ongoing basis. Describe the following:

C.9.i.i How the Vendor will use data to inform and prioritize initiatives to address Enrollee needs.

Using Data to Inform, Prioritize and Drive Initiatives

Data. To prioritize and drive initiatives, Passport uses data and reports from the following areas:

- **Quality Workplan.** The QI workplan reflects ongoing activities and progress on QI activities throughout the year. It addresses program structure, quality of service, quality of clinical care, member safety, member service and communication, network adequacy, and performance improvement. The workplan captures the time frame and frequency of activities, responsible parties and monitoring of issues to maintain visibility into the performance and trends of major programs across the organization.

- **Annual QI Program Evaluation.** The program evaluation report is written annually to evaluate the results of QI initiatives in measurable terms trended over time and compared with performance objectives as defined in the QI workplan.
- **Network Provider Performance.** These reports are designed to give Passport visibility into key performance metrics for practices and providers. Data is trending over time, and providers are benchmarked against each other. The data can signal where there is an opportunity to engage a specific provider, group of practices or region. Measures that directly relate to member needs include access, utilization and clinical quality performance.

Prioritization. Through our organization’s committee structure, we prioritize initiatives that Passport will execute. The QMMC and QMAC are the primary committees that set these priorities.

- **QMMC Prioritization.** When reviewing data from the quality workplan and annual program evaluation, the QMMC evaluates and prioritizes potential initiatives based on (1) alignment with DMS contractual requirements, goals and aims; (2) performance that has trended down over two measurement cycles; (3) financial and operational impact to the organization; and (4) expected impact to members, providers and the community. These factors are weighted, and then performance areas are ranked based on the highest weight. The QMMC then sets the priority and monitors the execution of initiatives.

If we identify a negative trend in network provider performance, the QMMC prioritizes specific provider engagement initiatives targeted with those providers. This is a separate prioritization process and is guided by the same method as above. However, this process is focused on improving performance at the provider or practice level. The process may inform the overarching macro-level initiatives but is designed to work independently.

- **QMAC Prioritization.** The QMAC reviews data specifically related to areas of the QI workplan that impact members. This includes access and availability of care, complaints and grievances, and member services. The QMAC provides valuable feedback to our community engagement team on the areas they deem the highest priority from the member’s perspective. Feedback from the QMAC is prepared and shared with the QMMC for use in the weighting and prioritization of organization-wide priorities and initiatives.

This data, and the needs and perspectives of our members, informs our ongoing quality efforts and guides our annual quality focus and strategy.

C.9.i.ii. Methods for measuring provider performance against practice guidelines and standards adopted by the QIC and follow up activities to be conducted with providers based on the ongoing review of findings.

Measuring Provider Performance Against Clinical Practice Guidelines

Passport maintains a process to measure provider performance against CPGs and standards set by the QMMC (QIC) to meet regulatory requirements. Passport applies the same analytic rigor of our quality process with medical record audits and real-time, in-person feedback and education with providers. We measure and audit contracted and subcontracted providers’ performance against evidence-based standards and CPGs, other performance indicators, key performance indicators (KPIs) and other key related factors using a combination of our extensive analytic tools, data (HEDIS data) and other available electronic and

paper records. As a provider-owned organization, we are uniquely positioned to understand what can help them make quality improvements, and we as Passport are managing, guiding and leading the efforts.

Locally, if a new CPG is identified for use, it goes through a subcommittee specific to the CPG, when appropriate, and then is presented for consideration at the QMMC. The adoption of local CPGs is then sent to the subcontractor for adoption at the national level to ensure consistency and that it follows the required process for NCQA accreditation. As part of the NCQA process for accredited Population Health Management programs, our subcontractor is required to review the evidence base for the CPGs every two (2) years.



There are two (2) distinct ways we measure provider performance against CPGs: through continuous monitoring, and with a rigorous annual review.

Continuous Monitoring of CPGs

- If a provider does not meet the minimum eighty percent (80%) performance threshold during a CPG or EPSDT audit, Passport enacts provider monitoring, and in some cases, creates a corrective action plan (CAP).
- Ongoing performance on quality measures based on HEDIS, national or state measure steward specifications are shared regularly with providers. Approved measures for monitoring quality performance, by design, are deeply rooted in evidence-based medicine and clinical practice guidelines.

Annual Review of CPGs

- **CPG Audit.** Passport selects certain CPGs for annual review and examines related HEDIS performance rates by the provider. We select CPGs for review based on annual QMMC priorities. HEDIS rate targets are determined based on trend analysis and national benchmarks. We provide performance against targets to providers. If a provider does not meet the target rate, Passport performs medical record audits of the provider files for compliance with the requirements of the CPG. If the provider's file review results do not meet the minimum standard, Passport offers education and training to improve performance. We remeasure the provider's performance at six (6)- and twelve (12)-month intervals to ensure that improvement is achieved and maintained, and that ongoing education is provided if needed or upon request.
- **EPSDT Audit.** Passport audits pediatric and family practice providers for compliance with screening and documentation of EPSDT members. Charts are reviewed based on a three (3)-year cycle to ensure that each age group is receiving the correct screenings and services as outlined by Bright Futures.

Ensuring that providers are aware of and understand CPGs is key to this process. It is the goal of the Quality Department to provide ongoing awareness, education, and supportive, useful data relating to clinical practice guidelines ensuring that members are receiving the highest standard of care and that we are continually working with our stakeholders, providers and those same members to constantly gain improvements.

- CPGs are sent to providers regularly through eNews updates are available on the provider page on www.passporthealthplan.com and are addressed in the provider manual.
- Our Provider Relations and Population Health Managers meet daily with different providers and actively engage them when we identify positive and negative trends and issues or need their input on programs and initiatives that support our member community. During this time, the team will address any knowledge gaps surrounding CPGs. We leverage extensive reporting dashboards to help them meet the goals of the QMMC but the goals of their organizations as well.
- Passport utilizes the results of the CPG and EPSDT audit to develop better and more effective provider education tools targeted to the network or a specific provider type.

Below are two examples where we identified an opportunity using our CPG process:

Example #1: Passport identified an opportunity to improve documentation relative to the well-child visit, specifically parental education about physical activity and nutrition. In reviewing medical records, Passport could not find documentation of member education in many cases. To address this, **we shared best practices** on documentation of member education and counseling and the availability of charting tools such as Bright Futures for pediatricians to add to the documentation or the EMR, and tips on ways to incorporate member education during the normal office workflow. We also looked at related material, including our member website, which we provide under our support for WIC and other children’s programs to see if we could make an additional impact.

Example #2: Passport identified limited documentation regarding obstetric (OB) education during the first OB pregnancy visits and encouraged providers to use standardized American College of Obstetrics & Gynecology (ACOG) tools, provided education on our expectations that education should occur in the first two (2) visits, and provided ways to document member education tools distributed during a visit. When a provider performed at less than our expected target, **we shared the results face to face and demonstrated best practices** on incorporating the requirement into documentation, which resulted in improved results in subsequent audits.

C.9.i.iii. A summary of the Vendor’s approach to the annual evaluation of the overall effectiveness of the QAPI program and how the Vendor will use findings for continuous quality improvement efforts.

Evaluating the Overall Effectiveness of Our QAPI Program and Using Findings for Continuous Quality Improvement

As mentioned in the above section, Passport conducts an annual QI Program **evaluation to gauge the effectiveness of the QI Program**, which allows Passport to determine how well it has utilized its resources to improve the quality of care, service, and culturally and linguistically appropriate services provided to Passport’s membership. Passport’s QI program provides the infrastructure for continuous monitoring, evaluation, and improvement in care, safety and service. Based on this annual review, we modify as necessary quality programs, including quality improvement policies and procedures, clinical care standards practice guidelines, member protocols, utilization and access standards practice guidelines, and the needs of members.

Annually, this goal is measured by the following objectives included in the QI program:

- To continuously monitor and analyze key clinical and service indicators
- To manage disease and health management programs
- To conduct outreach and health education activities
- To develop programs for populations with special needs
- To conduct intervention studies in clinical and service areas, selected based on data reviews
- To perform appropriate oversight of delegated activities
- To conduct satisfaction surveys for members and providers/practitioners
- To coordinate activities across functional areas to improve care and service
- To foster an environment that assists practitioners and providers with improving safety
- To conduct oversight of risk management and evaluate the effectiveness of the QI program

As part of this evaluation, Passport’s approach assesses the following program aspects and makes recommendations:

- QI staff, resources and committee structure
- Network adequacy and expansion
- Qualified providers and practitioners
- Member cultural needs and preferences
- Delegation oversight
- Quality improvement activities and guidelines
- Accessibility of services
- Administrative and medical necessity appeals
- Service indicators
- Member satisfaction and provider satisfaction
- Public affairs
- Utilization management
- Statutory requirements
- Kentucky Medicaid PIPs
- EQRO annual evaluation
- Program impact goals

When the program has not met its goals, we complete root cause analysis to identify barriers. The barriers are addressed by the identification of improvement opportunities through interventions. The appropriate changes are integrated into the subsequent annual QI workplan. Feedback and recommendations from various committees are integrated into the evaluation as well as the external yearly review results conducted by the EQRO on behalf of DMS, accreditation status and annual reevaluation results. The final document is presented to the QMMC, the Partnership Council and the Board of Directors for review and approval.

An example of this process: At the end of 2019, we reviewed overall performance improvement and identified an opportunity involving preventive health and screenings that could increase not only member

health outcomes related to preventive services but also chronic condition monitoring and avoidable ED and hospitalization usage. Through the QMMC, we set this as a focus of the 2020 quality strategy and incorporated in the QI workplan interventions to engage more members with their PCPs through direct outreach, VBP, birthday reminders, PIP pilots and enhanced member health incentives.

Annual Review and Update of QI Workplan

Based on the results of the annual QI program evaluation, and with input from our board, the Partnership Council, QMMC, other stakeholders, and relevant Passport Health Plan Departments, we develop an annual QI workplan addressing planned and ongoing quality initiatives. The QI workplan includes objectives, goals, scope, identified barriers and planned activities that address the quality and safety of clinical care, quality of services, CLAS and **reduction of health care disparities** for the year. This workplan incorporates both areas of needed improvement and areas of special focus identified by DMS, or through our robust governance structure. Planned monitoring of issues previously identified by internal and external customers are integrated, including tracking of issues over time and the planned evaluation of the QI Program. Also included are persons responsible for each activity and the time frame for achieving each activity. As a recommendation of the EQRO, quantifiable goals, a timeline for implementation of activities and achievement of goals, and an annual “Executive Summary” of the workplan highlighting key milestones and the dates the milestones were achieved is completed annually and incorporated into the QI workplan. The final document is presented to the QMMC, the Partnership Council and the Board of Directors for review and approval. Once completed and approved by DMS, we openly present to all community stakeholders, subcontractors and providers through multiple channels, community presentations and joint development sessions to ensure network adoption and that critical focus is placed on the findings to take the next step in improving care.

C.9.j. Provide a summary of how the Vendor will collaborate with the Department and other Vendors in developing and implementing a value-based payment (VBP) program. Include proposed approaches for the following at a minimum:

A fee-for-service model unintentionally encourages overutilization; siloed care delivery occurs and unfortunately allows members to fall through the cracks. This causes a cycle of further overutilization and repeated testing, unmanaged referrals to specialists, misunderstood care plans, and medications either not taken or taken in excess. Without an engaged and informed provider or physician, members are often required to manage their healthcare without the knowledge or resources to guide them, leading to a population with significant gaps in inappropriate preventive care. Through our VBP strategies, Passport strives to improve the quality and health outcomes of members, reduce or manage cost at the provider panel level, and inform our providers and physicians with actionable information. If we can give providers and physicians actionable information and incentivized payment structures that reward educating, engaging, and supporting members to achieve improved health outcomes, then our VBP programs will be successful.

We want Kentucky providers to become more knowledgeable about and accepting of alternative payment models. We are continually working with providers to iteratively test and improve our programs to create an approach that aligns with their practice workflows. As we describe in detail below, if we can do that

collectively together with DMS and the other MCO's, choosing metrics and VBP program elements thoughtfully, receiving feedback from physicians and provider groups, and finding the best standardized performance metrics to highlight high quality clinical performance to incentivize then we will find our providers more willing to engage in VBP programs. Our proposal to how Passport will collaborate with the Department and the other MCO's is to propose we work together to standardize key performance metrics around primary care physician (PCP) focused population health metrics, preventable utilization, and maternity to reduce the administrative burden of physicians having to focus on multiple, unaligned metrics from each payor individually. The addition of maternity also allows the Department and the MCO's to include a key specialty group in OB/GYN providers and maternity a key area of Medicaid populations. Standardization also allows for the Department to share provider group performance across entire provider populations publicly and not just across smaller MCO-based memberships. This would really engage physicians and providers around key quality standards and allow them to focus across their entire member population on the clinical activities to support better member outcomes. It would also lead to more standardized VBP programs approaches and better adoption by Kentucky providers.

C.9.j.i The Vendor's lessons learned in developing and implementing VBP models, examples of models that have been most effective in improving performance and outcomes.

Lessons Learned Developing and Implementing VBP Models

Passport has built a variety of VBP programs, focusing on primary care versus specialty care provider type, design sophistication, funding mechanism and provider risk. Through our VBP strategies, Passport strives to improve the quality and overall health of members, reduce or manage cost at the member panel level, and engage and inform providers and physicians with actionable information on their member panel. We are continually working with providers to iteratively test and improve our programs to create an approach that aligns with the quality and member care workflows within their practices. Through the process of building our VBP programs, Passport has developed a consistent approach to identifying and building out initiatives for VBP and has identified several lessons learned in building effective programs that improve performance and outcomes and attempt to reduce the administrative burden on providers.

Build a VBP Program with Provider Input End-to-End

To gain buy-in and minimize abrasion among providers, it is essential to work with them from the outset of developing the program. Our provider-driven governance structure is a differentiator for Passport in developing VBP programs because we can work directly with key provider leadership in the design choices and approval of our VBP programming.

The PCP Workgroup, a standing subcommittee of Passport's Quality Department made up of providers and provider group leadership from our network, offers invaluable insight on actionable quality and utilization metrics and incentive payment approaches so we can achieve the best outcomes with the highest provider participation. **All of Passport's**



practitioner initiatives are reviewed and approved by the provider-driven Partnership Council as a final step before Passport leadership will move forward with deployment.

- An example of the important and thorough discussion with providers for feedback was on population health metrics like preventable ED utilization. A healthy discussion ensued about the impact PCPs have on members going to the ED. Early discussion focused on how members have many factors that lead to ED visits, including guidance from specialists, access challenges, member choice, member experience with their health needs and other factors. As the discussion continued, most PCPs felt they could make a bigger impact with the adult population than with the pediatric population. Accordingly, Passport removed the ED utilization metric for the pediatric population. Practitioner buy-in is the most important factor in engagement and building a successful VBP program.

We continue to work with our provider leadership network after selection of metrics to review provider reports and scorecards, make sure payment models and calculations are understandable and have conferences with providers at their offices to continue to drive activity and feedback into the program.

Even with some of the challenges and lessons learned, we have had an understanding VBP provider community that has stuck by Passport and our VBP program knowing that we have been honest with those challenges and worked with them on solutions instead of either coming up with metrics on the front end or solutions or reports on the back end on which they had no input.

Choose Measures Thoughtfully

With earlier VBP pilot programs, Passport initially selected a larger number of measures to evaluate for payments. As pilots progressed, we determined that it was best to ask providers to focus on fewer performance metrics, so they can best focus their attention on specific key areas leading to improved processes and quality of care for members. We will also offer reports on a broader set of quality and utilization indicators about their member panel but will focus on a smaller set to measure and pay out for performance. Otherwise, buy-in was difficult because practitioner feedback was that there were too many measures, and they had varying degrees of control over their impact on some of them.

- An example included PCPs saying that they are not involved in hospital follow-up after behavioral health hospitalization because that follow-up is almost exclusively done by psychiatrists and behavioral health specialists. We still want them to focus on making sure their members get follow-up in this specialty-driven situation. Still, it was very important to build provider buy-in to select metrics they felt they influenced, especially when tying this to compensation and incentives. The narrowed metric focus also helped our central analytics teams to focus on the critical elements to measure outcomes and results as accurately as possible, and it allows Passport to provide more granular-level actionable data and insights that providers seek to enhance care. It is also essential to provide education on programs and measures with providers. This is also an opportunity to align required measures across payers for similarities and alignment opportunities (e.g., Kentucky Core Measure set that was developed collaboratively with the CHFS, the Kentuckiana Health Collaborative, and multiple stakeholders, providers, and payers) and to work together with DMS and across MCOs.



There Will Be Data Challenges to Work Through

Practitioner buy-in and confidence are foundational to the success we described earlier. Significant effort is required to resolve data challenges and develop accurate reporting and measurement evaluation.

Key areas include:

- Member-PCP panel attribution
- Developing appropriate rules around each specific measure to incorporate exact data elements for both numerator and denominator
- Ensuring that claims data flows to populate those metrics and serial review and adjustment with each data run
- Being accurate and transparent in explaining in detail how scorecard performance ties to payment calculations. Mistrust with data, calculations, and payments is a significant source of frustration among providers.

We are lucky to have strong and loyal relationships with our key practitioner network partners and through the Joint Operating Committee, and practice meetings can review data with group leadership and individual practitioners to get feedback. Our intensive practitioner engagement process and staff—including our CMO, medical directors, Population Health Managers and practice engagement staff who focus on clinical programs and reports with providers in their offices—have maintained strong loyalty from providers who have willingly worked with us as we take their constructive feedback and adjust our data and reports.

Our providers are the standard-bearers for these initiatives, and we work with VBP program provider groups as well as our Partnership Council and PCP Workgroup provider-driven governance groups when we experience variable provider acceptance or key feedback. Passport invests time and resources to address provider data concerns, such as (1) member-PCP attribution logic, (2) appropriate definitions for each specific measure, and (3) ensuring that claims data flows to populate metrics appropriately and leads to accurate calculations and payments. Passport is building foundations for robust reporting and analytics through internal and provider reviews.

- In 2018, provider groups offered feedback around VBP program member attribution logic and how better alignment with their reality would not only improve population health management but also help them feel more empowered to perform against program metrics and subsequently enhance their earnings. In response, Passport partnered extensively with provider groups to understand underlying opportunities with the attribution logic, iteratively refining the attribution algorithms. Provider confidence in VBP program attribution logic and its ultimate impact on earnings is of the utmost importance to Passport. Passport's VBP team worked on data issues until providers had more confidence in the attribution and data analytics. Passport's partnership with providers resulted in all groups that formally participated in the previous HealthPlus program renewing their participation for 2020. Additionally, a group that was receiving population health management support outside of the VBP program felt so supported by our analytics that they decided to join the 2020 HealthPlus program.

Face-to-Face Interactions Because Provider Engagement Is Variable

Two important lessons learned are meeting providers at their office when they have time to meet outside of member care time and to have a robust provider engagement process and team. It is crucial to analyze provider group challenges, including confusion or disagreement with measures and calculations, information or technical gaps (like with data that could come from KHIE) and support needed to achieve incentives. There are also often office workflow efficiency challenges both to accomplish the quality goals and opportunities to help connect members to broader social and community providers and programs. Passport has invested in a VBP provider engagement team that includes, beyond the traditional yet helpful PR staff in the field, the following roles:



- Population Health Managers who are practice SMEs who can help address provider challenges, including workflow; create educational materials; educate and distribute provider panel reports and actionable member data; and facilitate jointly developed CCs at provider offices to review all materials monthly
- Provider Network Operations that works on provider-member attribution and provider data management
- Analytics that works on all data rules to measure VBP metrics accurately and the performance reporting for actionable member data to inform providers and performance reports, so providers know how they are performing on scorecards related to the VBP
- Passport CMO, Medical Directors and VBP staff that work on all aspects of the program and manage the challenges and feedback from providers to find solutions. They are also the leaders for provider engagement, education, communication and support. It is their leadership that focuses on maximizing provider performance (and member health improvement) and simplification of provider administrative burden

Member Compliance Can Be Low, and Some Members Are Hard to Locate and Engage

One of the biggest challenges for both providers and health plans is having the right member contact information. Social and financial difficulties often lead members to have to change phone numbers frequently or not have a phone. Even when they have a number, they are afraid to answer or give out the information because of legal or financial risk.



Passport care team staff embed within high-volume providers' offices, sharing contact information bidirectionally to help practice staff engage members to schedule necessary preventive appointments, immunizations and care needs. Care management teams that are connecting with at-risk members during inpatient-to-home transitions or with complex-needs members also engage members for preventive care with their PCP. Passport also has a member incentive program to reward engagement, including getting necessary PCP or prenatal appointments or care and other healthy behaviors. The care coordination team can also help arrange transportation when needed, eliminating that barrier for some members in obtaining care.

Meet the Providers Where They Are in Their Transition to Value-Based Payment Models

Providers are at different points in their transition to VBP models beyond traditional fee-for-service payments. Targets in VBPs need to be achievable for providers, regardless of where they are in this transition, and must be based on change over time rather than fixed metrics. “Meeting providers where they are” is multifaceted, and it is very important to have experience implementing and managing provider VBP programs. Having the right levels across a continuum of provider risk tied to the VBP program (e.g., upside only, partial risk, full risk, partial capitation or full capitation) allows for providers to participate at different levels. We must also ensure that the correct model sophistication is used (e.g., activity based, mixed model or outcome based) and that we understand our individual provider group’s competencies and comfort levels and offer the appropriate level of risk payment program. Lastly, thresholds for metrics must be adjusted incrementally to improve performance and reward providers as they progress year after year.

Early and Frequent Earnings Payouts

Paying out program earnings as early and frequently as possible makes a VBP program “sticky” with physicians; that is, it will help physicians sustain their involvement with the program. To the extent permitted by the VBP program model and data needed to evaluate performance, it should include periodic or performance-conditioned interim payments. As we noticed in our early experience, having VBP metrics limited only to HEDIS quality metrics meant that payments often would not be finalized until Q3 of the following year to have data be finalized to be accurate for completeness and payment. This was not financially viable to many small and large provider offices because to improve member health and hit accompanying quality-of-care targets, you often need additional staff or technology investments. However, we found that interim payments for activity-based models and shortening the lag time to finalize total payment after the measurement period ends for outcome-based models allowed for some regular activity-based payments and an often larger payout based on quality performance.

Focus on Meaningful Outcomes over Activity

Passport’s philosophy in “meeting providers where they are” includes helping providers new to value-based care build the infrastructure needed to support future participation in VBP programs (i.e., a CMS Health Care Payment Learning and Action Network [LAN] Category 2 program). For some providers, this took the form of a per member per month (PMPM) care management capitation to help providers fund and integrate population health management that would foster fruitful participation in VBP programs. One of Passport’s largest provider groups began their transition to value-based care with such a PMPM capitation; from there, Passport partnered with the provider group to evolve their participation over several years to that of an upside outcome-based VBP program with analytics and tools to support performance (i.e., a CMS Health Care LAN Category 3 program). Passport recognizes that to shift focus to meaningful outcomes, it may need to help providers set the foundations with stepwise VBP payment strategies that ultimately support more independent population health management.

Successful Passport VBP Programs

Several of the VBP programs that Passport has implemented have produced outcomes that we are proud of and hope to expand on in the coming years. Some examples of meaningful results include:

- Behavioral-health focused shared savings model with Centerstone Kentucky (Seven Counties Services) served 142 members with severe mental illness for up to six (6) months over a period of nine (9) months and observed the following impact:
 - Sixty-three percent (63%) reduction in combined medical, emergency, and behavioral health inpatient expenses
 - Forty-five percent (45%) reduction in inpatient hospital stays
 - Twenty-seven percent (27%) reduction in ED visits
 - Sixty-nine percent (69%) reduction in hospital readmissions
- The HealthPlus PCP program, Outcome-Based Shared Savings program, with seven (7) PCP groups—approximately thirty-seven percent (37%) of plan membership (about 120,000 lives) and sixty-one percent (61%) of network providers (2,100 providers)—**generated \$6.7 million in shared savings in 2018.**
- VBP program with Care Management PMPM for Clinically Integrated Network (CIN) achieved the following measurable outcomes:
 - Reduced MER six percent (6%)
 - Exceeded the target for HbA1C control greater than or equal to nine (9) adults by thirty-eight percent (38%)
 - Decreased inpatient PMPM by thirty-four percent (34%)
 - Decreased outpatient PMPM by seventeen percent (17%)
 - Decreased ED PMPM by eleven percent (11%)

C.9.j.ii. Recommended goals and focus areas in the first two years of implementation of the VBP program.

Recommended Goals and Focus Areas for Our VBP Programs

Passport launched the 2018 HealthPlus VBP program, incorporating extensive provider input with design and metric selection from both the provider-driven PCP Workgroup and approval coming from the Partnership Council, and continues to integrate provider feedback as it evolves and grows the program.

Passport’s goals for the first two (2) years of implementation of the VBP program include:

- Developing an even more reliable, accurate PCP program model that provides precise data measurement, reports and payouts to providers
- Seeing improvement in provider scorecard indicators in terms of target quality and utilization metrics year over year
- Maintaining the high level of provider satisfaction from survey data among Passport’s VBP provider groups as well as indirectly from improvement in target quality and utilization metrics, leading to stronger provider incentive payments to reward clinician and office staff efforts
- Improving VBP provider retention by satisfying existing provider groups and adding new provider groups to the HealthPlus program, eventually incorporating most of the applicable provider network

- Continuing to build confidence and comfort in the practice level effort and panel member management necessary to drive success in VBP and move PCP provider groups ultimately to more advanced risk-based contracts as providers are willing and able in later phases, as well as to start to develop several bundled payment VBP models with specialists, including behavioral health, OB/maternity and possibly other specialties



The intent is to continue to scale this program across the network, strategically moving providers along the value-based continuum. Passport will advance VBP programs when providers are ready and willing. Passport will use the Centers of Medicare & Medicaid Services (CMS) Health Care Payment LAN Framework as our framework for defining APMs, such as VBP programs, which includes a four (4)-category payment model classification system:

- Category 1: Fee for service with no link of payment to quality
- Category 2: Fee for service with a link of payment to quality and value
 - Including foundational payments for infrastructure and operations, payment for reporting, rewards for performance and rewards, and penalties for performance
- Category 3: Alternative payment models built on fee-for-service architecture
 - Including APMs with upside gainsharing or APMs with upside gainsharing and downside risk
- Category 4: Population-based payment
 - Including condition-specific population-based payment or comprehensive population-based payment

In time, Passport hopes to move more providers from Category 3 to Category 4 APM contracts. As the program continues, Passport will work with DMS to advance program sophistication and performance targets so that HealthPlus impacts priority focus areas for Kentucky. Also, we propose to implement a few smaller programs of a more transformative nature, especially moving to develop specialty provider VBP programs. These will focus on a smaller number of specialty providers but focus more comprehensively on the quality metrics and member health goals demanded.

For example, we identified a need to engage behavioral health hospitals to focus on post-discharge management specifically. We have developed a program whereby Providers could earn additional incentives resulting in payment above the traditional per diem if they achieve two goals: connection to an outpatient visit within seven (7) days and avoidance of thirty (30)-day readmission.

To maximize the impact on quality and population health, Passport focused on nonclaims-based clinical data to drive performance. Passport is currently partnering with several large provider groups for EMR integration. Not only does this enhance performance reporting and analytics, but it also allows for more real-time bidirectional communication on member impact opportunities.

Other overall focus areas that tie back to our goals in the first two (2) years of our VBP programs:

- Continue to refine our provider data management and analytics to attribute members to provider panels with a high specificity, leading to highly reliable provider panels and actionable panel reports

- Expand provider engagement, especially with our larger provider groups, and encourage them to allow more practices to have CCs with our PHMs to review actionable member data and support practice workflow transformation at regular repeating intervals
- Encourage increased provider attendance and active participation, discussion and feedback at our PCP Workgroup (a subcommittee of the Quality committee) and the Partnership Council

C.9.j.iii. Proposed approaches to collaborate with the Department and other MCOs to develop the VBP program and to implement a coordinated approach to achieve statewide improvement in outcomes.

Collaborating with DMS and Other MCOs

Passport is fully supportive of anything it can do collectively with DMS and other MCOs to relieve burdens on its providers and improve the health of its members. As described previously, Passport has extensive experience collaborating with providers and DMS in the development of the VBPs implemented to date. We will continue this process and welcome the opportunity to engage with the other MCOs to establish statewide targets.

Passport understands the work entailed by all parties to set up systems to measure outcomes accurately. For smaller provider groups that work with multiple payers, this could be quite cumbersome and challenging to accomplish if the provider must create unique measurement systems for each payer. On a larger scale, it is challenging to aggregate data and demonstrate a collective impact on health outcomes if the information is being gathered in slightly different ways to measure similar constructs.

One approach that Passport is open to is working collaboratively with DMS and the other MCOs, together with input from provider groups, to decide on one standardized metric set that each PCP group would be measured against for performance. This was done with the Kentucky core measure set initiative, sponsored by the CHFS and managed jointly with the Kentuckiana Health Collaborative, to gain consensus on metrics that would be incented and implemented in a more standardized fashion for measurement-based care across MCOs.

While the specifics and subtleties of contracting might be unique to the MCO and provider relationship, the agreed-upon key measures and methods for capturing their outcomes could be determined and standardized in advance. Having single standardized quality and utilization **Kentucky Population Health Metrics**, all provider groups would become very familiar with the measure sets and would be able to focus their resources on managing to those core metrics.

Narrowing metrics runs the risk of a “managing only to the measures” bias and not focusing on the whole person. But as mentioned before, under lessons learned, choosing metrics wisely is key. Including broad primary care initiatives like EPSDT ratios and access by adults, children and adolescents to primary care, well-child visits and other adult screenings would ensure that members are getting core, high-quality primary care.

This would also allow DMS to collect data from each MCO regularly and be able to publish statewide provider data across these key metrics, removing the barrier that each MCO was asking providers to divide their focus. With the Kentucky Population Health Metrics, statewide data could be measured for each group



regardless of what stage of CMS Health Care Payment LAN framework they are at from a VBP category. Even groups that were still at Category 1 (fee for service with no link of payment to quality) would receive performance data on the standardized measure set if DMS and the MCOs were to consider collaborating in this initiative.

By collaborating with DMS and the other MCOs to select targets for improvement and standardizing the measurement for outcomes, we would help the practitioners tremendously by avoiding multiple metric sets from each MCO, which frustrate their ability to focus as well as distract them from the primary focus of member health. Standardizing to a core measure set would also help DMS and the MCOs determine on a much larger scale the impact of interventions and meaningful changes in health for the Commonwealth.

Another approach to collaboration we propose is to broaden the standardized metrics that DMS and MCOs would collaborate on to a broader focus of preventable utilization across the population. These **Kentucky Preventable Utilization Metrics** could include ambulatory care sensitive condition ED visits per 1000, inpatient admissions per 1000, and all-cause 30-day readmissions rate. This approach would put a significant focus on PCPs identifying their at-risk members (at risk for ED visit, admission, or readmission) and ensuring they are managed as well as emphasizing the need for members to have access to acute primary care beyond regular hours.

The third approach to DMS and MCO collaboration we propose is to develop a standardized approach to measuring the quality of maternity care across the Commonwealth members and OB/GYN providers. It would also incentivize collaboration between OB/GYN and PCPs as well, especially since often prenatal care responsibilities are shared based on pregnancy stage, which is an opportunity for a member to fall through the cracks. With input from OB and PCP providers, we could establish the **Kentucky Maternity Monitoring Metrics** that could include the frequency of ongoing prenatal care (FPC), prenatal and postpartum care (PPC), primary C-section rate, preterm delivery rate and neonatal abstinence syndrome (NAS) rate per 1,000 live births. Such a collaboration would be an important focus of standardization for this very vulnerable population.

Any of these approaches to collaboration would most likely require additional staff or technology investment from the primary care and OB/GYN practice groups. It would be an important step to promoting any of these initiatives for DMS and the MCOs to also come together along with a broad, diverse provider group feedback panel to discuss standardizing the incentive payments or possibly adding a kick payment or additional incentive tiering model from the state for high-quality performance.

Regardless of which collaboration initiative is chosen or considered, **building the VBP program with the provider's input end-to-end** is crucial to the success of any DMS and MCO collaboration. Passport is uniquely positioned to ensure provider input to a collaborative process by leveraging our long-standing Partnership Council and Primary Care Workgroups. These groups have been providing Passport with advice and governance for over twenty (20) years. Passport would be happy to engage in convening this diverse group of providers that represents providers across the state and gauge their interest in being part of a

focus group that meets regularly with DMS and VBP leaders from other MCOs as a feedback group for any initiatives from DMS and MCO collaboration.

C.9.j.iv. Potential challenges specific to Kentucky and the Vendor’s proposed methods for addressing identified challenges.

Addressing Kentucky’s Specific Challenges

Although Kentucky experiences poor health results across the Commonwealth, especially outside of urban areas, there are often unique regional characteristics that make varying contributions to health. This is especially true in the health care delivery system, where distance and time often have a different meaning, whether that is getting around a range of mountains in eastern Kentucky, Lake Cumberland in southeastern Kentucky or crossing the land between the lakes in far western Kentucky. There are similar examples throughout the state. Factors such as this contribute to challenges in creating an extensive program that fits across the entire landscape, a landscape that from the provider’s perspective is ideally agnostic to payer source. Said another way, the providers would prefer a universal system across all Medicaid MCOs as well as commercially insured clients. Passport believes that there is an excellent opportunity to unite all stakeholders to create a more uniform solution for all of Kentucky.

Other specific challenges that Passport believes are impacting providers and system development across Kentucky include:

- Limited access to concurrent data
- Limited access to member contact information
- Wide variance in member attribution at the provider level
- Wide variance in access to providers
- Variability in community and social supports
- Lack of common approaches by payers



Limited Access to Concurrent Data

The evolution of the KHIE offers an outstanding opportunity to connect health records across the state. Passport is ready and willing to work with the Cabinet to support widespread utilization. This method of interconnectivity, and the rich data collected in the KHIE, offers practitioners and MCOs a unified way to submit or access data in real time or near real time to help populate data fields and metrics and close specific care gaps. It would also help inform immediate hot spots to focus on, such as members who are in the hospital or ED, to ensure safe and smooth transitions and reduce readmissions. Within our network of contracted providers, we are working to grow connectivity to increase access to “real-time” information concerning admission, discharges and transfers, additional transitions, and gaps in care. Passport also understands that many hospitals are electing to participate in a collaborative that allows information to be shared regarding ED visits among those facilities that are participating.

Our proposed methods to address the challenge are to evaluate all our VBP-participating provider groups and all our other large member volume practices and meet to discuss and potentially assist them in

connecting to KHIE. Our IT director is very willing to review a provider's EHR capabilities and technical requirements, and Passport would be willing to assist the groups in applying for the recently announced Provider Assistance program or any grant or extramural funds available for connecting to KHIE. Passport is considering offering an incentive to offset a provider's implementation costs.

Limited Access to Member Contact Information

Member contact information is often a challenge for both plans and providers because our membership is often financially and legally at risk and will often not have consistent phone numbers or be willing to share contact information, including their address.

Our proposed methods to address the challenge would be to have a bidirectional feed for contact and demographic information much like the state database for childhood immunizations so that any provider, facility, pharmacy or plan would have secure access to necessary contact information to help in emergencies as well as to help providers and plans support members with their health care needs.

Wide Variance in Member Attribution Panel Sizes at the Provider Level

VBP programs tend to flourish in situations where providers have significant member volume, thereby making certain staffing, process and protocol changes needed to drive performance worthwhile. Larger provider groups are better able to make these necessary changes and fund the resources needed to support them; these groups typically reside in urban or suburban parts of Kentucky. It is difficult to use VBP programs to drive health care improvement in rural settings, which tend to have significantly smaller provider groups or independent practitioners. If the ratio of members on a provider panel is small, it also complicates the identification of a significant trend, addressing actuarial soundness at the micro level and creation of an incentive program and pool that is likely to facilitate behavior change. Smaller panel sizes also make it harder to identify actionable clinical-improvement trend opportunities due to low utilization volumes (e.g., if a practice has less than one hundred [100] deliveries per year or a practice has only zero to three [0-3] admissions per month).

The method we propose is to aggregate providers into functional collaboratives, similar to clinically integrated networks or Kentucky Primary Care Association (KPCA), where several smaller groups could have their data pooled to be able to identify trends and focus efforts and smooth out the data challenges that affect small numbers to be able to address actuarial soundness, especially when it comes to incentive payments for providers.

Wide Variance in Access to Providers

This has obvious impacts on referrals to specialists and delays in seeking early preventive services. Issues such as this can disproportionately impact a provider or region due to the utilization of high acuity services while solutions are identified and implemented. A less obvious example for some would be the reality that many counties in Kentucky do not have ready access to "private" ambulance services and might have only

one (1) or two (2) ambulances for the entire county, supported either by a local hospital or local government. This limitation on ground ambulance transportation can increase the need for the use of air transport, not only for tertiary or quaternary care but also for an initial evaluation at a local facility. The providers are evaluated before launch because regional variations can have adverse impacts.

Our proposed methods to address the challenge is to sit down with these provider groups to get their feedback to the access challenges with their members and brainstorm solutions, including educating them and their members on the broader use of telehealth and discussing opportunities for the plan sponsored transportation options for members. We would also consider in a VBP program adding additional dollars proportionally to support and incentivize increased primary care access after regular business hours and on weekends for these rural provider groups.

Variability in Community and Social Supports

While the urban areas have greater access to many services in absolute numbers, it does not always translate into significant improvement at the global level. Passport believes that lack of availability of many of these services will contribute to poor performance in health care results, i.e., quality and costs. Anything that impacts quality and health care costs will have an impact to consider in a VBP program. We understand that community and social supports are important to addressing the holistic needs of members independent of where they live. As a result, we use systems to track resources (Healthify and Unite Us) to assist in resource finding for our members.

Our proposed methods to address the challenge include meeting with our VBP provider groups to discuss and gain their feedback on what challenges they have in connecting at-risk members to the community and social supports. We can then offer care management support, even at specific times in their offices, to meet directly with members and to help connect at-risk members to ancillary community resources, especially community mental health services so often necessary in our vulnerable populations. Passport health educators are also willing to train and offer access to its internal resource database identification systems (Healthify and Unite Us) that it uses to identify support for at-risk members. Passport provider relations is also willing to contact any unresponsive community agencies on behalf of the provider groups that might be having trouble placing at-risk members.



Lack of Common Approach by Payers

Passport believes that providers want to focus on providing health care—what they do best—rather than keeping track of multiple programs for various health plans. It is easy to think only about the program that we offer or that other Medicaid MCOs might offer. From the provider perspective, there are these and so many more for commercial insurers, Medicare, TRICARE and other payors. Considering the scenario from a much broader view, we understand why providers are frustrated and why the results that we all want to achieve have been slower to materialize and track over time. Passport welcomes the opportunity to participate in a statewide DMS and MCO collaborative to reach common ground, potentially following a

model like the development of the Kentucky Core Measure Set. Although there might be unique characteristics to consider, the value is worth the effort.

Nationally, no standardized metrics exist for VBP programs. CMS is currently updating the quality metrics that will be used for MIPS in 2020 and will provide standardized measurement-based care metrics by specialty area. This standardization will simplify VBP on many levels.

Our proposed methods to address the challenge are detailed in the previous section; we suggest convening a broad representation of statewide provider group leaders with MCOs and DMS. Or, we would be glad to ask the Passport PCP Workgroup and Partnership Council to volunteer to be the focus group and to gather their feedback on a proposed standardized Kentucky Population Health metric set that would be tracked statewide across entire membership panels, inclusive of all MCOs, tracked over time, and publicly posted. DMS and MCOs could consider either continuing to have each MCO and provider negotiate their VBP payment models or potentially standardizing a single statewide payment model.

C.9.j.v. Regardless of the model implemented, the Vendor’s approaches to analyzing performance against targets, frequency of analyses, reporting results to the Department and use of analyses to modify interventions that are not making progress towards achieving targets.

Passport’s Approach to Performance Analysis and Reporting

Passport uses its standard PDSA approach to analyze performance. Once the VBP measures are selected, we embark on the following process during our implementation and ongoing operations:

- Establishing a performance baseline—key to selecting measures and ongoing trends
- Selecting a target or goal—these may be developed from a percentage improvement required, informed by trend performance or selected, and extrapolated from the “best-in-class” 50th or 90th percentile nationally
- Implementing the intervention—in this case, the VBP metric set performance by provider group and if possible, by the individual provider; however, this raises the issue of small number bias
- Assessing performance compared to goals or targets at least quarterly and meeting with each provider group leadership in JOC quarterly to discuss performance and feedback. We will also use our provider engagement staff, including practice facing Population Health Managers, to meet with individual practices in CCs monthly with actionable member data reports that help providers understand and identify at-risk members and members who have open care gaps. This important process step is defined in more detail below.
- Conducting a root cause analysis if overall program performance is not tracking to achieving the goals. One important goal of the VBP program is to make sure that provider groups can attain the chosen metrics. Sometimes the actual metric performance trend doesn’t follow preliminary expectations due to real-world challenges, and we want to make sure that we make any midcourse corrections that make our VBP program metrics fair and reasonably attainable by the provider groups.
- Conducting a root cause analysis if the individual performance by groups is not tracking to achieving the goals. This activity is done in collaboration with the provider groups.

- Implementing a midcourse correction as warranted.
- Re-monitoring performance in the next quarter.
- Submitting aggregate performance on the VBP program metrics to DMS at least annually or upon request, including a summary of actions taken.

We have determined that a quarterly evaluation gives providers enough time to impact the metrics, while still providing us the opportunity to adjust program metrics or elements together as needed.

Passport takes a two (2)-tiered approach to physician engagement and scorecard report distribution that offers a comprehensive top-down and bottom-up structure.

JOC meetings: The purpose of the quarterly in-person JOC meeting is to work collaboratively with the provider organizations' executive leadership teams to discuss group-level program performance data and best practices that ultimately lead toward improved quality and satisfaction for members while reducing unnecessary expense. These meetings allow us to work with the practitioner group leadership to review interventions, measure result progress and jointly determine opportunities for improvement.

CC meetings: The purpose of the monthly CC meeting is to engage organizations' key practice managers and providers, ensuring that they understand the VBP program and have actionable information they can use to address member health opportunities. Passport's PHMs play a critical role in supporting practice-specific performance as SMEs around practice transformation, specifically clinical care management programs and VBP initiatives.

CCs' focus goes beyond just the VBP metrics and elements. We use the opportunity to provide feedback and inform about broader HEDIS, EPSDT, quality and clinical action items that we can work on together to benefit member health more broadly as well as improve relationships between Passport and its practitioner network. Passport has an extensive support team for its providers in addition to the PHMs, including CMO, medical directors, care managers, pharmacists, BH specialists and community health workers. As data-driven opportunity areas necessitate, these SMEs will join JOCs and CC to help providers take concrete action steps to improve member care while efficiently using resources. This unique, comprehensive support strategy fosters candid conversations and a shared commitment to improving member care.

We also share feedback on our VBP programs and our JOCs and CC meetings with Passport's provider-driven PCP Workgroup and Partnership Council as part of our regular program governance, especially because many of them are leaders within the VBP network. We regularly share and update them with feedback, both on performance results and feedback from JOCs and CC meetings so they can suggest and implement midcourse corrections and adjustments to program elements and metrics, but also including feedback from any part of the VBP process, such as data, reports and incentive payments.

Reporting to DMS is provided annually or as requested, and we will notify DMS of any major program adjustments. We welcome further cooperative development with the other MCOs and DMS.

9.k. Will the Vendor and Subcontractors implement VBP arrangements with providers? If so, describe the following:

C.9.k.i. The types of VBP arrangements the Vendor and Subcontractors plan to use and why these models were selected. As part of your description, map your proposed VBP arrangement to the HCP-LAN APM Framework maturity level.

Alternative Payment Model VBP Programs

Partnership in Advancing Value-Based Programs

Passport believes that to improve the health care system, it is essential to transition from fee-for-service payments that incentivize volume to APMs such as Provider Incentive Plans, which reward providers for keeping their members healthy. Passport defines a Provider Incentive Plan as any compensation program that rewards providers for improving the quality of member care and outcomes. Although a Provider Incentive Plan is often implemented in the form of a value-based purchasing (VBP) program, it can also take place through per member per month (PMPM) incentives that help providers establish a population health management infrastructure.

Passport knows that taking on risk is often intimidating for providers, and they are therefore hesitant to engage in a shared savings program.



Passport is unique in its commitment to understanding the challenges providers face in the shift to **value-based purchasing models**, as evidenced by the meaningful steps Passport has taken to ensure that the provider community has direct input into the evolution of VBP through forums such as the Partnership Council.

We focus on infrastructure development with our providers to support that shift. Most providers in our network still need to enhance their population health management capabilities before participating in more advanced forms of APMs. As a result, Passport has partnered with several providers to administer foundational Provider Incentive Plans that establish population health infrastructures such as a PMPM payment for care management services or PCMH certification. These programs help providers build core VBP capabilities by allowing for incentives to change behavior.

Passport is committed to advancing the progression of the delivery system in Kentucky toward a focus on higher quality and better outcomes. The pages that follow will describe, in more detail, the following innovative approaches Passport is taking to ensure that the provider community is modifying its behaviors and participating in a meaningful way in our programs that are supporting this evolution toward value:

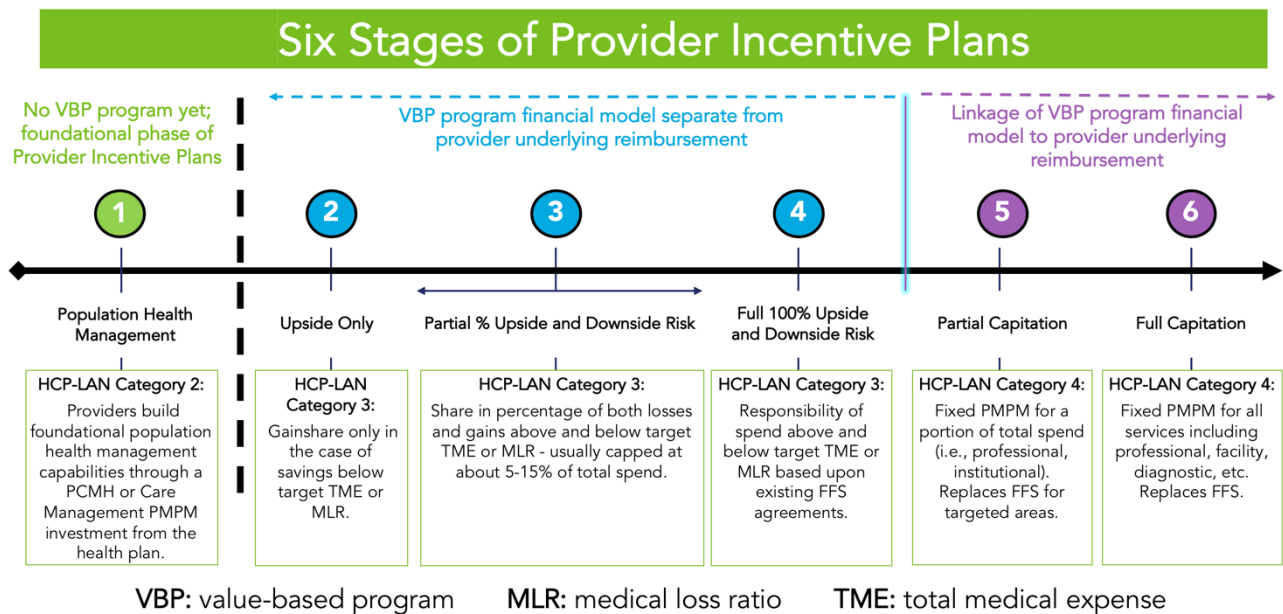
- Develop, and continue to evolve, a variety of Provider Incentive Plans that “meet the provider where they are” in terms of infrastructure, capabilities and risk tolerance
- Invest in providers’ ability to advance their population health capabilities by providing financial support for infrastructure buildout
- Incorporate customizable quality measures, designed for the needs of a specific practice, such as adjusting for adult primary care or pediatric care
- Provide meaningful, actionable data in a format that is readily available and easily digestible
- Provide frequent on-the-ground coaching and support through our PHMs

- Hold regular JOCs and CCs with providers participating in one of our VBP programs

Passport’s Forward-Facing VBP Program Strategy

Exhibit C.9-15 below depicts the six (6) stages of Provider Incentive Plans. The first phase is a preparation phase, focused on building core population health capabilities through the aforementioned per member per month (PMPM) programs. Stages Two (2) through Six (6) incorporate a VBP program with increasing levels of provider risk. Given that we do not consider Stage One (1) to be VBP in its truest form, we will focus on Stages Two (2) through Six (6); section C.03, **Capitation**, contains more detail on the Stage One (1) programs.

Exhibit: C.9-15: Glidepath of Physician Incentive Plans



Passport **will advance VBP programs** when providers are ready and willing. Passport will use CMS’ HCP-LAN framework as our basis for defining APMs, such as VBP programs, which includes a four-category payment model classification system, as follows:

- Category 1—Fee-for-service with no link of payment to quality
- Category 2—Fee-for-service with a link of payment to quality and value
 - Including: Foundational payments for infrastructure and operations, payment for reporting, rewards for performance, and rewards and penalties for performance.
- Category 3—Alternative payment models built on a fee-for-service architecture
 - Including: APMs with upside gainsharing or APMs with upside gainsharing and downside risk
- Category 4—Population-based payment
 - Including: Condition-specific population-based payment or comprehensive population-based payment

Most of Passport’s providers are in the very early stages of VBP program sophistication. Currently, our Care Management PMPM and Member-Centered Medical Home PMPM programs align with LAN framework Category 2. However, Passport’s primary care upside-only outcome-based VBP program, HealthPlus, aligns with LAN framework Category 3. Passport’s goal is to graduate as much of its network as possible into some form of risk-sharing through Category 3 (financial model separated from underlying reimbursement) and Category 4 APMs (financial model linked to underlying reimbursement, such as bundled payments).



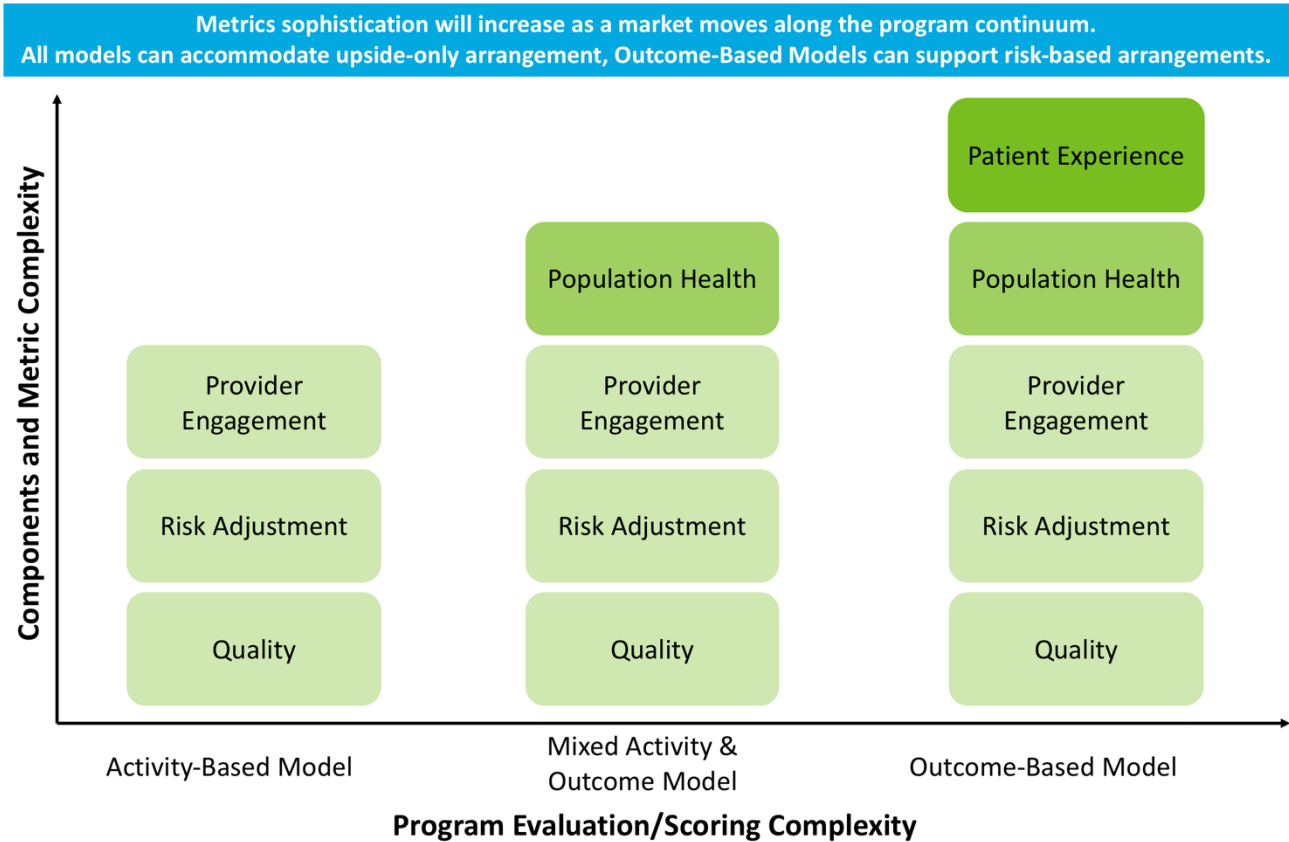
While Passport is evolving its VBP programs with an understanding of provider readiness, we have devised a forward-facing strategy to move providers along the risk continuum. Passport recognizes that payment transformation must be deliberate and incremental, and thus has developed a tiered VBP program framework that allows for more mature models as providers improve population health capabilities.

Our VBP program strategy has the following three defined stages:

1. The first stage is an **Activity-Based Model** in which providers receive a defined payment for completing specific tasks around quality, risk adjustment and provider engagement (i.e., submitting Member Assessment Forms for risk adjustment, attending JOC meetings, etc.).
2. The second stage is a **Mixed Activity-and Outcome-Based Model** in which providers can earn defined dollars by completing specific tasks and performing well on metrics around quality, risk adjustment, provider engagement and population health (e.g., exceeding the HEDIS 50th percentile, reducing ED utilization by a particular percentage relative to prior year).
3. The third stage is an **Outcome-Based Model** in which providers can share in savings by performing well on metrics around quality, risk adjustment, provider engagement, population health and member experience. For providers needing encouragement to try an outcome-based model, Passport may incorporate additional PMPM earnings to reward high-quality scorecard performance even if the MER does not decrease to generate shared savings. Furthermore, we may also offer a PMPM bonus for providers with an already efficient MER, which may be hard to reduce further.

Our VBP models have a sliding scale of program sophistication while covering the full risk continuum. Risk-bearing VBP programs will have proportional upside and downside risk for the providers. Since 2018, Passport has more than doubled the number of provider groups participating in LAN Category 3 APMs, and we plan to continue to engage more groups in shared-savings VBP programs. As providers establish foundational capabilities for upside gainsharing VBP programs and become comfortable in population health management techniques, we would like to introduce partial or full risk VBP programs. Should a particularly advanced provider group be ready and willing, Passport would welcome the opportunity to deploy LAN Category 4 APMs, in which we combine a capitation arrangement with an outcome-based VBP program. **Exhibit C.9-16** provides an overview of our strategy for aligning metric type with program sophistication.

Exhibit C.9-16: Program Evaluation and Scoring Complexity



Passport’s Experience with VBPs

A core tenet of Passport’s VBP philosophy is to “meet providers where they are.” Passport has deployed several physician incentive plans, including VBP models, over the last several years. We have taken meaningful steps, such as through the Partnership Council and PCP Workgroup, toward ensuring that the provider community has direct input into the evolution of our VBP programs and that they have the support they need to be successful. Passport has refined the models we currently have in the market based on our learnings and input from the provider community. The following pages describe those VBP programs that will serve as a springboard for future models as providers are ready to participate in more mature HCP-LAN framework categories.

Below we detail four (4) VBP programs that progress along the HCP-LAN framework continuum that: (1) demonstrate Passport’s experience launching a provider-centric primary care VBP program, (2) demonstrate our Behavioral Health Shared Saving Models, (3) exemplify a VBP pilot program for foster care, and (4) highlight a sample downside risk arrangement that incorporates capitation in another market supported by Passport’s subcontractor, Evolent.

HealthPlus Primary Care VBP Program

Passport launched its primary care HealthPlus VBP program in 2018 after receiving input from the PCP Workgroup and approval from DMS. HealthPlus is uniquely physician-centric and is built upon the following guiding principles of Passport’s value-based care strategy:

- Ensure value-based incentive strategy aligns with the plan’s mission and governance from DMS.
- Begin by focusing on an (adult/pediatric) PCP incentive program designed to manage quality and cost at the member level. Confirm the program has metrics that are inclusive of all primary care practitioners—pediatric, family medicine, and adult-only internal medicine practitioners. Continually work with providers to iteratively test and improve the program to create the best approach.
- Ensure the value-based incentive program is driven by a true partnership between the plan and providers, including sharing information and resources to attain success. Provider engagement and communication are critical elements of the program.

HealthPlus is an upside-only provider gainsharing program that rewards providers for improved cost and quality outcomes after a quality gate has been achieved. The program is uniquely physician-centric and rewards incremental progress. In direct response to feedback from our provider community and lessons learned from implementing earlier versions of the program, in 2020 Passport is offering three earning mechanisms as an enhancement to the program, as compared to its initial roll-out in 2018, which had only two earning mechanisms. The three earning mechanisms are further described in **Exhibit C.9-17**. In the exhibit, “MER” is the medical expense ratio, the percentage of premium spent on health care for assigned members, and “YoY” stands for year-over-year.

5 PCP Groups

5 Domains:

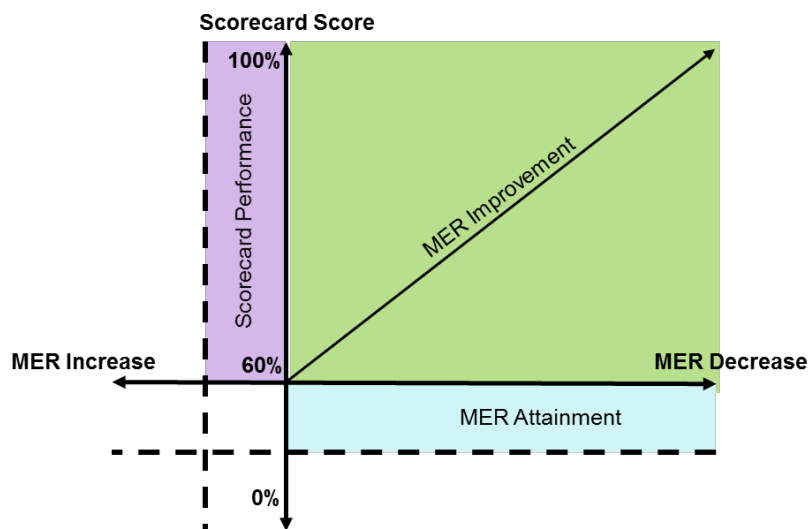
- Population Health
- Risk Adjustment
- Provider Engagement
- Patient Experience
- Quality

Payer Program Design

Exhibit C.9-17: HealthPlus Outcome-Based Earning Opportunities

There are 3 separate potential earning mechanisms for a participating provider group; the mechanism with the greatest calculated payout will be the one applied.

- **MER Improvement** earnings potential is generated from their individual cost savings from YoY lower MER. The portion of the incentive shared with the provider group is based on their scorecard performance, minimum of 60%. A group can earn up to 50% of its incentive potential.
- **MER Attainment** earnings rewards provider groups that maintain an MER at or below 85% in the case their MER does not improve. Groups must have at least 60% on the Scorecard. MER Attainment only applies for groups that do not have MER improvement.
- **Scorecard Performance** earnings mechanism rewards providers for achieving at least 80% on their scorecard. This earning mechanism only applies for groups that do not have any MER improvement or MER at or below 85% (MER Attainment).



The Passport Quality Scorecard, shown in **Exhibit C.9-18**, includes fifteen (15) quality measures, customized to the needs of the specific practice, such as adjusting for adult primary care or pediatric care. Performance is measured over a calendar year, and rewards are paid out the following year once claims have matured, creating an accurate measurement of the provider’s performance. These quality metrics were carefully selected with the PCP Workgroup focusing on performance opportunities for the health plan and aligned with areas in which providers felt they could have a meaningful impact. The metrics go through a process of refinement based on participating group feedback gathered through in-person meetings and a survey. Please see our response to C.03 Capitation for additional details on how the program evolved from 2018 to 2020.

Exhibit C.9-18: 2020 HealthPlus Scorecard Performance Metrics

Domain	Measure	Weighting
Quality Adults	<ol style="list-style-type: none"> 1. Comprehensive diabetes care—HbA1c testing 2. Antidepressant medication management—acute phase 3. Medication management for adults with asthma-appropriate medications for at least 75% of the treatment period 	25% Weighted Adult
Quality Pediatrics	<ol style="list-style-type: none"> 1. Medication management for children with asthma-appropriate medications for at least 75% of the treatment period 2. Adolescent well-care visits 3. Child well-care visits 4. Appropriate treatment of children with an upper respiratory infection 	50% Weighted Pediatric
Population Health Adults	<ol style="list-style-type: none"> 1. Plan all-cause readmissions 2. Ambulatory care sensitive ED rate 3. Use of imaging studies for low back pain 	25% Weighted Adult
Provider Engagement	<ol style="list-style-type: none"> 1. Practices' physician/clinical leadership and administrative leadership attendance at quarterly JOC meetings 2. Practices' key location(s) physician/clinical leadership and administrative leadership attendance at monthly CC meetings 	20% Weighted All
Patient Visit Rate	<ol style="list-style-type: none"> 1. Medicaid condition addressed rate—the percentage of suspect conditions addressed for members identified as having an intervention opportunity 	20% Weighted All
Member Experience	<ol style="list-style-type: none"> 1. The personal doctor explained things 2. The personal doctor showed respect 	10% Weighted All

In 2018, **participating provider groups generated \$6.7 million in shared savings**. Of the participating groups, a large practice serving the needs of adult and pediatric members earned incentives resulting from their performance in 2018. They demonstrated strengths in improving quality scores in all four measures for adults and reduced MER by 2.9%. Achievements in scorecard performance were less than optimal at the beginning of the program; however, we established a baseline to improve and tailor improvement efforts in 2020. **Exhibit C.9-19** reflects the final performance evaluation for participating groups in 2018.

Exhibit C.9-19: 2018 Final Performance Evaluation

Scorecard Domain	Measure	Percent of Groups that Exceeded Baseline Threshold	Percent of Groups that Exceeded Target Threshold
Quality Adults	Comprehensive Diabetes Care: Medical Attention for Nephropathy	20%	0%
	Antidepressant Medication Management	0%	0%
	Medication Management (Asthma)	80%	20%
Quality Pediatric	Medication Management (Asthma)	86%	0%
	Adolescent Well-Care Visits	29%	14%
	Child Well-Care Visits	29%	14%
	Appropriate Treatment (Respiratory Infection)	86%	43%
Population Health Adults	All-Cause Readmissions	20%	0%
	Ambulatory Care Sensitive ED Rate	80%	0%
	Use of Imaging Studies for Low Back	0%	0%
Provider Engagement	Leadership Attendance at JOC Meetings	100%	100%
	Provider Group Use of Identifi Practice	100%	100%
Patient Visit Rate	Medicaid Condition Addressed Rate	43%	43%
Member Experience	Personal Doctor Explained Things	86%	86%
	Personal Doctor Showed Respect	86%	86%

Behavioral Health-Focused Value-Based Payment Program

Centerstone Kentucky (Seven Counties Services) has been a provider with us since the BH benefit started in 2013. They were initially paid on a fee-for-service basis. Our first value-based arrangement with Seven

Counties was a pay-for-performance model under which they had the opportunity to earn additional dollars for demonstrating that they were putting recommended procedures in place and building relationships to increase seven (7) and thirty (30) day follow-up post-hospitalization. Later, the incentive was enhanced to increase the number of discharged members receiving their seven (7) and thirty (30) day follow-up appointments. Payments were made quarterly for earned incentives.

Our second arrangement with Seven Counties was a blended case rate/bundle of services. They had the opportunity to bundle a group of services and receive payment for delivery of high-fidelity wraparound services in the foster care pilot. They also had a chance to earn an incentive on top of this if they achieved their quality performance targets for the following two primary goals of the pilot:

1. Percentage of children who maintained their foster care placement or returned to their natural family
2. Percentage of children who improved their functioning on a standardized assessment

Payments on the blended case rate/bundle of services arrangement occurred monthly, with any earned incentives paid out at the end of the program.

Our current value-based arrangement with Seven Counties is a shared savings model that offers the following two opportunities to earn incentives:

- **Population Incentive:** Through our Population Incentive, Seven Counties' members are identified and agreed upon before the measurement period begins. Members are then measured for one quarter, and pre-quarter and end-of-quarter expenses per member are compared (after allowing a quarter for claims lag). A pool is created from any savings on medical inpatient stays, BH inpatient stays, and ED visits. Thirty percent of the savings over a quarter for the agreed-upon members are placed into an "incentive pool," which Seven Counties may earn. Half the pool is awarded for achieving savings. The other half is tied to the following quality measures:
 - Follow-up after hospitalization
 - Documenting members' body mass index (BMI) and having a plan for addressing it if it is outside the normal range
 - Documenting members' tobacco use, and having an intervention if they use tobacco
 - Documenting obtaining of release and sharing of records with PCP
 - Documenting obtaining of release and sharing of records with referring provider
 - Completing A1C hemoglobin screenings for members with schizophrenia or bipolar disorder
 - Documenting suicide risk assessments at least every six months for members with major depressive disorder
 - Screening members for SUD and linking to treatment if needed

- **Partners in Wellness Incentive:** Seven Counties is provided a list of two hundred (200) members (in advance of the quarter), beginning with their members with a severe mental illness and their members with the highest expenses due to their health care utilization. Seven Counties is also provided a list of members (who are not currently with Seven Counties) with a severe mental illness and higher expense rates, but who have not been engaged in care. Seven Counties can engage these members into the Partners in Wellness program, an integrated behavioral and medical case management model with 24-hour access to nursing. Again, this is a shared savings model with pre- and post-measurement before and after the quarter (after allowing another quarter for claims lag). Thirty percent (30%) of any savings over the quarter from medical inpatient stays, BH inpatient stays, and ED visits are placed into an incentive pool. Seven Counties can earn half of the incentive pool by closing the quarter with savings. The other half of the pool is tied to specific quality metrics for the intervention's following two primary goals:
 - Member activation
 - Documentation of member having a health goal with documented progress toward achieving that goal



Additional health behaviors and performance on HEDIS targets are documented for possible use as baseline clinical metrics for future value-based relationships.

The most significant challenge Passport has experienced in implementing the multiple iterations of this highly collaborative VBP arrangement is the needed investment in time, resources, and relationship-building to optimize this partnership and establish mutual trust. Both Passport and Seven Counties have invested countless hours in ensuring that data can be shared bi-directionally in a timely fashion, that processes are working smoothly, and that we are establishing meaningful measures that will truly continue to drive outcomes. As we continue the relationship, our metrics will remain focused on the member receiving whole-person integrated care to improve overall health and well-being.

During a Grand Rounds at the University of Louisville, Passport shared its BH program design with Stephen Bartels, MD, MS from the Substance Abuse and Mental Health Administration (SAMHSA) – Health Resources & Services Administration (HRSA) National Center of Excellence for Integrated Health Solutions (CIHS). He strongly supported the idea of focusing on member activation and physical health goals for outcomes for members with severe mental illness. He also reported that emerging research shows that focusing on symptoms of mental illness results in only incremental change. Dr. Bartels indicated that to achieve transformative change, the focus needs to be on overall health, even though the program was initially designed for individuals with severe mental illness. The integrated, whole-person approach helps members make impactful changes. The results of this value-based experience align with this emerging research (see **Exhibit C.9-20**).

Exhibit C.9-20: Results from Partners in Wellness Incentive Program

The program ran for 9 months and served 142 members with severe mental illness for up to 6 months each.

Within that period, we observed the following impact:

- 63% reduction in combined medical inpatient, emergency, and BH inpatient expenses
- 45% reduction in inpatient hospital stays
- 27% reduction in emergency visits
- 69% reduction in hospital readmissions

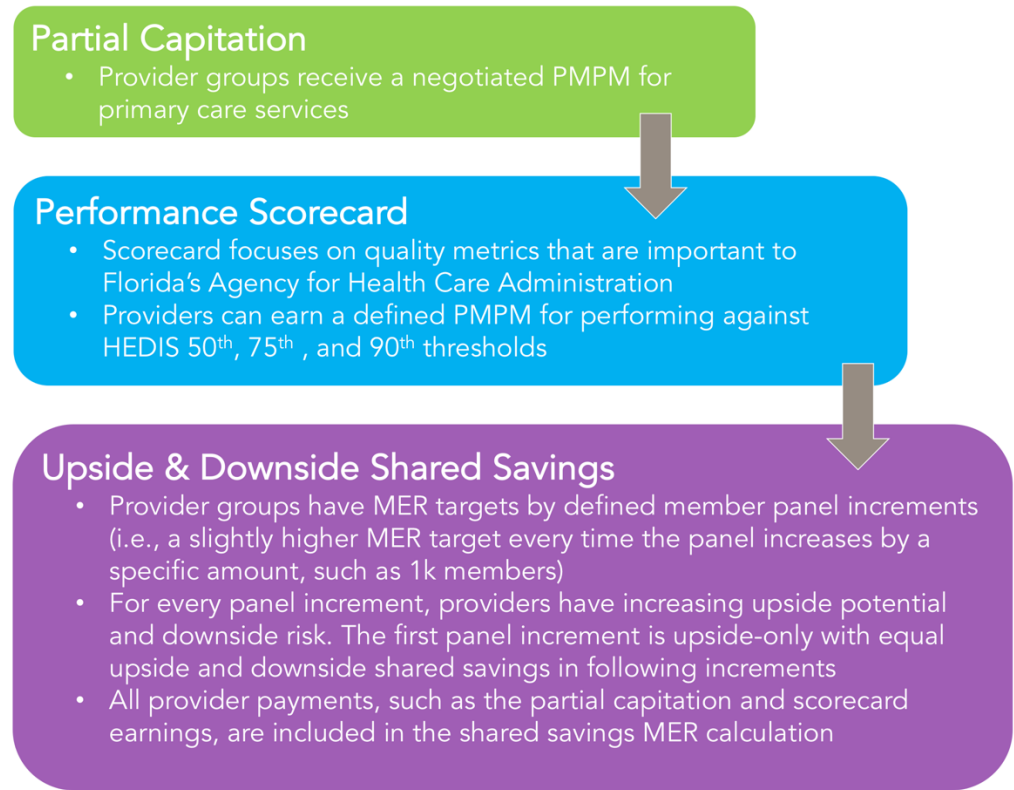
These initial results suggest we have created an integrated program that could bring medical case management into the relationship of trust with the BH provider and help us to promote appropriate utilization of intensive care resources

Members with chronic medical and comorbid mental health or substance use disorders generally experience higher costs. Because of this, savings opportunities exist through VBP programs that address this specific population.

Bringing National Capabilities to Kentucky

Passport's subcontractor, Evolent, has industry-leading experience with VBP models in markets across the nation. As the delivery system in Kentucky continues to evolve toward more sophisticated VBP models, Passport will benefit from Evolent's capabilities and experience. An example of an advanced HCP-LAN Category 4 model that is currently in place at another provider-driven, Evolent-supported health plan in Florida could be implemented in Kentucky when the provider community is ready. One of the models now in place in South Florida incorporates both differentiated underlying reimbursement (partial capitation) as well as a VBP component. Providers participating in this program have partial upside and downside risk, subject to hitting both financial and quality targets. This VBP model itself has gone through multiple iterations over the past two (2) years as the health plan has adjusted based on lessons learned and provider feedback. One specific modification made to maximize outcomes consists of adjustments to specific quality measures. Passport is prepared to implement a model such as this in Kentucky.

Exhibit C.9-21: Example Partial Capitation with Risk-Based VBP Program



C.9.k.ii. How an improvement in health outcomes will be addressed through the VBP arrangements implemented.

Improving Health Outcomes Through VBP Arrangements

Provider payment models are not considered “value-based” unless payments have a strong link to improved outcomes and cost savings. As described previously, our VBP programs include a quality gate that is applied based on an integrated scorecard of up to five (5) domains: quality, risk adjustment, provider engagement, population health, and member experience. Satisfying the quality gate thresholds is a prerequisite for providers to share in the rewards. Because of this, we expect to achieve better outcomes on the metrics included in our VBP programs. **Exhibit C.9-22** offers a list of “measures that matter” for PCPs, hospitals and specialists that are considered in conjunction with the domains and quality gates. This is a nonexhaustive list of metrics that support our VBP programs and quality gates.

As highlighted above in the HealthPlus VBP program overview, Passport teams with the Partnership Council and PCP Workgroups to select program metrics that both target areas of performance opportunity and ensure that **providers feel they can directly impact member care**. For example, when selecting program metrics, the PCP Workgroup voiced that providers were not in a position to meaningfully impact pediatric ED utilization and readmission. Accordingly, Passport only evaluates providers’ adult member panel on these population health metrics.

Exhibit C.9-22: Quality Metrics

Clinical and Efficiency	Population Health, Access and Satisfaction
<ul style="list-style-type: none"> Follow-up visit made within seven (7) days following a post-acute stay Admission rate ED utilization rate Plan all-cause readmissions (adult & peds) Ambulatory care sensitive ED rate (adult & peds) Use of imaging studies for low back pain (adult only) Completion of screenings such as the PHQ-9 for detection of depression in the primary care setting or completion of the Edinburgh Depression Scale for women with postpartum depression 	<ul style="list-style-type: none"> Expanded office hours outside the hours of 8:00 a.m. to 5:00 p.m. Member satisfaction (member experience score) Quarterly care plans Transition visit within five (5) days of discharge Physician attendance at Physician Engagement programs Pre-visit planning Visit made following the stratification of a member into a complex care program Practices adoption and use of our technology platform, IdentifiPractice
Adults	Peds
<ul style="list-style-type: none"> Comprehensive diabetes care—nephropathy Antidepressant medication management—acute phase Medication management for people with asthma-appropriate meds for at least 75% of the treatment period 	<ul style="list-style-type: none"> Medication management for people with asthma-appropriate meds for at least 75% of the treatment period Adolescent well-care visits Immunization status—Combo 2 Appropriate treatment of children with upper respiratory infections
Specialists VBP Measures that Matter	BH VBP Measures that Matter
<ul style="list-style-type: none"> Many of the PCP metrics and specialist metrics can cross over to others Hospital readmission at thirty (30), sixty (60), ninety (90) and one hundred and eighty (180) days (including psych.) Follow up after hospitalization (all types) Cesarean section and early elective delivery rates Obstetricians—prenatal care (first-trimester prenatal visit, frequency of prenatal care visits, six (6) weeks postpartum) Medication management, including follow-up targeting specific types of drugs 	<ul style="list-style-type: none"> Initiation and engagement of alcohol and other drug dependence treatment (IET) Antidepressant medication management (AMM) Follow-up care for children prescribed ADHD medication (ADD) Participation in vocational rehabilitation and other measurable results

Hospitals VBP Measures that Matter	Maternity/OB VBP Measures that Matter
<ul style="list-style-type: none"> All-cause readmission rate Risk-adjusted average length of stay Hospital-acquired conditions/infections Emergency to observation/inpatient escalation rate Radiology service utilization National Member Safety and National Quality Improvement goals Hospital Consumers Assessment of Healthcare Providers and Systems (HCAHPS) Mortality rate for three (3) conditions present on admission indicators Admission notifications within twenty-four (24) hours 	<ul style="list-style-type: none"> Regarding OB specialty, our quality gate would focus on OB care using Medicaid HEDIS® and Joint Commission measures. We aim for HEDIS® 90th percentile as a target, with partial points for 50th and 75th percentile. For Joint Commission measures, we use the Healthy People 2020 goal. Three (3) measures we focus on for OB care are frequency of ongoing prenatal care (FPC), prenatal and postpartum care (PPC), and the Joint Commission: C-section for nulliparous singleton term vertex (NSTV).

Our VBP programs are designed to reduce the number of preventable events in a member’s care. We have identified several clinical and efficiency measures that support and can be attributed to a reduction in preventable events. To ease the burden of providers participating in multiple VBP programs, we may align our metrics with existing state and MCO initiatives for potentially preventable events. Examples of VBP program metrics that target preventable events are outlined in **Exhibit C.9-23**.

Exhibit C.9-23: Potentially Preventable Event Measures

PCP Measures	Preventable Events
<ul style="list-style-type: none"> Follow-up visit made within seven (7) days following a post-acute stay Admission rate ED utilization rate Plan all-cause readmissions (adult & pediatrics) Ambulatory care sensitive ED rate (adult & pediatrics) Use of imaging studies for low back pain (adult only) Completion of screenings designed to identify members who need specific interventions such as the PHQ-9 for detection of depression in the primary care setting, or completion of the Edinburgh Depression Scale for women who are identified with postpartum depression 	<ul style="list-style-type: none"> All-cause readmission rate Risk-adjusted average length of stay Hospital-acquired conditions/infections Emergency to observation/inpatient escalation rate Radiology service utilization National Member Safety and National Quality Improvement goals HCAHPS Mortality rate for three (3) conditions present on admission indicators Admission notifications within twenty-four (24) hours

Analysis of these measurements is the basis for provider discussion and program planning. Passport's experience with VBP programs has informed our approach to analyzing performance against targets. We evaluate programs and provide feedback to participating providers every quarter. We have determined that a quarterly evaluation gives providers enough time to impact the metrics, while still providing us the opportunity to adjust program metrics or elements in partnership as needed.

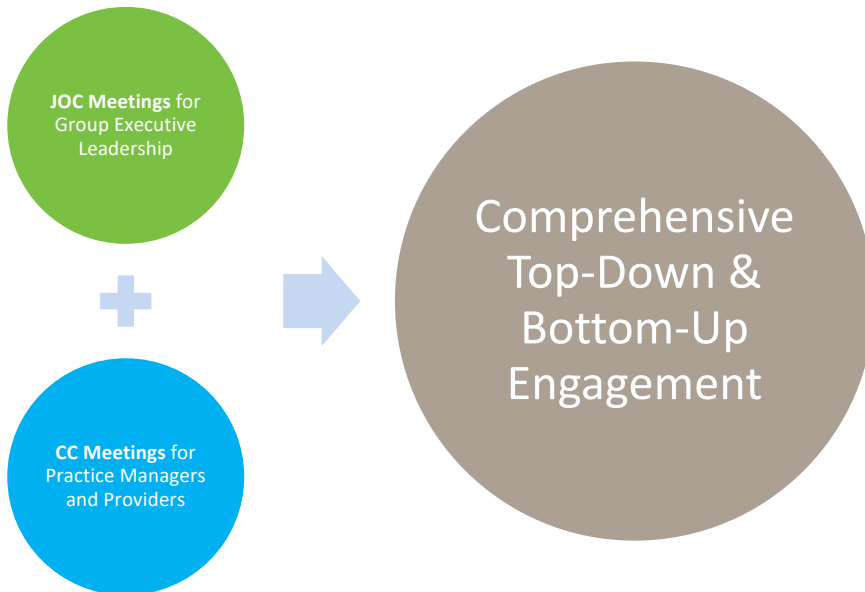
Passport takes a two-tiered approach to physician engagement and scorecard report distribution that offers a comprehensive top-down and bottom-up structure, as follows:

JOC Meetings: The purpose of the quarterly in-person JOC meeting is to work collaboratively with the provider organizations' executive leadership teams to discuss group-level program performance data and best practices that ultimately lead toward improved quality and satisfaction for members while reducing unnecessary expense. These meetings allow us to work with the practitioner group leadership to review interventions, measure result progress and jointly determine opportunities for improvement.

CC Meetings: The purpose of the monthly CC meeting is to engage organizations' key practice managers and providers, ensuring they understand the VBP program and have actionable information they can use to address member health opportunities. Passport's PHMs play a critical role in supporting practice-specific performance as SMEs around practice transformation and specifically clinical CM programs and VBP initiatives.

A significant focus of CCs goes beyond just the VBP metrics and elements; we also use the opportunity to provide feedback and information about broader HEDIS®, EPSDT, quality and clinical action items that we can work on together to benefit member health more broadly, as well improving relationships between Passport and its practitioner network. Passport has an extensive support team for its providers in addition to the PHMs, including CMO, medical directors, care managers, pharmacists, BH specialists, and community health workers. As data-driven opportunity areas necessitate, these SMEs will join JOCs and CC to help providers take concrete steps to improve member care while efficiently using resources. This unique, comprehensive support strategy fosters candid conversations and a shared commitment to improving member care.

Exhibit C.9-24: Passport’s Multifaceted Physician Engagement Strategy



C.9.k.iii. Methods for evaluating the effectiveness of VBP, including tracking of costs and improvement in health outcomes.

Passport has the technical capacity and engagement resources to continue to successfully administer APMs with providers. Passport deploys our organizational approach to quality, the PDSA cycle, to inform the structure and process of all monitoring and evaluation activities. This process is described in detail in **Section C.9.j.v**. We monitor and evaluate the performance in cost management and health outcomes of our VBP programs against targets or goals at least quarterly.

Effectiveness Through Lowering MER and Increasing Scorecard Performance

Our VBP program strategy is rooted in a top-down and bottom-up provider engagement strategy, so evaluating the engagement of our providers and their medical value performance and health outcomes is essential. We accomplish this through JOC meetings at the provider group leadership level and CC meetings at the practice level (see **Exhibit C.9-24**). Both meeting forums feature customized analytics, guidance, scorecard performance updates, discussion about metric performance related to outcomes, and training to help providers succeed in our VBP programs, as appropriate for the audience level. Passport adjusts the support at these engagement meetings per the unique needs of the provider groups and what they feel will be most useful to them.

Notably, every quarter we do a deep-dive Cost & Use Report analysis, focusing on the most significant areas of opportunity both in total medical costs and health outcomes with a key focus on opportunities to reduce unnecessary care or overutilization and requests for deeper dive areas from participating provider groups.

Our focus on total medical expenses beyond those directly linked to the VBP program metrics supports providers in their overall medical expense ratio (MER) performance, focusing on outcomes beyond just the incentive metrics, which contribute to overall shared savings.

We will also evaluate provider group performance against VBP program metric performance baseline and target thresholds, such as HEDIS 50th and 90th percentiles. Providers enhance their earning potential the closer they perform to the target threshold. If we identify a measure or group of measures that are not on track to meet our goal, we complete a root cause analysis, implement corrective actions, and then remeasure the next quarter.

Our big-picture MER and more granular metric performance analytical support help providers in generating shared savings while also keeping focus on member care and outcomes. For example, under the 2018 HealthPlus VBP program, **our participating providers generated \$6.7 million in shared savings**. Several **provider groups exceeded the minimum performance for the scorecard**, with one large provider group earning shared savings because they both lowered their MER by 2.9% and had a qualifying scorecard. We expect the number of providers receiving incentive payments to increase in 2020 with the addition of a third earning mechanism to reward just high scorecard performance.

Our BH VBP program with Seven Counties also demonstrated value through improvement in population health management. Passport observed material reductions in costly services, such as inpatient stays, ED utilization, and hospital readmissions, as outlined in **Exhibit C.9-20**.

Improving Health Outcomes Through Care Management

Passport also provides authorized providers access to our CM and reporting capabilities through our provider portal, Identifi Practice. This platform documents care gaps and coding accuracy opportunities on a member-by-member basis and enables providers to understand in near-real-time precisely how to close the care gap and thereby improve their performance metrics. Practitioner reports are available on Identifi Practice, and providers have the option to submit electronic authorizations via this portal. Passport will continue to work with our practitioners, especially with input from those that serve on the PCP Workgroup, to further develop and test efficiency enhancements to the tool. We will also pursue additional areas of collaboration with providers to achieve improvements in content and workflow and ease of use, such as the development of easy, single sign-on capabilities.

Our PHM and CM team also backs up the provider office to support individual care gap closure, actionable clinical guidance regarding member health and well-being, and VBP program arrangements and data results. Local medical directors and PHMs will work with physician offices to understand the practice's



**Providers are
in Our DNA**

opportunities and disseminate local and national best practice strategies to improve performance in the areas of care gap closure, identifying and confirming suspected diagnoses that will drive our risk stratification program, and engaging the most complex members. PHMs are critical assets to provider practices; they work together with physicians, care managers, and office staff to ensure that they have

access to complex member rosters and gaps-in-care reporting. They are a resource to the practice to enable it to fully utilize the Identifi Practice tools, analytics and reporting capabilities. PHMs are also unique to Passport as practice transformation and population health SMEs whose capabilities go beyond the typical knowledge and experience of traditional provider network representatives. They are deployed to all our VBP program partners and other vital network practitioners.

Program Effectiveness Through Participation Renewal and Growth

The ultimate marker of an effective VBP program is that, in addition to reducing costs and improving the quality of care, it also makes providers want to participate and remain in the program. Our provider-centric approach to program design gives our network a voice in the development and refinement processes, whether through formal Partnership Committee/PCP Workgroup sessions or survey feedback. We are committed to developing VBP programs that set up both Passport and the provider network for success.

The HealthPlus VBP program highlights program effectiveness in its evolution and growth. Not only did all provider groups that officially participated in the 2018 program renew their participation for the revised 2020 program, but three more groups also joined. Another example of successful provider engagement in Passport's VBP programs is the experience of Seven Counties. This provider group was willing to expand the number of BH VBP programs they were participating in and include an **innovative foster care pilot (see callout box below)**. Seven Counties' willingness to not only participate in two VBP programs but also to be a partner in developing a new program demonstrates the value Seven Counties sees in its relationship with Passport and the impact our programs have on member care.

QUALITY IMPROVEMENT IN ACTION:

Addressing Behavioral Health Needs of Foster Care Members

Define Problem Statement: Unaddressed behavioral health care needs of Foster Care members resulting in increased number of placements and poor outcomes.

Set Goals and Direction: The *Behavioral Health Advisory Committee (BHAC)* was tasked with evaluating and designing an evidence-based model of care to address the identified problem. The *QMAC* was consulted and *member feedback* was provided to help further define the problem with access to behavioral health services. Objectives of the program included maintaining foster care placement or children returned to their natural family, improve functioning on a standardized assessment, and implementing a VBP program

Plan, Align Resources, and Execute: The *Health Integration* and *Clinical Operations* teams at Passport identified 60 high-risk children between the ages of 4 and 17.5 years old who experienced 3 or more placements within 24 months and were at risk for entering a group home, psychiatric hospital or 24-hour behavioral health treatment facility. Through an iterative process with the *BHAC* and *QMMC*, the team incorporated feedback from BH providers to develop the Foster Care Pilot, with approval and oversight by the *QMMC* and *Partnership Council*. Pilot included:

- Team-based decision-making; including care manager, child welfare, therapists, and child/family.
- Monitoring system for high fidelity wraparound evidence-based practice.
- Alternative payment model case rate and performance incentives:

Analysis & Results: Data were collected between March 2015 and September 2017. Observed results include:

- Child and Adolescent Functional Assessment Scale (CAFAS) scores improved with longer lengths of service.
- 150% increase in children living with natural/adoptive family compared with six months pre-intervention

Continued Improvement Efforts: Upon analysis and experience, an adjustment was made to the sub-capitation rate. The analysis demonstrated that the initial rate was higher than needed and infrastructure had been developed reducing the overall cost of the program. Other identified challenges include the significant culture change required of team members to accommodate a model of care that promoted youth and family choice and voice.

C.9.1. Provide results of any provider satisfaction survey reflecting the Vendor’s performance in Kentucky or any other state Medicaid program over the last three (3) years. Where results identified provider dissatisfaction, describe strategies the Vendor has implemented to address improvement and examples of how those strategies have been effective.

Passport conducts provider satisfaction surveys annually using a third party. This survey meets or exceeds NCQA Standard QI4 (Member Experience) and QI5 (Continuity and Coordination of Medical Care) guidelines and targets providers to measure their satisfaction with Passport. **Exhibit C.9-25** highlights three provider satisfaction measures from 2017 to 2019. Within our Provider Relations and Quality Department planning, our use of annual practitioner satisfaction survey results includes, for example, the following:

- Determining how satisfied practitioners are on key drivers and opportunities

- Benchmarking performance against other MCOs, both Medicaid and Medicare, within Kentucky and nationally
- Identifying actionable information to drive improvements
- Creating a culture of high practitioner satisfaction and member quality of care

Exhibit C.9-25: Three (3) Year Summary of Selected Provider Satisfaction Measures

Measure	2017	2018	2019
Overall Satisfaction	70.10%	67.5%	71.40%
Loyalty	32.3%	64.6%	70.7%
Recommend Passport to Other Physician Practices	82.00%	80.10%	81.20%

The following is a summary of our performance:

- The Overall Satisfaction score has improved, based on 2019 results, to 71.40%. Over the past several years, Passport has undergone an essential transformation to improve technology capabilities and build a sustainable long-term infrastructure. We experienced a decrease in performance during this time of change.
- Loyalty scores have steadily increased, with our most recent 2019 score of 70.7% trending well above our 2017 score of 32.3%. Loyalty is calculated as the percentage of respondents who answered “Yes” to Recommend Passport to Other Physicians Practices **and** rated Overall Satisfaction with Health Plan as “Completely Satisfied” or “Somewhat Satisfied.”
- Overall score on “Would you recommend Passport Health Plan to other physician practices?” was rated as 81.2% in 2019.
- Over the years, Passport has bolstered its provider network impact by maintaining consistent and regular practitioner collaboration visits from its PR teams, addressing provider shortage gaps, enhancing payment rates, building trusted relationships, providing regular communication, and working with our large-volume and key-provider network partners around VBP and capitation arrangements, along with focusing on developing actionable member-practitioner analyses **to benefit provider efficiency and member quality of care.**



Our three (3) year provider satisfaction survey results can be seen in Attachment C.9-5_Passport Health Plan 2019 Provider Satisfaction Survey Results.

In keeping with **our Culture of Quality and our commitment to continually improving our service** to members and providers, Passport’s Provider Relations team reviewed survey results for 2019 with the various functional departments in January of 2020. We identified process gaps that we felt impacted provider satisfaction results and created targeted action plans for follow-up from each of the key service areas that interact with our practitioner network in our comprehensive practitioner engagement process. We will continue to send our practitioner surveys annually during August-October. Our QMMC will review survey results and action plans across all departments. Our provider-driven Partnership



Council and the Board of Directors will also carefully review the results and action plans.

Our provider survey results reveal strengths as well as areas for improvement. We have organized the results into key drivers and opportunities for internal service departments to focus on in 2020. Key drivers of provider satisfaction include the following:

- Resolution of claims payment or disputes (Claims)
- Accuracy of claims processing (Claims)
- Consistency of reimbursement fees with contract rates (Claims)
- Access to case/care managers from this health plan (UM, Clinical)
- Access to knowledgeable UM staff (UM)
- Timeliness of claims processing (Claims)
- Overall satisfaction with the health plan's call center (Call Center).

Financial, utilization, and quality management are highly correlated to provider satisfaction. Improvement in these areas **is a top priority for Passport**. The following subsections discuss how Passport has implemented strategies to improve provider satisfaction.

Strategies Implemented to Address Opportunities

Claims

Passport had maintained consistent, accurate reimbursement based on the contractual rates for the providers, except for 2018, when it was briefly hindered as a result of system migrations. During 2018, Passport's Claims team and the Contracting team invested significant efforts to make corrections and reduce turnaround times for corrections. The team created a cross-functional tracking process that allowed for real-time updates that could be shared with providers. They also engaged and collaborated with providers in meetings with claims SMEs to ensure that all parties had a full understanding of the issues and concerns. The team increased their audits to ensure we captured the issues, quantified and analyzed those issues expeditiously, and worked with the technical team to prioritize and solve the highest-volume issues in terms of both dollars and quantity. We introduced automation to reduce the cycle time and added trained resources to provide assistance. The Claims team also used "lean" process improvement practices to conduct full root-cause analyses and correct issues at the source, thereby resolving them fully. As the team made changes, they updated the documentation and trained our staff to ensure consistent and accurate processing.

In 2019, our average time to pay Medical claims was 6.5 days, which is reflected in our higher percentage of claims paid within thirty (30) days over the past calendar year (although still meeting state requirements). Our average of 6.5 days to pay during 2019 marks a 50% reduction in time to pay from the 2018 average.

Utilization Management

Another opportunity we identified was to ensure timely access to knowledgeable UM staff and employ collaborative procedures for prior authorizations. This opportunity became a key focus area related to

provider satisfaction for our UM Department. The UM team has undertaken direct efforts to improve satisfaction in these areas, investing time and effort in educating staff to encourage and cover preventive care.

The UM team has a dedicated trainer who provides education to all stakeholders. During 2018, the UM Department hosted seven educational forums that assisted all Passport associates in managing the population we serve. The forums were hosted by SMEs and were evaluated afterwards by the Passport associates in attendance. The seven educational forums were as follows:

- InterQual® *and* InterQual® Clinical Instructor (IQCI) Train the Trainer
- New Health Plan Training, including Appeals Training
- Documentation, NCQA, IPRO Training
- Identifi (Claims System) *and* DRG Calculator
- CCSI Portal Training



Through efforts such as these forums, the UM Department has enhanced relationships with providers, and is available to assist providers with any issues that may arise.

In 2017 we experienced a significant reduction in satisfaction related to access to knowledgeable staff. Following a root cause analysis, we determined there was a need to change the way we approached staff training; we therefore dedicated a trainer to periodic training. Early in 2019, we enhanced our staff training with the inclusion of internal SMEs who develop specific content to educate and provide ongoing support to the UM team. In 2019 we demonstrated a 4.1% improvement in provider satisfaction with access to knowledgeable staff.

Clinical

Facilitation and support of appropriate clinical care and access to case/care managers are critical elements of our partnership with the practitioner network to better manage the health needs of members. Member engagement in CM programs to help them self-manage their conditions has increased by fifty-one percent (51%) since 2017. Another strategy to enhance facilitation and support of clinical care is enhancing the Remote Care Monitoring (RCM) program. This program enables remote monitoring of members inside the home, which increases access to care for high-risk members. RCM teaches members to identify and manage their symptoms and gathers member-generated health data to share with case/care managers and health care professionals who may make appropriate care interventions when needed.

Passport worked directly with provider groups to raise awareness of the CM programs available to their members. This increased the number and engagement of members who participate in CM programs, as well as improving provider communication. One current area of focus is childhood obesity, with a recent increase in referrals for CM from providers. The team has had focused conversations with providers about helping families make changes to improve children's nutrition and overall health.

Call Center

Ease of reaching call center staff over the phone is another opportunity; we recognized this as a key contact relationship with our providers and an important determinant of satisfaction with our plan. We implemented a variety of corrective actions to improve practitioner satisfaction, including the following:

- Providing additional call center staffing and training staff to handle calls in a more efficient and consistent manner
- Working with practitioner offices to supply specific information in a more efficient manner
- Updating our practitioner queue management system to more efficiently route calls to cross-trained staff who could assist with specific questions
- Working with high-call-volume practitioners to understand their call triggers so we could be proactive in resolving issues and updating our guides
- Implementing several IVR enhancements (in 2018) so that practitioners no longer need to navigate through unnecessary call prompts

As a result of these and other changes, the current average speed of answer (ASA) is under thirty (30) seconds and provider satisfaction has improved. Scores related to the accuracy of member information have also improved. We have also made system and process improvements to support timely eligibility verification. Scores related to the helpfulness of call center staff in obtaining referrals for members in the provider's care improved. In addition, through the adoption of EMR systems, providers now submit referral information on the CMS 1500 claims form, which they find far more efficient. Passport is committed to making changes whenever necessary to address issues and concerns quickly.

Overall, in the areas identified for improvement, we demonstrated notable progress that we believe will be reflected in our 2020 satisfaction survey results.

CONCLUSION

Passport is firmly committed to DMS' goal of significantly improving the quality of care and health care outcomes, and of reducing or eliminating health disparities. This focus aligns with our commitment to the Passport promise: To Help Improve the Health and Quality of Life of Our Members.

Our provider-driven governance model orients our focus on quality and whole-person care because our provider-sponsor stakeholders do not just provide input—they hold critical responsibility and approval-level oversight through the QMMC, the Partnership

Council, and the Board of Directors. With their oversight, Passport pursues a fully integrated approach to whole-person care across medical, behavioral, pharmacy, dental and vision. This same committee structure takes full accountability for quality and outcomes across the entire service spectrum, including the provider network, Passport, and all of our subcontractors. Overall, Passport's collaborative and robust connection to providers and the provider perspective helps to enhance the quality of care, improve access to primary



health care services, drive efficiency, and reduce physician abrasion, which positions Passport well to continue serving the Commonwealth.

Passport has been honored to serve the Kentucky Medicaid and foster care populations for 22 years and will continue to comply with all provisions of the Medicaid Managed Care Contract and Appendices (including Kentucky SKY) as we continue to serve them in the future.